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

In the Matter of the Accusation Against: Joel Ivan Sarachek, M.D. Physician's and Surgeon's Certificate No. G 78560 Respondent.	Case No.: 800-2020-068032

DECISION

The attached Stipulated Settlement and Disciplinary 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 August 1, 2024.

IT IS SO ORDERED: July 2, 2024.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, Chair
Panel B

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
CHRISTINA SEIN GOOT
Deputy Attorney General
State Bar No. 229094
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6481
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOEL IVAN SARACHEK, M.D.** **2701 Ocean Park Blvd., Suite 118** **Santa Monica, CA 90405** **Physician's and Surgeon's Certificate No. G 78560,** Respondent.	Case No. 800-2020-068032 OAH No. 2023100347 **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 Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Christina Sein Goot, Deputy Attorney General.

2. Respondent Joel Ivan Sarachek, M.D. (Respondent) is represented in this proceeding by attorney Rae Lamothe, whose address is: 323 Pershing Drive, Playa Del Rey, CA 90293-7739.

3. On or about March 23, 1994, the Board issued Physician's and Surgeon's Certificate No. G 78560 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. 800-2020-068032, and will expire on August 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2020-068032 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 April 28, 2023. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2020-068032 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2020-068032. Respondent has also carefully read, fully discussed with his counsel, and 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.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2020-068032, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent hereby gives up his right to contest those charges and allegation.

10. Respondent agrees that, at an administrative hearing, Complainant could establish a

prima facie case with respect to the charges and allegations contained in Accusation No. 800-2020-068032 and that he has thereby subjected his license to disciplinary action.

11. ACKNOWLEDGMENT. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

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

CONTINGENCY

13. 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.

14. 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. 800-2020-068032 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.

15. 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 agreement of the parties in this above-entitled matter.

16. The parties understand and agree that Portable Document Format (PDF) and facsimile

copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 78560 issued to Respondent Joel Ivan Sarachek, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. PATIENT DISCLOSURE. Before a patient's first visit following the effective date of this order and while the Respondent is on probation, the Respondent must provide all patients, or patient's guardian or health care surrogate, with a separate disclosure that includes the Respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on the Respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the Respondent's probation on the Respondent's profile page on the board's website. Respondent shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent shall not be required to provide a disclosure if any of the following applies: (1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the patient until immediately prior to the start of the visit; (4) Respondent does not have a direct treatment relationship with the patient.

2. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any opioid medications, with the exception of naloxone hydrochloride, until Respondent has successfully satisfied both Condition No. 5 (Prescribing Practices Course) and Condition No. 7 (Clinical Competence Assessment

Program) of his probation as set forth herein, and has been so notified by the Board or its designee in writing of his successful satisfaction of each of Condition No. 5 (Prescribing Practices Course) and Condition No. 7 (Clinical Competence Assessment Program).

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

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

and 4) the indications and diagnosis for which the controlled substances were furnished.

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

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

5. 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.

6. 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.

7. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation

Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation as determined by the program for the assessment and clinical education and evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

8. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose

licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

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

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

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent

shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

10. 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.

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

12. 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.

13. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement in the amount of $60,000 (sixty thousand dollars and zero cents). 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.

14. 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.

15. 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.

16. 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.

17. 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; Abstain from the Use of Alcohol and/or

Controlled Substances; and Biological Fluid Testing..

18. 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.

19. 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.

20. 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.

21. 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.

22. 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. 800-2020-068032 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, Rae Lamothe. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4/23/24

JOEL IVAN SARACHEK, M.D.
Respondent

I have read and fully discussed with Respondent Joel Ivan Sarachek, 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: 4/24/24

RAE LAMOTHE
Attorney for Respondent

[Endorsement on following page]

ENDORSEMENT

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

DATED: 4/24/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General

CHRISTINA SEIN GOOT
Deputy Attorney General
Attorneys for Complainant

LA2022603437
66739950.docx

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
State Bar No. 195729
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6000
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOEL IVAN SARACHEK, M.D.** **St. Johns Physician Partners** **2701 Ocean Park Blvd., Suite 118** **Santa Monica, CA 90405** **Physician's and Surgeon's** **Certificate No. G 78560,** Respondent.	Case No. 800-2020-068032 **A C C U S A T I O N**

PARTIES

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

2. On or about March 23, 1994, the Board issued Physician's and Surgeon's Certificate Number G 78560 to Joel Ivan Sarachek, 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 August 31, 2023, 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 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:
>
> (a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.
>
> (b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.
>
> (c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

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

STATUTORY PROVISIONS

6. 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.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. 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.

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

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

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

. . .

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

. . .

9. Section 2238 of the Code states:

A violation of any federal statute or federal regulation or any of the statutes or

regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

10. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d)(1) For purposes of this section and Section 2241.5, addict means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

11. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a

questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

12. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

13. Section 741 of the Code states:

(a) Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed within a year from the date a prescription for benzodiazepine has been dispensed to the patient.

(C) The patient presents with an increased risk for opioid overdose, including a patient with a history of opioid overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to the patient on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression.

(3) Consistent with the existing standard of care, provide education on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

(b) A prescriber is not required to provide the education specified in paragraphs (2) or (3) of subdivision (a) if the patient receiving the prescription declines the education or has received the education within the past 24 months.

(c) This section does not apply to a prescriber under any of the following circumstances:

(1) When prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.

(2) When ordering medications to be administered to a patient while the patient is in either an inpatient or outpatient setting.

(3) When prescribing medications to a patient who is terminally ill, as defined in subdivision (c) of Section 11159.2 of the Health and Safety Code.

14. Health and Safety Code § 11165.4 states:

(a)(1)(A)(i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III,

or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, first time means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a

nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as

described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

COST RECOVERY

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DEFINITIONS

16. As used herein, the terms below will have the following meanings:

"Acetaminophen" is a widely used over-the-counter analgesic (pain reliever) and antipyretic (fever reducer). It is also known as paracetamol, or APAP. It is typically used for mild to moderate pain relief, such as relief of headaches. It is a major ingredient in numerous cold and flu remedies. In combination with opioid analgesics, paracetamol can also be used in the management of more severe pain such as post-surgical pain and providing palliative care in advanced cancer patients. Acute overdoses of paracetamol can cause potentially fatal liver damage and, in rare individuals, a normal dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including under the brand name Tylenol®.

"Adderall®" is a brand name for a combination medication used to treat attention deficit hyperactivity disorder (ADHD) which contains mixed amphetamine salts, including four salts of amphetamine. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11055(d), and a dangerous drug as defined in Code section 4022.

"Ambien®" is a brand name for zolpidem, which is a sedative drug primarily used to treat insomnia. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand names Ambien® and Intermezzo®. It is a Schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Code section 4022.

"Amphetamine" is a strong central nervous system stimulant that is used in the treatment of attention deficit hyperactivity disorder, narcolepsy, and obesity. It is also commonly used as a recreational drug. It is a dangerous drug as defined in Code section 4022. It is a Schedule II controlled substance, as designated by Health and Safety Code section 11055, subdivision (d)(1).

"Ativan®" is a brand name for lorazepam, a benzodiazepine and anxiolytic. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"Benzodiazepines" are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses, and are used for a limited time period. Benzodiazepines are commonly misused and taken in combination with other drugs of abuse. Commonly prescribed benzodiazepines include alprazolam (Xanax®), lorazepam (Ativan®), clonazepam (Klonopin®), diazepam (Valium®), and temazepam (Restoril®). Risks associated with use of benzodiazepines include: 1) tolerance and dependence, 2) potential interactions with alcohol and pain medications, and 3) possible impairment of driving. Benzodiazepines can cause dangerous deep unconsciousness. When combined with other CNS depressants such as alcoholic drinks and opioids, the potential for toxicity and fatal overdose increases. Before initiating a course of treatment, patients should be explicitly advised about the following: the goal and duration of benzodiazepine use; its risks and side effects, including risk of dependence and respiratory depression; and alternative treatment options.

"Carisoprodol" is a muscle-relaxant and sedative. It is sold under the brand name "Soma®." It is a Schedule IV controlled substance pursuant to the federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"Clonazepam" is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is sold under the brand name Klonopin®. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Code section 4022.

"Controlled substance agreement" or pain management agreement is agreement which outlines the joint responsibilities of the physician and patient and should include: the doctor's policies and expectations regarding the number and frequency of refills of prescriptions and replacement of lost or stolen medications; specific reasons why drug therapy may be changed or discontinued; and the patient's responsibility for safe use; and the patient's agreement to share information with family or close contacts about addressing overdose, to only obtain drugs from the contracting doctor,

and to undergo drug testing.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Diazepam" is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It can produce psychological and physical dependence and should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence. It is sold under the brand name Valium®. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1), and is a dangerous drug as designated in Health and Safety Code section 4022.

"Dilaudid®" is a brand name for hydromorphone, an opioid pain medication used to treat moderate to severe pain. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug as designated in Health and Safety Code section 4022.

"Fentanyl" is a potent, synthetic narcotic opioid analgesic with a rapid onset and short duration of action. It is sold in its various forms under the brand names Duragesic®, Subsys®, Ionsys® among others. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug pursuant to Code section 4022.

"Hydrocodone" is a semisynthetic opioid analgesic similar to but more potent than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin®, Hycodan® (or generically Hydromet®), Lorcet®, Lortab®, Norco®, and Hydrokon®, among others). Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Hydromorphone" is an opioid pain medication used to treat moderate to severe pain. It has been marketed, in its varying forms, under a number of brand names, including Dilaudid®. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Code section 4022.

"Klonopin®" is a brand name for clonazepam.

"Lorazepam" is a benzodiazepine medication. It is used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy induced nausea and vomiting, as well as for surgery to interfere with memory formation and to sedate those who are being mechanically ventilated. It is sold under the brand name Ativan® among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,

subdivision (d)(16), and a dangerous drug pursuant to Code section 4022.

"MME" means morphine milligram equivalents, which is an opioid dosage's equivalency to morphine. The MME/day metric is often used as a gauge of the overdose potential of the amount of opioid that is being given at a particular time. Calculating the total daily dosage of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose. In the *Guidelines for Prescribing Controlled Substances For Pain,* November 2014 (p. 14) the Board recommended caution (yellow flag warning) once the morphine equivalent dose reaches 80 mg per day. In 2016, the American Society of Addiction Medicine (ASAM) in their *Public Policy Statement on Morphine Equivalent Units/ Morphine Milligram Equivalents* stated, that clinicians "should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to over 50 MME per day, and should avoid increasing dosage to greater than 90 MME per day or carefully justify a decision to titrate dosage to greater than 90 MME per day." (ASAM. 2016. p. 1), www.asam.org. Additionally, Centers for Disease Control and Prevention (CDC) guidelines of 2016, indicate dose greater than 50 MME places the patient at higher risk of negative outcomes. In 2017, the Veteran's Administration guidelines state greater than 20 MME can lead to negative outcomes.

"Morphine" is an analgesic and narcotic drug obtained from opium and used medicinally to relieve moderate to severe pain. It can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration. Abrupt cessation or a sudden reduction in dose after prolonged use may result in withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must be undertaken gradually. It is sold in its various forms under the brand names Kadian®, Morphabond®, MS Contin®, Oramorph SR®, and Roxanol® among others. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug as designated in Health and Safety Code section 4022.

"MS Contin®" is a brand name for a form of morphine.

"Norco®" is a brand name for a combination medication that contains oxycodone and acetaminophen. This combination of hydrocodone and acetaminophen is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerate. Other brand names for this combination of drugs include Hycet®, Lorcet®, Lortab®, Maxidone®, Vicodin®, Zamicet® and Zydone®.

"NSAID" means nonsteroidal anti-inflammatory drug. NSAIDs are members of a drug class that reduces pain, decreases fever, prevents blood clots, and in higher doses, decreases inflammation. Side effects depend on the specific drug but largely include an increased risk of gastrointestinal ulcers and bleeds, heart attack, and kidney disease. NSAIDs are good at treating pain caused by slow tissue damage, such as arthritis pain. NSAIDs also work well fighting back pain, menstrual cramps and headaches. NSAIDs work like corticosteroids (also called steroids), without many of the side effects of steroids. NSAIDs are sold in various forms under the brand names aspirin (Bayer®, St. Joseph® Anacin®, Ascriptin®, Bufferin®, and Excedrin®), ibuprofen (Motrin® and Advil®), and naproxen (Aleve® and Naprosyn®).

"Oxycodone" is an opioid analgesic medication that has a high potential for

abuse. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand name, including OxyContin® (a time-release formula) and Roxicodone®. Oxycodone is also available in combination with other drugs and sold under brand names including, acetaminophen (Endocet®, Percocet®, Roxicet®, and Tylox® among others); aspirin (Endodan®, Percodan® and Roxiprin® among others); and ibuprofen (Combunox®). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Code section 4022.

"Percocet®" is a brand name for a combination medication that contains oxycodone and acetaminophen that is used to help relieve moderate to severe pain.

"Prozac®" is a brand name for fluoxetine, a medication used to treat depression, obsessive-compulsive disorder (OCD), bulimia nervosa, and panic disorder. It belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It is dangerous drug as defined in Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. It is a centrally-acting opioid agonist and SNRI (serotonin/norepinephrine reuptake inhibitor). Tramadol is sold under various brand names, including Ultram® and ConZip®. It is a Schedule IV controlled substance pursuant to the federal Controlled Substances Act, and a dangerous drug pursuant to Code section 4022.

"Valium®" is a brand name for diazepam.

"Vicodin®" is a brand name for a combinations drug, namely, hydrocodone/paracetamol, also known as hydrocodone/acetaminophen or hydrocodone/APAP.

"Zolpidem" is a sedative drug primarily used to treat insomnia. It has a short half-life. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is sold under the brand names Ambien® and Intermezzo®. It is a Schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32) and a dangerous drug pursuant to Code section 4022.

FACTUAL ALLEGATIONS

17. The Board received an 805 report from UCLA Health.[1] The report indicated that Respondent had excessively prescribed narcotics to patients.

18. On or about April 4, 2022, an investigator and medical consultant with the Department of Consumer Affairs' Division of Investigation's Health Quality Investigations Unit ("HQIU") interviewed ("Subject Interview") Respondent on behalf of the Board. During his Subject Interview, Respondent alleged that his goals for his patients were to reduce their pain and improve their function. He further stated that in or around 2013, neither he, nor his colleagues

[1] UCLA Health is a health system which comprises a number of hospitals, the David Geffen School of Medicine at UCLA (University of California Los Angeles) and an extensive primary care network in the Los Angeles region.

monitored compliance of their patients regarding their controlled substance prescribing, but that over time, this practice changed. When asked by the medical consultant whether he reviewed CURES, Respondent stated that he rarely reviewed CURES prior to October 2018, but thereafter he did so regularly. However, the medical records for Patients A, B, C, D and E do not contain evidence of adequate review of CURES data by Respondent, if any. Respondent also stated that he retired from UCLA Health after he was placed on investigatory leave there, which occurred on or about June 1, 2020.

Patient A[2]

19. Respondent saw and treated Patient A for several years (multiple times a year), including from on or about June 12, 2013 through at least in or around July 2020. During that time period, Respondent continuously prescribed controlled substances to Patient A in a negligent manner. On or about June 12, 2013, Patient A was a 56-year-old male, who presented to Respondent with chronic back pain, which worsened at that time due to straining it the prior week. Respondent stated that Patient A's knee is much better with minimal pain since an injection the previous week. In his assessment and plan, Respondent stated that Patient A had back pain, hypertension, and lumbar disk disease, and was noted to be taking a high blood pressure medication and hydrocodone (5/500). Respondent continued to see Patient A regularly thereafter, and in or around June 2016, Respondent provided steroid injections into Patient A.

20. From in or around June 2016 through in or around June 2020 (Patient A Treatment Period), Respondent continued to regularly see and treat Patient A, including for injections for pain. During the Patient A Treatment Period, Respondent continued to prescribe controlled substances to Patient A, including on or about the following dates:

Date Filled by Patient A	Controlled Substance Prescribed
October 10, 2017	Oxycodone/APAP
October 17, 2017	Oxycodone/APAP
October 21, 2017	Oxycodone/APAP
November 16, 2017	Oxycodone/APAP

[2] The patients are designated by letters to address privacy concerns. The identities of the patients are known to Respondent.

Date Filled by Patient A	Controlled Substance Prescribed
November 22, 2017	Oxycodone/APAP
December 4, 2017	Oxycodone/APAP
January 12, 2018	Oxycodone/APAP
January 19, 2018	Oxycodone/APAP
January 29, 2018	Oxycodone/APAP
February 5, 2018	Oxycodone/APAP
February 12, 2018	Oxycodone/APAP
February 20, 2018	Oxycodone/APAP
February 26, 2018	Oxycodone/APAP
March 5, 2018	Oxycodone/APAP
March 16, 2018	Oxycodone/APAP
April 3, 2018	Oxycodone/APAP
April 16, 2018	Oxycodone/APAP
April 27, 2018	Oxycodone/APAP
May 11, 2018	Oxycodone/APAP
May 18, 2018	Oxycodone/APAP
May 20, 2018	Oxycodone/APAP
June 1, 2018	Oxycodone/APAP
June 7, 2018	Oxycodone/APAP
June 14, 2018	Oxycodone/APAP
June 21, 2018	Oxycodone/APAP
June 29, 2018	Oxycodone/APAP
July 5, 2018	Oxycodone/APAP
July 17, 2018	Oxycodone/APAP
July 23, 2018	Oxycodone/APAP
July 27, 2018	Oxycodone/APAP
August 14, 2018	Oxycodone/APAP
August 27, 2018	Oxycodone/APAP
August 30, 2018	Oxycodone/APAP
September 6, 2018	Oxycodone/APAP
September 13, 2018	Oxycodone/APAP
September 20, 2018	Oxycodone/APAP

Date Filled by Patient A	Controlled Substance Prescribed
September 26, 2018	Oxycodone/APAP
October 1, 2018	Oxycodone/APAP
October 8, 2018	Oxycodone/APAP
October 15, 2018	Oxycodone/APAP
October 22, 2018	Oxycodone/APAP
October 29, 2018	Oxycodone/APAP
November 5, 2018	Oxycodone/APAP
November 9, 2018	Oxycodone/APAP
November 14, 2018	Oxycodone/APAP
November 19, 2018	Oxycodone/APAP
November 26, 2018	Oxycodone/APAP
December 3, 2018	Oxycodone/APAP
December 10, 2018	Oxycodone/APAP
December 17, 2018	Oxycodone/APAP
December 24, 2018	Oxycodone/APAP
January 8, 2019	Oxycodone/APAP
January 14, 2019	Oxycodone/APAP
January 20, 2019	Oxycodone/APAP
January 26, 2019	Oxycodone/APAP
February 4, 2019	Oxycodone/APAP
February 12, 2019	Oxycodone/APAP
February 19, 2019	Oxycodone/APAP
February 27, 2019	Oxycodone/APAP
March 4, 2019	Oxycodone/APAP
March 10, 2019	Oxycodone/APAP
March 16, 2019	Oxycodone/APAP
March 24, 2019	Oxycodone/APAP
March 25, 2019	Tramadol
March 31, 2019	Oxycodone/APAP
April 6, 2019	Oxycodone/APAP
April 12, 2019	Oxycodone/APAP
April 16, 2019	Tramadol

Date Filled by Patient A	Controlled Substance Prescribed
April 23, 2019	Tramadol
April 27, 2019	Oxycodone/APAP
May 4, 2019	Oxycodone/APAP
May 6, 2019	Tramadol
May 10, 2019	Oxycodone/APAP
May 11, 2019	Tramadol
May 15, 2019	Oxycodone/APAP
May 21, 2019	Tramadol
May 23, 2019	Oxycodone/APAP
May 28, 2019	Tramadol
May 29, 2019	Oxycodone/APAP
June 6, 2019	Tramadol
June 10, 2019	Oxycodone/APAP
June 11, 2019	Tramadol
June 17, 2019	Tramadol
June 19, 2019	Oxycodone/APAP
June 24, 2019	Oxycodone/APAP
June 25, 2019	Tramadol
July 1, 2019	Oxycodone/APAP
July 9, 2019	Tramadol
July 11, 2019	Oxycodone/APAP
July 15, 2019	Oxycodone/APAP
July 16, 2019	Tramadol
July 19, 2019	Oxycodone/APAP
July 22, 2019	Tramadol
July 23, 2019	Oxycodone/APAP
July 30, 2019	Oxycodone/APAP
August 1, 2019	Tramadol
August 12, 2019	Oxycodone/APAP
August 13, 2019	Tramadol
August 18, 2019	Oxycodone/APAP
August 19, 2019	Tramadol

Date Filled by Patient A	Controlled Substance Prescribed
August 22, 2019	Oxycodone/APAP
August 26, 2019	Tramadol
August 30, 2019	Oxycodone/APAP
September 4, 2019	Oxycodone/APAP
September 5, 2019	Tramadol
September 10, 2019	Oxycodone/APAP
September 14, 2010	Tramadol
September 17, 2019	Oxycodone/APAP
September 23, 2019	Tramadol
September 25, 2019	Oxycodone/APAP
October 4, 2019	Oxycodone/APAP
October 4, 2019	Tramadol
October 11, 2019	Oxycodone/APAP
October 12, 2019	Tramadol
October 18, 2019	Oxycodone/APAP
October 21, 2019	Tramadol
October 25, 2019	Oxycodone/APAP
October 29, 2019	Tramadol
November 1, 2019	Oxycodone/APAP
November 7, 2019	Tramadol
November 8, 2019	Oxycodone/APAP
November 15, 2019	Oxycodone/APAP
November 17, 2019	Tramadol
November 21, 2019	Tramadol
November 23, 2019	Oxycodone/APAP
November 29, 2019	Oxycodone/APAP
December 7, 2019	Oxycodone/APAP
December 14, 2019	Oxycodone/APAP
December 16, 2019	Tramadol
December 20, 2019	Oxycodone/APAP
December 26, 2019	Tramadol
December 27, 2019	Oxycodone/APAP

Date Filled by Patient A	Controlled Substance Prescribed
January 3, 2020	Oxycodone/APAP
January 4, 2020	Tramadol
January 13, 2020	Oxycodone/APAP
January 15, 2020	Tramadol
January 21, 2020	Oxycodone/APAP
January 24, 2020	Tramadol
January 31, 2020	Oxycodone/APAP
February 3, 2020	Tramadol
February 12, 2020	Oxycodone/APAP
February 12, 2020	Tramadol
February 19, 2020	Oxycodone/APAP
February 28, 2020	Oxycodone/APAP
March 2, 2020	Tramadol
March 7, 2020	Oxycodone/APAP
March 10, 2020	Tramadol
March 13, 2020	Oxycodone/APAP
March 16, 2020	Oxycodone/APAP
March 18, 2020	Tramadol
March 22, 2020	Oxycodone/APAP
March 25, 2020	Tramadol
March 31, 2020	Oxycodone/APAP
April 8, 2020	Oxycodone/APAP
April 14 2020	Tramadol
April 16, 2020	Oxycodone/APAP
April 25, 2020	Oxycodone/APAP
April 27, 2020	Tramadol
May 3, 2020	Oxycodone/APAP
May 9, 2020	Tramadol
May 11, 2020	Oxycodone/APAP
May 18, 2020	Oxycodone/APAP
May 27, 2020	Oxycodone/APAP
May 29, 2020	Tramadol

Date Filled by Patient A	Controlled Substance Prescribed
June 15, 2020	Tramadol

21. During the Patient A Treatment Period, Respondent continued to prescribe controlled substances to Patient A, including opioids, primarily oxycodone (and/or Percocet®), and the following patient encounters were documented in Patient A's chart on or about each of the following dates:

- August 26, 2016 (patient seen for knee pain and received injections from Respondent);
- October 25, 2016 (patient complained of back pain);
- November 18, 2016 (annual visit);
- January 11, 2017 (patient complained about chest pain);
- March 16, 2017 (patient stated that he has cut out sweets and stated he had, "a lot at AA meetings.");
- April 5, 2017 (patient complained of ear pain);
- May 30, 2017 (patient complained of knee pain and face itching from medication);
- July 26, 2017 (post-op from total knee replacement surgery);
- October 10, 2017 (patient complains of knee pain and Respondent continued Patient A's prescription for oxycodone which was started by another provider/doctor on or about August 7, 2017);
- October 18, 2017;
- November 16, 2017;
- November 22, 2017 (Respondent noted at this visit that the patient was taking Percocet® "doled out by his brother");
- December 4, 2017 (Respondent noted at this visit that the patient used his 20 oxycodone and would like more);
- January 12, 2018;
- January 19, 2018;
- February 5, 2018;
- March 5, 2018 (Respondent notes that patient needs a refill of Percocet® and the patient has his brother hold and give them to him);

- May 18, 2018[3] (patient reported taking two Percocet® daily and Respondent prescribes oxycodone three days early);

- September 26, 2018;

- October 1, 2018 (prescribed eight oxycodone per day; patient used 25 Percocet®);

- October 8, 2018 (Respondent noted that the patient had a family history of drug abuse and needs "Norco" refill and had been prescribed tramadol recently by another doctor);[4]

- March 25, 2019 (Respondent increases the patient's prescription for tramadol to 50 mg and the patient fills a prescription for oxycodone on March 24, 2019);[5]

- May 14, 2019 (Respondent noted that the patient was using more Norco® than normal);

- May 15, 2019 (patient called stating the pharmacy was out of hydrocodone "until Friday" and requested 15 oxycodone; he receives a prescription for 50 oxycodone, 10mg);

- June 24, 2019 ("early refill due to travel;" however, patient received another prescription for 56 oxycodone pills from a different provider on or about June 21, 2019);

- July 1, 2019 (approval; he was out of medication early);[6]

- September 10, 2019,

- December 20, 2019 (pharmacy will not dispense oxycodone until December 21, 2019; patient wants to leave town and needs drugs now, Respondent writes, "Done" and prescription is filled);

- December 26, 2019;

- February 12, 2020;

- February 19, 2020 (Respondent diagnoses the patient with opioid abuse, a drug screen dated February 12, 2020 is positive for opiates and oxycodone);

- February 28, 2020;[7]

---

[3] On or about March 29, 2018 another doctor refused to fill a prescription for oxycodone for the patient. In a note dated July 23, 2018, Respondent wrote that the patient is taking four pills per day; the patient also alleged that he was out of pills.

[4] In a note dated January 4, 2019, another doctor notes Respondent's absence and inquires about data in a CURES report that indicates that the patient received several refills for Percocet over a two to three week period; and that the patient was requesting yet another 50 tablets of Percocet®; another note dated January 7, 2019 states that there was no reply; a message is left with Respondent for his review and decision.

[5] In a note dated April 19, 2019, another doctor indicates that Respondent is out of the office and that the patient's refill is too early – the patient had already filled 20 pills for tramadol on April 16, 2019 and 50 pills of oxycodone on April 12, 2019.

[6] In a note dated August 9, 2019, another doctor indicates that Respondent is out of the office and that the patient is too soon for a refill – the patient had already filled 40 pills for tramadol on August 1, 2019 and 25 pills of Percocet® on August 5, 2019.

[7] In a note dated March 9, 2020, the front desk states that the pharmacy will not refill the tramadol early without approval.

- March 16, 2020;

- April 16, 2020 (patient is traveling to see brother and requests early refill; Respondent fills oxycodone prescription early);

- May 18, 2020 (front desk notes that patient requests early refill and Respondent authorizes early prescription for oxycodone).

- Thereafter in or around July 2020, telephone encounter notes indicated that the patient alleged that he was out of medication but his prescription was refused and he was told to schedule an appointment with specialists.

22. When asked about Patient A at his Subject Interview, Respondent stated that he was treating Patient A for knee arthritis and a rotator cuff injury. He stated that the patient was treated with narcotics as well as other therapies such as injections. When asked about the average amount of narcotics the patient had been prescribed, Respondent stated that it varied, but was between 40 to 140 (viz., MMEs) depending on the patient's level of pain and desired activity. When asked about whether he had a pain contract with the patient, he stated that it was not a routine practice in primary care when he initially saw the patient, and that none of his partners [at UCLA] "ever did such a thing either," and that he did not have one for Patient A. Respondent also stated that he discussed risks with the patient, and that "he knew the risks . . . and he was aware of the medications," but Respondent also stated that he did not document these discussions. When asked about how he monitored compliance with the use of pain medication, whether or not they are diverting, Respondent stated that at the beginning of the timeframe for his care of this patient, neither he, nor his colleagues, monitored compliance, but that this practice changed and currently he does monitor regularly.

Risk Factors; Patient A

23. Patient A had a history of drug abuse and his family history included substance/alcohol abuse as well. On or about December 2, 2013, Respondent saw Patient A and documented that the patient wanted to get off Vicodin®, which he had been buying on the street, suffered from withdrawal symptoms, and was taking 10-15 per day. Respondent also diagnosed Patient A with opioid dependence at that visit. On or about November 7, 2014, Respondent documented that the patient's sister had a history of alcohol/drug abuse. On or about March 16, 2017, Respondent documented that the patient had been to "AA meetings."

Red Flags; Patient A

24. As early as December 2, 2013, Respondent diagnosed Patient A with opioid dependence and documented that the patient wanted to get off Vicodin® which he had been buying on the street and that he had withdrawal symptoms. Despite this, Respondent continued to regularly prescribe opioids to the patient and in a chart note dated September 10, 2019, acknowledged that when Patient A was using his other opioids, he did not have mental clarity, which is a side effect of opioid use. In addition, the patient requested numerous early refills for narcotics, including on or about the following dates: May 18, 2018, April 19, 2019, June 24, 2019, July 1, 2019, December 20, 2019, March 9, 2020, April 14, 2020, and May 18, 2020. The patient also underwent dose escalations for controlled substances on or about the following dates: July 23, 2018, May 14, 2019, and July 6, 2020. Patient A also utilized multiple health providers, including on or about each of March 25, 2019 and June 24, 2019, when he obtained opioid prescriptions from multiple providers. Patient A also utilized multiple pharmacies. Patient A also had a high level of MMEs, including as follows:

Time period (on or about)	Average MME (Patient A)
November 16, 2017 to April 27, 2018	27 MME
May 11, 2018 to July 27, 2018	46 MME
July 31, 2018 to October 11, 2018	45 MME
October 15, 2018 to December 17, 2018	71 MME
December 24, 2018 to March 4, 2019	72 MME
March 10, 2019 to May 10, 2019	72 MME
May 11, 2019 to June 24, 2019	129 MME
June 25, 2019 to August 5, 2019	133 MME
August 8, 2019 to September 25, 2019	106 MME
October 4, 2019 to November 23, 2019	146 MME
November 29, 2019 to February 3, 2020	120 MME
February 12, 2020 to April 8, 2020	136 MME
April 14, 2020 to June 15, 2020	80 MME

Patient B

25. Respondent saw and treated Patient B for several years, including from on or about August 30, 2013 through at least in or around June 2020. During that time period, Respondent continuously prescribed controlled substances to Patient B in a negligent manner. On or about August 30, 2013, Patient B was a 55-year-old male, who presented to Respondent for a medication refill. His problem list at the time stated, Opioid Type Dependence. Patient B's medical history included anxiety and depression. His medications included Prozac® (10 mg daily), morphine (15 mg, 1 every 4 hours as needed) and morphine (30 mg, 1 every 12 hours), Ambien® (10 mg, 1 tab at bedtime), and hydromorphone (4 mg, 1 every 6 hours as needed). Respondent documented that the patient had a pain pump controlled by Dr. C. with "3 meds in the pump." He also wrote that Patient B required a lot of oral medications: Dilaudid® (4 mg, 2 pills 4 times daily); and MS Contin® (30 mg and 15 mg). Respondent noted that Patient B was planning to visit Seattle and Vancouver and to take a cruise to Alaska on September 4. Respondent diagnosed Patient B with lumbar disc disease and prescribed hydromorphone (4 mg, 1-2 tabs four times daily) and morphine (30 mg, 1-2 tabs every 12 hours). He also advised the patient to follow up with his pain specialist.

26. From in or around June 2016 through in or around June 2020 (Patient B Treatment Period), Respondent continued to regularly see and treat Patient B, including by issuing prescriptions for controlled substances on or about each of the following dates:

Date Filled by Patient B	Controlled Substance Prescribed
June 21, 2016	Diazepam
June 21, 2016	Lorazepam
June 21, 2016	Zolpidem
June 21, 2016	Morphine
July 15, 2016	Oxycodone/APAP
July 18, 2016	Oxycodone
July 18, 2016	Morphine
July 18, 2016	Zolpidem
July 18, 2016	Hydromorphone

Date Filled by Patient B	Controlled Substance Prescribed
July 24, 2016	Morphine
August 12, 2016	Diazepam
August 14, 2016	Zolpidem
August 18, 2016	Oxycodone
August 18, 2016	Oxycodone/APAP
August 22, 2016	Morphine
August 27, 2016	Lorazepam
September 2, 2016	Hydromorphone
September 10, 2016	Diazepam
September 10, 2016	Oxycodone/APAP
September 10, 2016	Oxycodone
September 12, 2016	Morphine
September 18, 2016	Zolpidem
September 30, 2016	Lorazepam
September 30, 2016	Diazepam
October 6, 2016	Morphine
October 6, 2016	Oxycodone/APAP
October 6, 2016	Hydromorphone
October 6, 2016	Oxycodone
October 18, 2016	Zolpidem
November 3, 2016	Oxycodone/APAP
November 3, 2016	Diazepam
November 3, 2016	Hydromorphone
November 3, 2016	Lorazepam
November 7, 2016	Morphine
November 14, 2016	Zolpidem
December 13, 2016	Morphine (30 mg; 60)
December 13, 2016	Oxycodone/APAP
December 13, 2016	Lorazepam
December 13, 2016	Zolpidem
December 13, 2016	Morphine (30 mg; 90)
December 13, 2016	Hydromorphone

Date Filled by Patient B	Controlled Substance Prescribed
December 13, 2016	Oxycodone
December 13, 2016	Diazepam
January 9, 2017	Lorazepam
January 9, 2017	Morphine (30 mg; 60)
January 9, 2017	Hydromorphone
January 9, 2017	Morphine (30 mg; 90)
January 9, 2017	Diazepam
January 9, 2017	Oxycodone
January 9, 2017	Oxycodone/APAP
January 9, 2017	Zolpidem
February 1, 2017	Oxycodone
February 1, 2017	Morphine
February 1, 2017	Diazepam
February 1, 2017	Oxycodone/APAP
February 5, 2017	Zolpidem
February 5, 2017	Hydromorphone
February 5, 2017	Morphine
February 6, 2017	Lorazepam
March 4, 2017	Zolpidem
March 9, 2017	Oxycodone/APAP
March 9, 2017	Morphine (30 mg; 60)
March 9, 2017	Morphine (30 mg; 90)
March 9, 2017	Oxycodone
March 9, 2017	Hydromorphone
March 31, 2017	Lorazepam
April 2, 2017	Oxycodone/APAP
April 2, 2017	Morphine (30 mg; 60)
April 2, 2017	Zolpidem
April 2, 2017	Morphine (30 mg; 90)
April 2, 2017	Oxycodone
April 7, 2017	Hydromorphone
April 25, 2017	Oxycodone

Date Filled by Patient B	Controlled Substance Prescribed
April 25, 2017	Oxycodone/APAP
April 25, 2017	Morphine
April 26, 2017	Morphine
May 2, 2017	Lorazepam
May 2, 2017	Zolpidem
May 2, 2017	Diazepam
May 15, 2017	Lorazepam
May 15, 2017	Diazepam
May 15, 2017	Hydromorphone
May 22, 2017	Morphine
May 22, 2017	Oxycodone
May 22, 2017	Oxycoden/APAP
May 23, 2017	Morphine
May 23, 2017	Diazepam
May 29, 2017	Zolpidem
June 20, 2017	Morphine
June 20, 2017	Oxycodone
June 20, 2017	Morphine
June 20, 2017	Hydromorphone
June 21, 2017	Oxycodone/APAP
June 21, 2017	Diazepam
June 27, 2017	Zolpidem
July 7, 2017	Lorazepam
July 19, 2017	Oxycodone
July 19, 2017	Hydromorphone
July 19, 2017	Oxycodone/APAP
July 19, 2017	Morphine (30 mg; 90)
July 19, 2017	Morphine (30 mg; 60)
July 27, 2017	Zolpidem
August 7, 2017	Lorazepam
August 15, 2017	Oxycodone/APAP
August 15, 2017	Oxycodone

Date Filled by Patient B	Controlled Substance Prescribed
August 15, 2017	Morphine
August 22, 2017	Hydromorphone
August 23, 2017	Zolpidem
September 8, 2017	Lorazepam
September 8, 2017	Oxycodone/APAP
September 8, 2017	Oxycodone
September 8, 2017	Morphine
September 25, 2017	Zolpidem
September 29, 2017	Hydromorphone
October 2, 2017	Oxycodone
October 2, 2017	Morphine
October 3, 2017	Morphine
October 5, 2017	Oxycodone/APAP
October 12, 2017	Lorazepam
October 27, 2017	Morphine
October 27, 2017	Hydromorphone
October 27, 2017	Oxycodone/APAP
October 27, 2017	Zolpidem
October 27, 2017	Oxycodone
October 29, 2017	Morphine
November 24, 2017	Zolpidem
November 27, 2017	Morphine
November 27, 2017	Oxycodone/APAP
November 27, 2017	Hydromorphone
November 27, 2017	Oxycodone
November 28, 2017	Morphine
December 14, 2017	Lorazepam
December 24, 2017	Morphine
December 24, 2017	Oxycodone
December 26, 2017	Zolpidem
December 26, 2017	Hydromorphone
December 26, 2017	Morphine

Date Filled by Patient B	Controlled Substance Prescribed
December 26, 2017	Oxycodone/APAP
January 24, 2018	Oxycodone/APAP
January 24, 2018	Morphine (30 mg; 60)
January 24, 2018	Zolpidem
January 24, 2018	Oxycodone
January 24, 2018	Morphine (30 mg; 120)
January 30, 2018	Hydromorphone
February 22, 2018	Morphine (30 mg; 60)
February 22, 2018	Oxycodone
February 22, 2018	Morphine (30 mg; 120)
February 22, 2018	Oxycodone/APAP
March 1, 2018	Hydromorphone
March 23, 2018	Hydromorphone
March 23, 2018	Morphine (30 mg; 60)
March 23, 2018	Morphine (30 mg; 120)
March 23, 2018	Oxycodone/APAP
March 23, 2018	Lorazepam
March 23, 2018	Zolpidem
March 23, 2018	Oxycodone
April 17, 2018	Oxycodone
April 17, 2018	Hydromorphone
April 19, 2018	Oxycodone/APAP
April 19, 2018	Morphine
April 23, 2018	Morphine
April 25, 2018	Zolpidem
May 17, 2018	Morphine
May 17, 2018	Oxycodone
May 17, 2018	Diazepam
May 17, 2018	Hydromorphone
May 17, 2018	Lorazepam
May 18, 2019	Oxycodone/APAP
May 18, 2018	Morphine

Date Filled by Patient B	Controlled Substance Prescribed
May 30, 2018	Zolpidem
June 13, 2018	Hydromorphone
June 13, 2018	Oxycodone
June 13, 2018	Morphine (30 mg; 60)
June 13, 2018	Morphine (30 mg; 120)
June 13, 2018	Oxycodone/APAP
June 30, 2018	Zolpidem
July 11, 2018	Diazepam
July 11, 2018	Oxycodone
July 11, 2018	Oxycodone/APAP
July 11, 2018	Morphine
July 16, 2018	Hydromorphone
July 29, 2018	Zolpidem
August 13, 2018	Oxycodone/APAP
August 13, 2018	Morphine
August 13, 2018	Hydromorphone
August 17, 2018	Oxycodone
August 22, 2018	Lorazepam
August 28, 2018	Zolpidem
September 14, 2018	Oxycodone
September 14, 2018	Oxycodone/APAP
September 14, 2018	Hydromorphone
September 14, 2018	Morphine
September 29, 2018	Zolpidem
October 15, 2018	Hydromorphone
October 15 2018	Morphine
October 15, 2018	Oxycodone/APAP
October 15, 2018	Oxycodone
October 28, 2018	Lorazepam
October 28, 2018	Zolpidem
November 19, 2018	Hydromorphone
November 19, 2018	Oxycodone/APAP

Date Filled by Patient B	Controlled Substance Prescribed
November 19, 2018	Morphine
November 21, 2018	Hydromorphone
November 21, 2018	Oxycodone
November 27, 2018	Zolpidem
November 29, 2018	Morphine
December 10, 2018	Lorazepam
December 13, 2018	Oxycodone
December 17, 2018	Oxycodone/APAP
December 17, 2018	Morphine (30 mg; 60)
December 17, 2018	Morphine (30 mg; 120)
December 17, 2018	Hydromorphone (0.6)
December 17, 2018	Hydromorphone (120)
December 26, 2018	Zolpidem
December 27, 2018	Lorazepam
January 8, 2019	Morphine (30 mg; 60)
January 8, 2019	Morphine (30 mg; 120)
January 8, 2019	Oxycodone
January 14, 2019	Oxycodone/APAP
January 14, 2019	Oxycodone/APAP
January 28, 2019	Hydromorphone
January 28, 2019	Zolpidem
January 31, 2019	Oxycodone
February 5, 2019	Morphine
February 5, 2019	Oxycodone/APAP
February 5, 2019	Morphine
February 10, 2019	Oxycodone/APAP
February 12, 2019	Morphine
February 14, 2019	Lorazepam
February 14, 2019	Diazepam
February 25, 2019	Hydromorphone
February 25, 2019	Oxycodone
February 25, 2019	Morphine

Date Filled by Patient B	Controlled Substance Prescribed
March 1, 2019	Zolpidem
March 2, 2019	Hydromorphone
March 6, 2019	Oxycodone/APAP
March 22, 2019	Oxycodone
March 22, 2019	Morphine
March 26, 2019	Hydromorphone
March 26, 2019	Zolpidem
April 16, 2019	Oxycodone
April 16, 2019	Oxycodone/APAP
April 17, 2019	Morphine
April 17, 2019	Hydromorphone
April 28, 2019	Zolpidem
May 7, 2019	Oxycodone (10)
May 7, 2019	Oxycodone (110)
May 10, 2019	Morphine
May 10, 2019	Oxycodone/APAP
May 11, 2019	Hydromorphone
May 29, 2019	Zolpidem
June 3, 2019	Oxycodone/APAP
June 3, 2019	Hydromorphone
June 3, 2019	Oxycodone
June 3, 2019	Morphine
June 28, 2019	Zolpidem
June 28, 2019	Morphine
June 28, 2019	Hydromorphone
June 28, 2019	Oxycodone/APAP
June 28, 2019	Oxycodone
July 23, 2019	Oxycodone
July 23, 2019	Hydromorphone
July 23, 2019	Morphine
July 23, 2019	Oxycodone/APAP
August 1, 2019	Zolpidem

Date Filled by Patient B	Controlled Substance Prescribed
August 16, 2019	Oxycodone/APAP
August 16, 2019	Morphine
August 16, 2019	Hydromorphone
August 16, 2019	Oxycodone
September 13, 2019	Oxycodone/APAP
September 13, 2019	Morphine
September 13, 2019	Hydromorphone
September 13, 2019	Oxycodone
October 15, 2019	Zolpidem
October 15, 2019	Oxycodone
October 15, 2019	Oxycodone/APAP
October 15, 2019	Oxycodone
October 15, 2019	Lorazepam
October 17, 2019	Morphine
October 17, 2019	Hydromorphone (20)
October 17, 2019	Hydromorphone (1000
November 7, 2019	Lorazepam
November 8, 2019	Oxycodone
November 8, 2019	Morphine
November 8, 2019	Oxycodone/APAP
November 14, 2019	Hydromorphone
November 14, 2019	Zolpidem
December 5, 2019	Morphine (60)
December 5, 2019	Morphine (30)
December 5, 2019	Oxycodone
December 5, 2019	Oxycodone/APAP
December 12, 2019	Hydromorphone
December 13, 2019	Zolpidem
January 2, 2020	Oxycodone/APAP
January 2, 2020	Morphine
January 2, 2020	Oxycodone
January 19, 2020	Zolpidem

Date Filled by Patient B	Controlled Substance Prescribed
January 31, 2020	Morphine
January 31, 2020	Oxycodone/APAP
January 31, 2020	Morphine
January 31, 2020	Hydromorphone
January 31, 2020	Oxycodone
January 31, 2020	Oxycodone/APAP
February 25, 2020	Oxycodone
February 25, 2020	Oxycodone/APAP
February 27, 2020	Morphine
February 27, 2020	Hydromorphone
February 27, 2020	Zolpidem
March 18, 2020	Oxycodone
March 24, 2020	Oxycodone/APAP
March 26, 2020	Morphine
March 26, 2020	Hydromorphone
March 29, 2020	Zolpidem
April 23, 2020	Morphine
April 23, 2020	Oxycodone
April 23, 2020	Hydromorphone
April 26, 2020	Oxycodone (40)
April 26, 2020	Oxycodone (80)
April 27, 2020	Zolpidem
May 22, 2020	Morphine
May 22, 2020	Oxycodone
May 22, 2020	Oxycodone/APAP
May 29, 2020	Zolpidem
June 26, 2020	Zolpidem

27. During the Patient B Treatment Period, Respondent continued to prescribe controlled substances to Patient B, including for opioid prescriptions, and the following patient encounters were documented in Patient B's chart on or about each of the following dates:

- June 21, 2016;

- June 27, 2016 (an annual exam and Respondent documented that the patient had the following history: opioid abuse; cocaine use disorder, moderate, in sustained remission; dependence, cocaine dependence in remission, alcohol use disorder, moderate, in sustained remission; dependence, alcohol dependence);

- July 15, 2016 (oxycodone/APAP);

- July 18, 2016 (oxycodone and morphine);

- September 8, 2016[8] (short-acting morphine, oxycodone, and diazepam; notes that patient has nausea with detoxing off drugs);

- March 2, 2017[9] (patient seen after a fall and suffering from withdrawal and opioid dependence daily use);

- April 26, 2017 (requests and obtained an early refill), May 19, 2017 (patient complains about excruciating back pain);

- June 16, 2017 (complaints of headaches, nausea and vomiting);

- July 27, 2017 (patient had been to ER for nausea and vomiting; complaints of severe back and knee pain);

- October 27, 2017 (complaints of abdominal pain);

- November 27, 2017 (ongoing stomach pain);

- January 24, 2018 (prescribed Narcan);

- May 22, 2018 (suffers from opioid dependence, daily use; alcohol use disorder, moderate in sustained remission);

- May 24, 2018 (suffers from cocaine use disorder, in remission; alcohol use disorder, remission; and opioid dependence, daily use);

- June 13, 2018 (refills five opioid prescriptions);

- November 19, 2018 (call from pharmacy notes asking "to verify pt's medications, as pt has multiple controlled substances all being approved at the same time, however they are supposed to be taken alternately");

- December 17, 2018 (depressed a good while living with chronic pain);

- February 5, 2019 (opioid fact sheet posted to the patient's chart);

- May 7, 2019 (phone message; refill request is five days early);

- May 20, 2019 (pain with sweats and vomiting);

---

[8] A phone encounter note dated September 7, 2016 documented that Patient B came into the office stating he saw a pain doctor and was going to be weaning off morphine and that the pain doctor advised an "increase in other oxy pain meds" during this process.

[9] On or about February 5, 2017, Patient B filled 120 tablets of hydromorphone and 60 tabs of morphine.

- October 26, 2019 (patient hospitalized and was unable to move his legs, he had multiple studies with no cause found); and
- January 6, 2020 (patient on vacation and prescription is running out).

28. At the Subject Interview, Respondent stated that Patient B had severe chronic low back pain and was hospitalized for pain at times. Patient B also had a pain pump and was taking pain medications, and had been seen by specialists, including pain management doctors. Despite this, Patient B still had uncontrolled pain according to Respondent. Respondent also stated that depending on Patient B's constipation, he would alternate between morphine, Dilaudid®, or Percocet®. Respondent stated that he did not have a pain management contract with this patient.

Risk Factors; Patient B

29. Patient B had a history which included: Opioid Use Disorder, mild and Cocaine Use Disorder, moderate, in sustained remission, dependence; a family history of substance abuse, viz., Patient B's mother overdosed on prescription drugs; a history of stated Alcohol Use Disorder, moderate, in sustained remission; a history of anxiety and depression treated with Prozac®; a history of diverting drugs, including on or about February 12, 2014, when Patient B tried his wife's Ativan®.

Red Flags; Patient B

30. As early as on or about June 26, 2014, Patient B lost his recommendation for medical marijuana. The patient also reported symptoms (side effects from drug use) on or about the following dates: September 12, 2014 (Patient B reportedly "sleeps a lot since meds(?) relieve pain" – nonetheless Respondent refilled the patient's prescriptions for hydromorphone, morphine and lorazepam, and stated that he remains pretty much totally incapacitated); May 12, 2015 (Patient B had gynecomastia (enlargement of breast tissue in men; a side effect of long-term opioid use); January 4, 2016 (Patient B experienced constipation, noting morphine is more constipating, and headaches from morphine); February 8, 2016 (the patient reported being sleepy on Dilaudid® and snores frequently and pauses breathing); June 16, 2017 (the patient reports headaches and migraines (a side effect of opioids); October 26, 2019 (the patient reports motor impairment (a side effect of opioids). Patient B also suffered from falls on or about March 16, 2015 and March 2, 2017 (Patient B had withdrawal symptoms as well). On or about June 17,

2015, Patient B learned of a Hepatitis C infection. Patient B also obtained controlled substance (benzodiazepine and opioids) prescriptions from multiple providers, and requested dose escalation for the prescribed controlled substances. Patient B also requested early refills for controlled substances on or about each of the following dates: April 26, 2017, February 5, 2019, May 7, 2019 and January 6, 2020. Patient B had a high level of MMEs, including as follows:

Time period (on or about)	Average MME (Patient B)
June 21, 2016 to July 18, 2016	241 MME
July 18, 2016 to September 18, 2016	355 MME
September 30, 2016 to December 13, 2016	286 MME
December 13, 2016 to January 9, 2017	817 MME
February 1, 2017 to March 31, 2017	420 MME
April 2, 2017 to May 2, 2017	674 MME
May 2, 2017 to May 29, 2017	442 MME
June 20, 2017 to August 7, 2017	505 MME
August 15, 2017 to September 29, 2017	509 MME
October 2, 2017 to October 29, 2017	942 MME
November 24, 2017 to December 26, 2017	731 MME
December 26, 2017 to February 22, 2018	434 MME
February 22, 2018 to April 17, 2018	457 MME
April 19, 2018 to May 30, 2018	532 MME
June 13, 2018 to August 13, 2018	480 MME
October 26, 2018 to December 17, 2018	496 MME,
December 17, 2018 to February 5, 2019	621 MME
February 10, 2019 to March 26, 2019	572 MME
April 16, 2019 to June 3, 2019	645 MME
June 3, 2019 to August 16, 2019	420 MME
August 16, 2019 to October 17, 2019	486 MME
October 17, 2019 to December 13, 2019	360 MME
December 19, 2019 to February 25, 2020	579 MME
February 25, 2020 to April 26, 2020	432 MME
April 27, 2020 to June 29, 2020	360 MME

///

Patient C

31. Respondent saw and treated Patient C for several years, including from on or about June 20, 2013 through on or about July 8, 2020. During that time period, Respondent continuously prescribed controlled substances to Patient C in a negligent manner. On or about June 20, 2013, Patient C was a 44-year-old male, who presented to Respondent and was treated for skin lesions. Respondent documented that Patient C saw another provider for right elbow epicondylitis and was prescribed oral and topical NSAIDs. He also needed a prescription for fentanyl patches (Duragesic®). Patient C was diagnosed with trigeminal neuralgia and chronic daily headaches. Respondent ordered fentanyl 30 patches (100 mcg each) for Patient C to place on his skin every three days, and fentanyl 30 patches (75 mcg each).[10]

32. From in or around May 2016 through in or around June 2020 (Patient C Treatment Period), Respondent continued to regularly see and treat Patient C, including by issuing prescriptions for controlled substances, including on or about the following dates:

Date Filled by Patient C	Controlled Substance
June 8, 2016	Fentanyl (100 mcg)
June 8, 2016	Fentanyl (75 mcg)
June 23, 2016	Fentanyl
June 23, 2016	Fentanyl
July 10, 2016	Fentanyl (100 mcg)
July 10, 2016	Fentanyl (75 mcg)
July 23, 2016	Fentanyl (100 mcg)
July 23, 2016	Fentanyl (75 mcg)
August 8, 2016	Fentanyl (100 mcg)
August 8, 2016	Fentanyl (75 mcg)
August 24, 2016	Fentanyl (100 mcg)
August 24, 2016	Fentanyl (75 mcg)
September 9, 2016	Fentanyl (100 mcg)
September 9, 2016	Fentanyl (75 mcg)
September 23, 2016	Fentanyl (100 mcg)

[10] A 75 mcg and 100 mcg fentanyl patch equals 180 and 240 MMEs per day, respectively.

Date Filled by Patient C	Controlled Substance
September 23, 2016	Fentanyl (75 mcg)
October 11, 2016	Fentanyl (100 mcg)
October 11, 2016	Fentanyl (75 mcg)
October 13, 2016	Fentanyl
October 26, 2016	Fentanyl (100 mcg)
October 26, 2016	Fentanyl (75 mcg)
November 14, 2016	Fentanyl (100 mcg)
November 14, 2016	Fentanyl (75 mcg)
December 17, 2016	Fentanyl
December 30, 2016	Fentanyl
January 14, 2017	Fentanyl (100 mcg)
January 14, 2017	Fentanyl (75 mcg)
February 4, 2017	Fentanyl (100 mcg)
February 4, 2017	Fentanyl (75 mcg)
March 1, 2017	Fentanyl
March 18, 2017	Fentanyl (100 mcg)
March 18, 2017	Fentanyl (75 mcg)
March 31, 2017	Fentanyl
April 16, 2017	Fentanyl
April 19, 2017	Fentanyl
May 5, 2017	Fentanyl (100 mcg)
May 5, 2017	Fentanyl (75 mcg)
May 22, 2017	Fentanyl
June 1, 2017	Fentanyl
June 9, 2017	Fentanyl
June 15, 2017	Fentanyl
June 27, 2017	Fentanyl (100 mcg)
June 27, 2017	Fentanyl (75 mcg)
July 12, 2017	Fentanyl (100 mcg)
July 12, 2017	Fentanyl (75 mcg)
July 24, 2017	Fentanyl
July 29, 2017	Fentanyl (100 mcg)

Date Filled by Patient C	Controlled Substance
July 29, 2017	Fentanyl (75 mcg)
August 13, 2017	Fentanyl (100 mcg)
August 13, 2017	Fentanyl (75 mcg)
August 30, 2017	Fentanyl
September 2, 2017	Fentanyl
September 12, 2017	Fentanyl
September 15, 2017	Fentanyl
September 27, 2017	Fentanyl (100 mcg)
September 27, 2017	Fentanyl (75 mcg)
October 11, 2017	Fentanyl (100 mcg)
October 11, 2017	Fentanyl (75 mcg)
October 27, 2017	Fentanyl (100 mcg)
October 27, 2017	Fentanyl (75 mcg)
November 7, 2017	Fentanyl (100 mcg)
November 7, 2017	Fentanyl (75 mcg)
November 18, 2017	Fentanyl
November 22, 2017	Fentanyl
November 30, 2017	Fentanyl
December 3, 2017	Fentanyl
December 12, 2017	Fentanyl
December 14, 2017	Fentanyl
December 15, 2017	Fentanyl
December 23, 2017	Fentanyl
December 27, 2017	Fentanyl
January 4, 2018	Fentanyl
January 12, 2018	Fentanyl
January 18, 2018	Fentanyl
January 24, 2018	Fentanyl
January 30, 2018	Fentanyl
February 6, 2018	Fentanyl
February 15, 2018	Fentanyl
February 21, 2018	Fentanyl

Date Filled by Patient C	Controlled Substance
February 28, 2018	Fentanyl
March 6, 2018	Fentanyl
March 14, 2018	Fentanyl
March 21, 2018	Fentanyl
March 28, 2018	Fentanyl
April 4, 2018	Fentanyl
April 12, 2018	Fentanyl
April 18, 2018	Fentanyl
April 24, 2018	Fentanyl
May 3, 2018	Fentanyl
May 6, 2018	Fentanyl
May 16, 2018	Fentanyl
May 23, 2018	Fentanyl
May 28, 2018	Fentanyl
June 4, 2018	Fentanyl
June 19, 2018	Fentanyl (100 mcg)
June 19, 2018	Fentanyl (75 mcg)
July 1, 2018	Fentanyl (100 mcg)
July 1, 2018	Fentanyl (75 mcg)
July 18, 2018	Fentanyl
July 18, 2018	Fentanyl
July 30, 2018	Fentanyl (100 mcg)
July 30, 2018	Fentanyl (75 mcg)
August 14, 2018	Fentanyl (100 mcg)
August 14, 2018	Fentanyl (75 mcg)
August 27, 2018	Fentanyl (100 mcg)
August 27, 2018	Fentanyl (75 mcg)
September 10, 2018	Fentanyl (100 mcg)
September 10, 2018	Fentanyl (75 mcg)
September 24, 2018	Fentanyl (100 mcg)
September 24, 2018	Fentanyl (75 mcg)
October 6, 2018	Fentanyl (100 mcg)

Date Filled by Patient C	Controlled Substance
October 6, 2018	Fentanyl (75 mcg)
October 19, 2018	Fentanyl (100 mcg)
October 19, 2018	Fentanyl (75 mcg)
October 31, 2018	Fentanyl (100 mcg)
October 31, 2018	Fentanyl (75 mcg)
November 13, 2018	Fentanyl (100 mcg)
November 13, 2018	Fentanyl (75 mcg)
November 25, 2018	Fentanyl (100 mcg)
November 25, 2018	Fentanyl (75 mcg)
December 8, 2018	Fentanyl (100 mcg)
December 8, 2018	Fentanyl (75 mcg)
December 21, 2018	Fentanyl (100 mcg)
December 21, 2018	Fentanyl (75 mcg)
January 2, 2019	Fentanyl (100 mcg)
January 2, 2019	Fentanyl (75 mcg)
January 2, 2019	Fentanyl (75 mcg)
January 15, 2019	Fentanyl (100 mcg)
January 15, 2019	Fentanyl (75 mcg)
January 15, 2019	Fentanyl (100 mcg)
January 15, 2019	Fentanyl (75 mcg)
January 28, 2019	Fentanyl (100 mcg)
January 28, 2019	Fentanyl (75 mcg)
January 28, 2019	Fentanyl (100 mcg)
January 28, 2019	Fentanyl (75 mcg)
February 21, 2019	Fentanyl (100 mcg)
February 21, 2019	Fentanyl (75 mcg)
March 5, 2019	Fentanyl (100 mcg)
March 5, 2019	Fentanyl (75 mcg)
March 17, 2019	Fentanyl (100 mcg)
March 17, 2019	Fentanyl (75 mcg)
March 26, 2019	Fentanyl (100 mcg)
March 26, 2019	Fentanyl (75 mcg)

Date Filled by Patient C	Controlled Substance
April 9 2019	Fentanyl (100 mcg)
April 9, 2019	Fentanyl (75 mcg)
April 21, 2019	Fentanyl (100 mcg)
April 21, 2019	Fentanyl (75 mcg)
May 2, 2019	Fentanyl (100 mcg)
May 2, 2019	Fentanyl (75 mcg)
May 3, 2019	Fentanyl (100 mcg)
May 3, 2019	Fentanyl (75 mcg)
May 18, 2019	Fentanyl (100 mcg)
May 18, 2019	Fentanyl (75 mcg)
June 2, 2019	Fentanyl (100 mcg)
June 2, 2019	Fentanyl (75 mcg)
June 15, 2019	Fentanyl
June 18, 2019	Fentanyl
July 1, 2019	Fentanyl
July 2, 2019	Fentanyl
July 3, 2019	Fentanyl (100 mcg)
July 3, 2019	Fentanyl (75 mcg)
July 17, 2019	Fentanyl (100 mcg)
July 17, 2019	Fentanyl (75 mcg)
July 29, 2019	Fentanyl (100 mcg)
July 29, 2019	Fentanyl (75 mcg)
August 12, 2019	Fentanyl
August 14, 2019	Fentanyl
August 26, 2019	Fentanyl
September 8, 2019	Fentanyl (100 mcg)
September 8, 2019	Fentanyl (75 mcg)
September 20, 2019	Fentanyl
September 21, 2019	Fentanyl
October 2, 2019	Fentanyl
October 3, 2019	Fentanyl
October 15, 2019	Fentanyl (100 mcg)

Date Filled by Patient C	Controlled Substance
October 15, 2019	Fentanyl (75 mcg)
October 29, 2019	Fentanyl (100 mcg)
October 29, 2019	Fentanyl (75 mcg)
November 13, 2019	Fentanyl (100 mcg)
November 13, 2019	Fentanyl (75 mcg)
November 25, 2019	Fentanyl (100 mcg)
November 25, 2019	Fentanyl (75 mcg)
December 7, 2019	Fentanyl (100 mcg)
December 7, 2019	Fentanyl (75 mcg)
December 19, 2018	Fentanyl (100 mcg)
December 19, 2018	Fentanyl (75 mcg)
January 1, 2020	Fentanyl (100 mcg)
January 1, 2020	Fentanyl (75 mcg)
January 13, 2020	Fentanyl (100 mcg)
January 13, 2020	Fentanyl (75 mcg)
January 30, 2020	Fentanyl
January 31, 2020	Fentanyl
February 13, 2020	Fentanyl (100 mcg)
February 13, 2020	Fentanyl (75 mcg)
February 26, 2020	Fentanyl (100 mcg)
February 26, 2020	Fentanyl (75 mcg)
March 11, 2020	Fentanyl (100 mcg)
March 11, 2020	Fentanyl (75 mcg)
March 23, 2020	Fentanyl (100 mcg)
March 23, 2020	Fentanyl (75 mcg)
April 7 2020	Fentanyl (100 mcg)
April 7, 2020	Fentanyl (75 mcg)
April 21, 2020	Fentanyl
April 23, 2020	Fentanyl
May 5, 2020	Fentanyl (100 mcg)
May 5, 2020	Fentanyl (75 mcg)
May 18, 2020	Fentanyl (100 mcg)

Date Filled by Patient C	Controlled Substance
May 18, 2020	Fentanyl (75 mcg)
June 4, 2020	Fentanyl
June 8, 2020	Fentanyl
June 9, 2020	Fentanyl
June 21, 2020	Fentanyl

33. During the Patient C Treatment Period, Respondent continued to prescribe controlled substances to Patient C, including opioid prescriptions, and the following patient encounters were documented in Patient C's chart on or about each of the following dates:

- May 18, 2016 (patient complained of a sore throat and desired Valium® which Respondent refilled without an adequate discussion of its medical indication);
- February 4, 2017 (patient unable to work due to breakthrough pain; Respondent refills fentanyl for chronic headaches);
- April 12, 2017 (patient tries to refill his fentanyl prescription early while Respondent is on vacation; another doctor writes, "too soon for a refill" patient complains that he has been Respondent's patient at UCLA for twenty years and has had this prescription filled under this exact circumstance in the last few years);
- April 13, 2017 (another provider states, "Too soon. [Respondent] will be back next week");
- April 13, 2017 (patient complains about stomach issues);
- July 21, 2017 (Respondent refills the patient's opioid prescription early and wrote, "I realize it's a few days earlier than usual for refilling my patches but I had to take a partial fill last time," and Respondent replies, "Ok, done.");
- July 24, 2017 (15 patches of fentanyl 100 mcg);
- July 28, 2017 (patient needs another script of patches);
- October 2, 2017 (patient using 225 mg fentanyl patch daily and suffers from headaches and constipation and would like to come off the fentanyl);
- November 28, 2017 (Respondent noted that a doctor at USC recommends three days of a drug-induced coma to reset pain receptors);
- February 13, 2018 (patient requests a copy of a prior letter to the manager at CVS explaining his opioid dosage because the old one was misplaced and "irresponsible fentanyl use" is now "the latest media boogeyman" and they won't refill his prescription);
- February 14, 2018 (the patient suffers from two separate types of headaches leaving him with constant variable pain and unpredictable extremely painful headaches; patient also has skin issues but Respondent feels confident that the patient is safely and

responsibly using the patches for their intended purpose; he also notes that, given the length of time the patient has been using the medication, his associated tolerance level and his close medical supervision, and for the sake of the patient's quality of life, he hopes the pharmacy would continue to honor the prescription);

- February 14, 2018 (in a letter to Respondent, the patient wrote, "I made adjustments to bring the numbers current," and that he would like to "shoot for late April/Early May to begin the ramp-down" in order to give "some additional time to find someone at UCLA to help with the process.");

- March 6, 2018 (stomach problems);

- March 20, 2018 (stool softener used but still uncomfortable with blood);

- September 7, 2018 (skin problems);

- February 21, 2019 (anxiety, disrupted sleep, headaches);

- April 29, 2019 (patient reports that he is changing insurance and anticipating delays and needs a week's safety)[11];

- April 30, 2019 (different dose approved by Respondent)[12];

- May 30, 2019 (Respondent documented the patient's pain management history noting that after years of pain issues, the patient's pain was best controlled by fentanyl patches but due to the patient's hyperhidrosis, the patches do not stick well and need frequent changing, and that the patient's pain has been well controlled on 100 and 75 mcg patches of fentanyl placed twice daily, and has received 30 patches of each every 2 weeks for many years – Respondent also states that, given the patient's 20 years of experience with chronic pain and narcotics, he is well versed on how to use these medications in the appropriate dosing and is well educated on the benefits, side effects, and alternatives to them);

- August 9, 2019 (another provider will not refill the prescription for opioids early when Respondent is out of the office);

- January 24, 2020 (another provider documented that while Respondent was absent: "due to the high number of fentanyl patches the patient is using, without detailed documentation of the patient's condition, there are two options: the patient can make the current supply last until [Respondent] returns or make an appointment with one of the other providers");

- February 13, 2020 (patient's request for fentanyl renewals have been denied because they have already been filled on January 31, 2020); and

---

[11] According to a CURES report, on or about April 21, 2019, Patient C filled 30 patches of both 100 and 75 mcg doses and on or about May 2, 2019, 30 patches of the 50 and 25 mcg doses were filled, and on or about May 3, 2019, another 30 of the 100 and 75 mcg doses were filled.

[12] Patient C wrote to Respondent, "Sorry, I wasn't clear in yesterday's message about writing a script for 50 mcg and 25 mcg patches, INSTEAD of 100 mcg and 75 mcg, so that the 'old' insurance will process it. They inadvertently got an 'early refill' request a month or so ago, so I cannot fill my usual script early. Only a different strength of the same medication will go through." Respondent replies, "Done."

- March 16, 2020 (Patient C states, "Given the current state of affairs, I may start sending my requests for Rx refills a little earlier than 2 days in advance, just in case for some reason you have to be out of the office unexpectedly. Also, I am wondering if it possible for you to put one or two hard copy scripts out for me to pick up in case you're out for longer than a couple of weeks, as getting a refill from your associates, historically, has been understandably a hard 'no'?" Respondent replies, "Ok, printed.").

34. At the Subject Interview, Respondent stated that in 2005, Patient C developed trigeminal neuralgia and noted that around 2007, he saw several specialists and his pain doctor started him on fentanyl patches; then in 2011, he saw another pain doctor who continued the patient on the medication. Patient C had psoriasis and hyperhidrosis and the patch was not sticking well and so he had to change it twice daily. Respondent stated that he did drug testing in 2017, 2018, 2019, and 2020 and they were positive for fentanyl and negative for everything else. He noted that he had a couple of pain contracts in 2019 and 2020, and that Patient C was the only patient of the five patients in this matter with whom he had a pain management contract.

Risk Factors; Patient C

35. Patient C's history included: PTSD, anxiety, disrupted sleep, and headaches.

Red Flags; Patient C

36. Patient C reported symptoms (side effects from drug use) on or about the following dates: October 14, 2013 (headaches); November 21, 2013 (chronic daily headaches and hypogonadism (side effects of chronic opioid use); September 4, 2014 (dizziness); August 27, 2015 (hyperhidrosis (excessive perspiration and a known side effect of long-term opioid use) and constipation due to pain management); March 17, 2016 (Patient C sweats all day); October 3, 2017 (sweats extensively and constipated and suffers headaches); November 28, 2017 (intractable cluster headache syndrome and chronic daily headaches); January 23, 2018 (hyperhidrosis). Patient C also refilled his controlled substance prescriptions early, including on or about the following dates: July 21, 2017, July 24, 2017, July 28, 2017, April 29, 2019, and April 30, 2019. In addition, Patient C also had a high level of MMEs, including as follows:

Time period (on or about)	Average MME (Patient C)
June 23, 2016 to October 11, 2016	846 MME
October 11, 2016 to February 4, 2017	759 MME

Time period (on or about)	Average MME (Patient C)
February 4, 2017 to June 27, 2017	679 MME
June 29, 2017 to October 11, 2017	840 MME
October 11, 2017 to January 4, 2018	1025 MME
January 12, 2018 to April 12, 2018	980 MME
April 18, 2018 to July 18, 2018	969 MME
July 30, 2018 to October 31, 2018	1014 MME
October 31, 2018 to January 15, 2019	1160 MME
January 15, 2019 to March 26, 2019	1157 MME
April 9, 2019 to June 18, 2019	1140 MME
July 1, 2019 to September 8, 2019	1095 MME
September 20, 2019 to December 7, 2019	991 MME
December 19, 2019 to March 11, 2020	1050 MME
March 23, 2020 to June 21, 2020	929 MME

Patient D

37. Respondent saw and treated Patient D for several years, including from on or about August 29, 2014 through at least in or around April 2020. During that time period, Respondent continuously prescribed controlled substances to Patient D in a negligent manner. On or about August 29, 2014, Patient D was a 24-year-old male, who presented to Respondent for a check-up relating to sexually transmitted diseases. Patient D's social history included a notation that the patient consumes about three drinks of 1.5 ounces of alcohol per week. The outpatient prescriptions section included a note about controlled substances: hydrocodone (5 mg) and zolpidem (10 mg). Respondent ordered blood work for the patient at this visit.

38. From in or around June 2016 through in or around June 2020 (Patient D Treatment Period), Respondent continued to regularly see and treat Patient D, including by issuing prescriptions for controlled substances, including on or about the following dates:

Date Filled by Patient D	Controlled Substance
May 25, 2017	Zolpidem
June 24, 2017	Zolpidem
September 7, 2017	Zolpidem
October 3, 2017	Hydrocodone/APAP

Date Filled by Patient D	Controlled Substance
October 31, 2017	Hydrocodone/APAP
November 14, 2017	Hydrocodone/APAP
November 20, 2017	Zolpidem
December 18, 2017	Zolpidem
January 23, 2018	Tramadol
January 23, 2018	Zolpidem
February 20, 2018	Hydrocodone/APAP
February 26, 2018	Tramadol
March 20, 2018	Tramadol
March 20, 2018	Hydrocodone/APAP
April 8, 2018	Zolpidem
April 10, 2018	Hydrocodone/APAP
May 7, 2018	Tramadol
May 15, 2018	Hydrocodone/APAP
June 1, 2018	Hydrocodone/APAP
June 18, 2018	Tramadol
June 18, 2018	Hydrocodone/APAP
July 5, 2018	Hydrocodone/APAP
July 5, 2018	Zolpidem
August 3, 2018	Hydrocodone/APAP
August 17, 2018	Hydrocodone/APAP
August 27, 2018	Zolpidem
August 31, 2018	Hydrocodone/APAP
August 31, 2018	Hydrocodone/APAP
September 6, 2018	Tramadol
September 7, 2018	Clonazepam
September 11, 2018	Hydrocodone/APAP
September 25, 2018	Hydrocodone/APAP
October 1, 2018	Zolpidem
October 4, 2018	Hydrocodone/APAP
October 17, 2018	Hydrocodone/APAP
October 17, 2018	Tramadol

Date Filled by Patient D	Controlled Substance
November 7, 2018	Hydrocodone/APAP
November 14, 2018	Hydrocodone/APAP
November 26, 2018	Tramadol
November 26, 2018	Hydrocodone/APAP
February 8, 2019	Clonazepam
March 25, 2019	Hydrocodone/APAP
April 2 2019	Clonazepam
April 30, 2019	Tramadol
April 30, 2019	Hydrocodone/APAP
May 8, 2019	Clonazepam
May 13, 2019	Hydrocodone/APAP
June 3, 2019	Hydrocodone/APAP
June 3, 2019	Zolpidem
June 7, 2019	Clonazepam
June 10, 2019	Hydrocodone/APAP
June 26, 2019	Hydrocodone/APAP
July 8, 2019	Clonazepam
July 15, 2019	Zolpidem
July 16, 2019	Hydrocodone/APAP
August 2, 2019	Hydrocodone/APAP
August 2, 2019	Tramadol
August 13, 2019	Clonazepam
September 24 2019	Clonazepam
October 16, 2019	Hydrocodone/APAP
October 16, 2019	Zolpidem
November 15, 2019	Hydrocodone/APAP
November 15, 2019	Tramadol
November 17, 2019	Clonazepam
November 25, 2019	Hydrocodone/APAP
December 12, 2019	Hydrocodone/APAP
December 30, 2019	Hydrocodone/APAP
January 16, 2020	Hydrocodone/APAP

Date Filled by Patient D	Controlled Substance
January 30, 2020	Hydrocodone/APAP
February 4, 2020	Clonazepam
February 24, 2020	Hydrocodone/APAP
March 10, 2020	Clonazepam
March 13, 2020	Hydrocodone/APAP
April 8, 2020	Hydrocodone/APAP
April 17, 2020	Clonazepam
May 18, 2020	Hydrocodone/APAP
May 21, 2020	Clonazepam
June 9, 2020	Hydrocodone/APAP
June 22, 2020	Clonazepam
June 30, 2020	Hydrocodone/APAP

39. During the Patient D Treatment Period, Respondent continued to prescribe controlled substances to Patient D, including opioid prescriptions, and the following patient encounters were documented in Patient D's chart on or about each of the following dates:

- February 23, 2017 (patient requests a refill of tramadol);
- May 10, 2017 (patient recently increased Norco use and states that tramadol helps; a drug screen dated April 27, 2017, shows that the patient is negative for drugs of abuse and negative for opioids (patient's drug history from Parkside Pharmacy[13] (not on CURES) indicates that the patient purchased hydrocodone on or about April 5, 2017, and on April 26, 2017 - the patient fills prescriptions for hydrocodone, each from different providers));
- August 7, 2017 (filled prescriptions for narcotics are not listed on CURES), different providers are prescribing additional narcotics as well contemporaneously;
- January 29, 2018 (patient attempts to fill prescriptions for narcotics early);
- February 20, 2018 (front desk reports that the patient is asking if Respondent could print and sign his prescription for Norco as he is traveling out of town. Respondent replies, "Done. But he got last month's early as well on 2/5 so should have enough until 3/5. He should have enough until April.");
- May 4, 2018 (patient is prescribed medication for migraine headaches; it is unclear why this medication was prescribed; a drug screen result from September 8, 2017 was negative for drugs of abuse and for opiates (the patient purchased a prescription for hydrocodone written by another provider on August 22, 2017 from Parkside Pharmacy

[13] The patient frequently fills prescriptions for narcotics at this pharmacy which consistently do not appear on CURES.

which was not reflected in the CURES));

• May 11, 2018 (Respondent notes "medication present" in a screen and the patient responds, "finally, the test shows I have been taking");

• June 18, 2018 (patient requests more narcotics because he is taking them more frequently);

• September 11, 2018 (at this annual exam, Respondent notes that the patient works for a large law firm, is under a lot of stress and has difficulty sleeping; he has obtained clonazepam last week prescribed by Respondent and filled on September 7, 2018; he also notes that zolpidem (filled on August 27, 2018) has not been working recently; a drug screen result dated May 4, 2018 was positive for opiates, cannabinoids, and negative for other drugs and alcohol. He specifically tested positive for hydrocodone; a pain management screen assay does not detect fentanyl, methadone, tramadol, clonazepam, and a few other opioids).

• September 27, 2018 (phone message to patient - no medication in urine);

• September 28, 2018 (phone message from patient – not sure why no medication in urine but alleges that it has happened in the past and believes it is due to his consumption of water);

• October 4, 2018 (patient requests early refill to Parkside Pharmacy due to his travel plans which Respondent approves);

• October 17, 2018 (patient fills a prescription for Norco®, 60 pills);

• October 25, 2018 (patient requests an early refill for Norco® and Ambien®);

• October 26, 2018 (Respondent replies to the patient's request, "done" and patient fills prescriptions for Norco® and Ambien® at Parkside Pharmacy);

• November 13, 2018 (patient requests early refill in light of Respondent's plan to be out of the office; Respondent replied to the patient as follows, "Ok, I did refill it. Seems like a lot of early refills. In the future, I can write for a month 120 pills.");

• December 3, 2018 (Respondent refills Norco® and tramadol. (Notwithstanding that the patient filled prescriptions for hydrocodone, number 120, and tramadol, number 120, on November 26, 2018));

• December 16, 2018 (patient requests an early refill due to holidays and family death, patient later fills hydrocodone 120 tabs, from Parkside Pharmacy (days early and not listed in the CURES report));

• January 6, 2018 (patient requests an early refill which is denied on January 7, 2018, but nonetheless the patient later fills hydrocodone from Parkside Pharmacy (not listed in the CURES report));

• January 18, 2018 (patient fills prescriptions for Ambien® and tramadol from Parkside Pharmacy (not reflected in the CURES report); the patient continues to fill multiple prescriptions from Parkside Pharmacy (not reflected in CURES, including on or about the

following dates: January 28, 2019 (hydrocodone), February 12, 2019 (hydrocodone), March 4, 2019 (hydrocodone and tramadol; early refill), March 8, 2019 (zolpidem));

- January 24, 2018 (patient reports stress from working long hours, poor appetite and inability to focus);

- February 7, 2018 (patient reports taking Norco three times a day and tramadol a few times a week; he has been off work for two weeks);

- April 10, 2019 (patient has been off work since January 24, 2019; plan is to return to work on June 24 2019);

- June 2, 2019 (patient filled tramadol prescription at Parkside Pharmacy which did not appear on CURES)

- June 11, 2019 (patient would like to extend return to work date by three weeks);

- July 10, 2019 (patient is having time to deal with PTSD);

- July 16, 2019 (patient requests an early refill, patient refills hydrocodone early);

- August 2, 2019 (patient requests an early refill due to travel, CURES data shows that a prescription from Respondent was filled on or about July 16, 2019 and then on or about August 2, 2019);

- September 9, 2019 (patient requests an early refill and patient fills hydrocodone early from Parkside Pharmacy which is not reported in CURES);

- September 25, 2019 (patient requests an early refill and patient fills hydrocodone and zolpidem early from Parkside Pharmacy which are not reported in CURES);

- October 17, 2019 (patient reports breast tenderness);

- October 28, 2019 (patient requests prescription alleging he lost his hydrocodone and zolpidem and these were replaced with drug refills from Parkside Pharmacy which are not in CURES);

- November 14, 2019 (patient requests early refills of tramadol and hydrocodone due to weekend and changing jobs; drugs are filled early from Parkside Pharmacy and not reported in CURES);

- November 25, 2019 (patient requests early refill of hydrocodone due to changing jobs; prescription is filled early from Parkside Pharmacy and not reported in CURES);

- March 13, 2019 (patient requests early refill of hydrocodone due to anticipated city shutdown; prescription is filled early from Parkside Pharmacy and not reported in CURES);

- April 30, 2020 (another provider writes in Respondent's absence, "Please contact the patient and tell him that since he received 120 tabs on March 13, it is too soon to refill his medication, and would need to make his supply last until Wednesday when [Respondent] is back" and the other provider further recommends that the patient follow-up at pain management due to apparent misuse or overuse of his narcotic pain medication" and further wrote, "[Respondent], note: even though this is marked as approved, I called [N.]to ask

when he filled Rx since it was not logged in CURES and when he told me he had filled in on 3/13, I canceled the approval, so PT will still need his Rx when you get back"); and

- Despite the lack of additional chart notes, Respondent continued to prescribe controlled substances through on or about June 22, 2020, and the patient filled prescriptions for hydrocodone on or about each of May 18, 2020 and June 9, 2020 (nine days early).

40. At the Subject Interview, when asked what condition of Patient D he was treating, Respondent stated Patient D had cervical and lumbar disease and suffered from car accidents and pain. He also noted that the patient had anxiety and sleeping issues. When asked what pain medications he used with the patient, Respondent stated Norco® and tramadol. When asked why he used both of those drugs, Respondent explained that Patient D took one versus the other depending on his pain. Respondent stated that he did not have a pain management contract with Patient D, and of the five patients in this case, Respondent only had a pain management contract with Patient C. Respondent was asked about his lack of clarity in his notes regarding a urine screen, including the nonspecific reference to "medication," and Respondent speculated that it was either oxycodone or Norco®. When asked about Patient D's test results that showed all negatives, Respondent stated that they had only partial notes and sometimes the results showed up in the notes and sometimes they did not. When asked about a negative test result in or around September 2017, and whether he spoke to Patient D about it, Respondent stated that he did, but that the hydrocodone would be out of his system in two to four days – he said this despite the fact that Patient D was taking opioids regularly and filling prescriptions for opioids from multiple providers. When asked if he ordered any imaging, Respondent stated that he ordered a cervical spine MRI, but the results were negative.

Risk Factors; Patient D

41. Patient D had a history which included mental health issues, including on or about May 4, 2018 (anxiety), January 24, 2019 (stress, migraines, poor appetite, and an inability to focus).

Red Flags; Patient D

42. Respondent should have known that Patient D was a poor candidate for long-term controlled substances therapy due to the red flags (raising concern for abuse, misuse, and

diversion) in this case, including on or about the following dates below. On or about each of the following dates, Patient D exhibited mental issues: May 4, 2018 (referral to psychology), and January 24, 2019 (stress with work, very long hours, and the loss of his assistants; feeling anxious, having racing thoughts, feeling despondent and lost, cannot focus, poor appetite, migraines, and cannot sleep – patient is diagnosed with anxiety). Patient D had inconsistent drug screening test results, including on or about the following dates: May 10, 2017 (negative for opioids despite taking Norco®), May 4, 2018 (negative for opioids despite filling prescriptions for hydrocodone), and September 27, 2018 (no medications in urine despite filling several prescriptions regularly for opioids – patient alleges he drank water which affected the test). Patient D also often refilled his opioid prescriptions early, including on or about the following dates: January 29, 2018, October 4, 2018, October 25, 2018, November 13, 2018, December 16, 2018, January 6, 2019, August 2, 2019, September 25, 2019, October 28, 2019, and April 30, 2020. On or about October 28, 2019 Patient D alleged that he lost his zolpidem and hydrocodone/APAP drugs at a funeral. Patient D also had a high level of MMEs, including as follows:

Time period (on or about)	Average MME (Patient D)
May 25, 2017 to November 20, 2017	37 MME
December 18, 2017, 2018 to July 5, 2018	26 MME
July 5, 2018 to October 17, 2018	56 MME
October 17, 2018 to June 7, 2019	34 MME
June 10, 2019 to November 25, 2019	56 MME
December 12, 2019 to June 22, 2020	55 MME

Patient E

43. Respondent saw and treated Patient E for several years, including from on or about July 25, 2013 through at least in or around July 2020. During that time period, Respondent continuously prescribed controlled substances to Patient E in a negligent manner. On or about July 25, 2013, Respondent saw Patient E, a 43-year-old female. He noted that the patient had moved from Houston in early April and was seen on or about April 23, 2013. He also noted that

the patient traveled to Europe for two months. Patient E had an elevated blood pressure. Respondent diagnosed Patient E with the following conditions: attention deficit disorder (ADD), fibroids, hypertension, anemia, and fatigue. Respondent ordered labs, started Patient E on atenolol (a beta blocker used to treat high blood pressure), and prescribed controlled substances to the patient, including tramadol (50 mg,) hydrocodone (10 mg), and Adderall® (10 mg).

44. From in or around May 2016 through in or around June 2020, Respondent continued to regularly see and treat Patient E, including with prescriptions for controlled substances. During that treatment period, Respondent continued to prescribe controlled substances to Patient E, including on the following dates:

Date Filled by Patient E	Controlled Substance
June 2, 2016	Tramadol
June 8, 2016	Oxycodone/APAP
June 12, 2016	Tramadol
June 20, 2016	Tramadol
June, 21 2016	Amphetamine
June 28, 2016	Tramadol
July 6, 2016	Tramadol
July 7, 2016	Oxycodone/APAP
July 16, 2016	Tramadol
July 22, 2016	Amphetamine
July 25, 2016	Tramadol
July 29, 2016	Oxycodone/APAP
August 5, 2016	Tramadol
August 23, 2016	Tramadol
August 26, 2016	Amphetamine
August 26, 2016	Oxycodone/APAP
September 3, 2016	Tramadol

Date Filled by Patient E	Controlled Substance
September 13, 2016	Tramadol
September 21, 2016	Tramadol
September 21, 2016	Oxycodone/APAP
September 29, 2016	Amphetamine
October 2, 2016	Tramadol
October 12, 2016	Tramadol
October 19, 2016	Oxycodone/APAP
October 24, 2016	Tramadol
October 30, 2016	Amphetamine
November 4, 2016	Tramadol
November 14, 2016	Tramadol
November 15, 2016	Oxycodone/APAP
November 26, 2016	Tramadol
December 1, 2016	Amphetamine
December 5, 2016	Tramadol
December 8, 2016	Oxycodone/APAP
December 16, 2016	Tramadol
January 2, 2017	Amphetamine
January 3, 2017	Oxycodone/APAP
January 9, 2017	Tramadol
January 19, 2017	Tramadol
January 27, 2017	Tramadol
January 27, 2017	Carisoprodol
February 2, 2017	Amphetamine
February 9, 2017	Tramadol
February 19, 2017	Tramadol

Date Filled by Patient E	Controlled Substance
February 27, 2017	Tramadol
March 3, 2017	Oxycodone/APAP
March 8, 2017	Amphetamine
March 10, 2017	Tramadol
March 20, 2017	Tramadol
March 21, 2017	Carisoprodol
March 30, 2017	Tramadol
March 31, 2017	Oxycodone/APAP
April 10, 2017	Tramadol
April 10, 2017	Amphetamine
April 21, 2017	Tramadol
April 28, 2017	Oxycodone/APAP
May 3, 2017	Tramadol
May 8, 2017	Amphetamine
May 12, 2017	Tramadol
May 23, 2017	Carisoprodol
May 23, 2017	Tramadol
May 30, 2017	Oxycodone/APAP
June 3, 2017	Tramadol
June 6, 2017	Amphetamine
June 13, 2017	Tramadol
June 22, 2017	Tramadol
June 27, 2017	Oxycodone/APAP
July 5, 2017	Amphetamine
July 5, 2017	Tramadol
July 14, 2017	Tramadol

Date Filled by Patient E	Controlled Substance
July 24, 2017	Tramadol
July 24, 2017	Oxycodone/APAP
August 2, 2017	Tramadol
September 5, 2017	Tramadol
September 6, 2017	Amphetamine
September 12, 2017	Tramadol
September 22, 2017	Tramadol
September 22, 2017	Oxycodone/APAP
October 3, 2017	Tramadol
October 19, 2017	Oxycodone/APAP
November 3, 2017	Tramadol
November 3, 2017	Amphetamine
November 14, 2017	Tramadol
November 17, 2017	Oxycodone/APAP
November 27, 2017	Tramadol
December 3, 2017	Amphetamine
December 4, 2017	Tramadol
December 13, 2017	Oxycodone/APAP
December 15, 2017	Tramadol
December 31, 2017	Tramadol
January 2, 2018	Amphetamine
January 9, 2018	Tramadol
January 11, 2018	Oxycodone/APAP
January 21, 2018	Tramadol
January 30, 2018	Amphetamine
January 30, 2018	Tramadol

Date Filled by Patient E	Controlled Substance
February 8, 2018	Tramadol
February 8, 2018	Oxycodone/APAP
February 20, 2018	Tramadol
March 2, 2018	Amphetamine
March 2, 2018	Tramadol
March 6, 2018	Oxycodone/APAP
March 11, 2018	Tramadol
March 21, 2018	Tramadol
March 30, 2018	Amphetamine
April 4, 2018	Tramadol
April 4, 2018	Oxycodone/APAP
April 18, 2018	Tramadol
April 27, 2018	Amphetamine
May 3, 2018	Oxycodone/APAP
May 21, 2018	Tramadol
May 25, 2018	Amphetamine
June 1, 2018	Oxycodone/APAP
June 4, 2018	Tramadol
June 18, 2018	Tramadol
June 25, 2018	Amphetamine
July 4, 2018	Oxycodone/APAP
July 4, 2018	Tramadol
July 16, 2018	Tramadol
July 26, 2018	Oxycodone/APAP
July 30, 2018	Tramadol
July 31, 2018	Amphetamine

Date Filled by Patient E	Controlled Substance
August 14, 2018	Tramadol
August 27, 2018	Oxycodone/APAP
August 27, 2018	Amphetamine
August 27, 2018	Tramadol
September 11 2018	Tramadol
September 25, 2018	Tramadol
September 25, 2018	Oxycodone/APAP
September 26, 2018	Amphetamine
October 11, 2018	Tramadol
October 24, 2018	Oxycodone/APAP
October 28, 2018	Tramadol
October 29, 2018	Amphetamine
November 11, 2018	Tramadol
November 26, 2018	Tramadol
November 28, 2018	Amphetamine
December 10, 2018	Tramadol
December 20, 2018	Oxycodone/APAP
December 22, 2018	Tramadol
January 2, 2019	Dextroamphetamine
January 9, 2019	Tramadol
January 17, 2019	Oxycodone/APAP
January 17, 2019	Oxycodone/APAP
January 26, 2019	Tramadol
February 5, 2019	Amphetamines
February 27, 2019	Tramadol
March 4, 2019	Amphetamine

Date Filled by Patient E	Controlled Substance
March 14 2019	Tramadol
March 14, 2019	Oxycodone/APAP
March 31, 2019	Tramadol
April 3, 2019	Amphetamine
April 4, 2019	Tramadol
April 12, 2019	Oxycodone/APAP
April 18, 2019	Tramadol
April 19, 2019	Carisoprodol
May 1, 2019	Tramadol
May 2, 2019	Amphetamine
May 10, 2019	Oxycodone/APAP
May 20, 2019	Tramadol
May 31, 2019	Amphetamine
June 2, 2019	Tramadol
June 7, 2019	Oxycodone/APAP
June 19, 2019	Tramadol
June 30, 2019	Amphetamine
July 2, 2019	Tramadol
July 3, 2019	Oxycodone/APAP
July 17, 2019	Tramadol
July 29, 2019	Amphetamine
July 31, 2019	Tramadol
August 2, 2019	Oxycodone/APAP
August 16, 2019	Oxycodone/APAP
August 16, 2019	Tramadol
August 27, 2019	Amphetamine

Date Filled by Patient E	Controlled Substance
August 31, 2019	Tramadol
September 6 2019	Oxycodone/APAP
September 15, 2019	Tramadol
September 26, 2019	Amphetamine
September 27, 2019	Tramadol
October 3, 2019	Oxycodone/APAP
October 3, 2019	Oxycodone/APAP
October 9, 2019	Tramadol
October 25, 2019	Tramadol
October 25, 2019	Amphetamine
October 29, 2019	Oxycodone/APAP
November 5, 2019	Oxycodone/APAP
November 13, 2019	Tramadol
November 26, 2019	Tramadol
November 27, 2019	Oxycodone/APAP
December 2, 2019	Amphetamine
December 6, 2019	Amphetamine
December 12, 2019	Tramadol
December 23, 2019	Oxycodone/APAP
December 27, 2019	Tramadol
January 15, 2020	Tramadol
January 24, 2020	Oxycodone/APAP
January 31, 2020	Tramadol
February 4, 2020	Amphetamine
February 16, 2020	Tramadol
February 20, 2020	Carisoprodol

Date Filled by Patient E	Controlled Substance
February 20, 2020	Oxycodone/APAP
March 3, 2020	Amphetamine
March 3, 2020	Tramadol
March 16, 2020	Oxycodone/APAP
April 1, 2020	Amphetamine
April 1, 2020	Tramadol
April 10, 2020	Oxycodone/APAP
April 15, 2020	Oxycodone/APAP
April 24, 2020	Tramadol
April 29, 2020	Amphetamine
May 8, 2020	Tramadol
May 8, 2020	Oxycodone/APAP
May 22, 2020	Tramadol
May 22, 2020	Oxycodone/APAP
May 28, 2020	Amphetamine
June 10, 2020	Tramadol

45. During the Patient E Treatment Period, Respondent continued to prescribe controlled substances to Patient E, and the following patient encounters were documented in Patient E's chart on or about each of the following dates:

- May 11, 2016 (Patient E requests to change her pain medication for a few months because she believes that she has built up a tolerance to Norco® that she has been using for her menses and occasionally for back pain. She stated that one Norco® usually lasts about 4 hours, but the previous night she took two pills because of her severe pain; she thought this was dangerous. She was concerned about putting herself in the same position as [redacted] who died from an overdose of pain medication – Respondent planned to try Percocet® instead of Norco® to address her concerns);

- June 6, 2016 (Patient E states she feels more winded when working out the past two months. Respondent orders labs, and refills Adderall®, oxycodone (10 mg), and tramadol);

- December 9, 2016 (patient is tired despite sleeping for eight hours a day);

- January 27, 2017 (patient requests a refill for a muscle relaxer but would like to switch back to Soma® and Respondent fills Soma®, tramadol, and Adderall®);

- March 3, 2017 (message from patient to Respondent that she is starting a weight loss program because she wants to get off some medications, including pain medicine for her bulging discs and uterine fibroids);

- March 31, 2017 (patient seen for a sinus problem, but there is no discussion of the previous message left by the patient);

- June 27, 2017 (patient takes tramadol daily for bulging discs and has taken Percocet® for one week for menses; she does not sleep more than four hours per night and feels tired during the day; Respondent orders labs and prescribes oxycodone);

- December 18, 2017 (Respondent notes the patient's menses is hurting more and she is having trouble with urinary frequency);

- April 4, 2018 (patient had a urinary tract infection and has chronic back pain and uses tramadol (3-4 per day); he orders oxycodone and tramadol) ;

- June 7, 2019 (patient is tired all the time and has bad insomnia; Respondent refills prescription for oxycodone);

- October 30, 2019 (patient states that she took a deep breath two days ago and went into very tight and painful back spasms);

- June 30, 2020 (patient complains of abdominal pain (9/10 in intensity) on period and was advised to go to the ER, but she refused; patient has uterine fibroids and two bulging discs; she is on oxycodone during her period for severe pain and on tramadol daily and has been trying to get refills for the past week; she took her last dose of tramadol today and states her PCP is out; another provider will not refill prescriptions without labs);

- July 1, 2020 (notes from a telephone encounter from the front desk states that two telehealth visits with two other providers occurred and both were uncomfortable prescribing medication to the patient); and

- July 2, 2020 (notes from a telephone encounter with another doctor states that the patient should be directed to the ER and that he was unable to prescribe any pain medications based on a previous telehealth visit).

46. At the Subject Interview, Respondent stated that he first saw Patient E, who presented with uterine fibroids, ADHD, chronic low back pain, and spinal stenosis, in or around April 2013. He treated her with Norco® for her uterine cramping and tramadol for lumbar disc disease and sciatica. He also stated that he did a self-report scale for ADHD noting that she had already been on Adderall. When asked whether he was concerned about the increased risk of fatal overdose when a patient uses an opiate and a stimulant together, and whether he had spoken to the patient about that risk, Respondent replied that the patient came to him already on those medications and

that they were working well and the patient was tolerating them. He further stated that he did not want to interfere with what seemed to be working. When asked about his treatment goals for Patient E, he said, regarding her ADHD, it was for her to go to school and regarding her pain, it was for her to have a functioning level allowing her to have a productive life. Respondent also stated that he did not perform any drug screening for this patient.

Red Flags; Patient E

47. Respondent failed to adequately address the red flags while providing care and treatment for Patient E, as described further below. On or about May 11, 2016, Patient E escalated her dosing of controlled substances. On or about the following dates, Respondent failed to adequately address Patient E's side effects: December 9, 2016 (tired despite sleeping 8 hours), and June 7, 2019 (tired all the time and insomnia). The patient utilized multiple pharmacies (8) which is concerning behavior and increases the likelihood of abuse, misuse, or diversion of controlled substances. Patient E also had a high level of MMEs, including as follows:

Time period (on or about)	Average MME (Patient E)
June 2, 2016 to July 6, 2016	66 MME
July 7, 2016 to October 2, 2016	48 MME
October 12, 2016 to January 9, 2017	47 MME
January 19, 2017 to April 10, 2017	39 MME
April 21, 2017 to July 24, 2017	46 MME
July 24, 2017 to November 3, 2017	44 MME
November 14, 2017 to January 30, 2018	48 MME
February 4, 2018 to April 17, 2018	54 MME
April 18, 2018 to July 16, 2018	50 MME
July 26, 2018 to October 28, 2018	52 MME
October 29, 2018 to February 5, 2019	45 MME
February 15, 2019 to May 31, 2019	47 MME
June 2, 2019 to September 6, 2019	74 MME
September 15, 2019 to December 6, 2019	82 MME
December 12, 2019 to March 16, 2020	47 MME
March 16, 2020 to June 10, 2020	52 MME

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

48. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in connection with the care and treatment of Patients A, B, C, D, and E. The circumstances are as follows:

49. Paragraphs 17 through 47, inclusive, are incorporated herein by reference as if fully set forth. In addition the following grossly negligent acts are alleged:

Patient A.

50. On or about April 30, 2016 and thereafter, Respondent committed the following acts of gross negligence in connection with Patient A:

Excessive Prescribing

A. Respondent prescribed excessive amounts of opioids to Patient A above guidance and continued to prescribe high-dose opiates in the face of multiple concerning red flags. Higher doses of opioids are more likely to lead to abuse and also cause serious dose-related effects including cognitive impairment, motor impairment, respiratory depression, and death.

Prescribing Without Medical Indication

B. Respondent prescribed chronic opioids (including in high doses) to Patient A who was addicted to that drug, for muscle-skeletal pain, increasing the risk of harm. There is weak evidence supporting the use of opioids for muscle-skeletal pain and more substantial evidence showing harm. Here, there was a lack of appropriate indication such as an underlying pathology requiring that medication. Respondent's records failed to adequately substantiate this prescribing practice.

Ongoing Assessment

C. Respondent failed to adequately evaluate Patient A's progress towards treatment objectives. He failed to utilize relevant objectives to comprehensively evaluate Patient A's controlled substances needs (analgesia, activity level, adverse effects, aberrant behaviors, and affect). Respondent's charting in Patient A's medical records is devoid of adequate use of a pain scale to assess the level of pain (analgesia) and failed to specifically describe the anatomical location

of pain, quality of pain, the timing of pain, palliation, and provocation of pain. Additionally, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and patient's affect (changes to mood, depression or anxiety).

Treatment Plan and Objectives

D. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient A. He failed to describe measurable goals for therapy with chronic opioid prescriptions. Despite alleging at his Subject Interview that his goals were to reduce the patient's pain and improve his function, Respondent failed to specify measurable goals and objectives used to evaluate the progress of his treatment of Patient A. His documentation failed to show any discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy becomes necessary.

Patient Consent

E. Respondent failed to adequately perform and/or document the informed consent process with Patient A. Respondent failed to elucidate the potential risks and/or side effects from long-term opioid use, and/or benefits of his treatment plan with the patient. The risks include risk of respiratory depression, motor impairment, cognitive impairment, and death. He also failed to adequately discuss and/or document his discussion about the risk of dependence, misuse, addiction, overdose, and death, with the patient.

Compliance Monitoring

F. Respondent failed to adequately or consistently monitor Patient A for compliance regarding the controlled substances he was using. Respondent failed to adequately investigate Patient A's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate). The medical records of the patient only reveal a single urine drug screen dated December 12, 2020.

///

Risk Stratification

G. Respondent failed to classify Patient A's risk during his care for the patient. He failed to undertake any risk assessment for his prescribing for long-term use of opioids such as the use of various screening tools (PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, and SOAPP-R). Risk stratification is an important tool to determine the level of risk and how to care for a patient based on the risk of harm. Patient A was at high risk of harm based on his medical comorbidities such as fall risk and mental clarity; behavior comorbidities such as history of substance abuse, family history of substance abuse, history of alcohol abuse, and mental health; aberrant behaviors such as early refills, illicit drug use such as purchasing Vicodin® on the street, multiple providers, and multiple pharmacies; and medication taken with a high morphine equivalent dose (i.e., > 90).

Pain Management Agreement

H. Respondent failed to enter into and/or amend or revise, a controlled substance agreement with Patient A despite long term use of controlled substances (greater than 90 days).

Medical Records

I. Respondent failed to maintain adequate and/or accurate medical records. His medical records failed to adequately document the rationale: for maintaining Patient A on controlled substances on a long-term basis; for dose changes; for dose increases; for the addition of a second controlled substance. His records failed to adequately document his discussions with the patient about the risks and benefits of his controlled substance use. Respondent's medical records for Patient A should have included adequate pertinent information, such as the patient's medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

Patient B.

51. On or about April 30, 2016 and thereafter, Respondent committed the following acts of gross negligence in connection with Patient B:

Prescribing Medications With Dangerous Interactions

A. Respondent prescribed to Patient B, for chronic use, three medications

(opioids, benzodiazepines, and sedatives) that, when used concurrently, are synergistic for negative health outcomes. Respondent concurrently prescribed multiple medications to Patient B which could potentiate the individual medications' negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death, viz. opioids (hydromorphone, morphine (short and extended release), and oxycodone) as well as the benzodiazepines (diazepam (at 2 mg and 10 mg doses) and a sedative hypnotic (zolpidem).

Excessive Prescribing

B. Respondent prescribed excessive amounts of opioids to Patient B well above guidance and continued to prescribe high-dose opiates in the face of multiple concerning red flags. Higher doses of opioids are more likely to lead to abuse and also cause serious dose-related effects including cognitive impairment, motor impairment, respiratory depression, and death.

Patient Evaluation

C. Respondent failed to adequately evaluate Patient B for long-term use of opioids for chronic non-cancer pain, given the potential risks associated with that type of opioid use, and failed to establish a diagnosis of medical necessity. There is poor evidence supporting the treatment of Patient B's muscle-skeletal pain with chronic opioids, including in high-dosages and greater risk for harm.

Ongoing Assessment

D. Respondent failed to adequately evaluate Patient B's progress towards treatment objectives. He failed to utilize relevant objectives to comprehensively evaluate Patient B's controlled substances needs (analgesia, activity level, adverse effects, aberrant behaviors, and affect). Respondent's charting in Patient B's medical records is devoid of adequate use of a pain scale to assess the level of pain (analgesia) and failed to specifically describe the anatomical location of pain, quality of pain, the timing of pain, palliation, and provocation of pain. Additionally, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and patient's affect (changes to mood, depression or anxiety).

Treatment Plan and Objectives

E. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient B. Despite alleging at his Subject Interview that his goals were to reduce the patient's pain and improve his function, Respondent failed to specify measurable goals and objectives used to evaluate the progress of his treatment of Patient B. His documentation failed to show any discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy becomes necessary.

Patient Consent

F. Respondent failed to adequately perform and/or document the informed consent process with Patient B. Respondent failed to elucidate the potential risks and/or side effects from long-term opioid use, and/or benefits of his treatment plan with the patient. The risks include risk of respiratory depression, motor impairment, cognitive impairment, and death. He also failed to adequately discuss and/or document his discussion about the risk of dependence, misuse, addiction, overdose, and death, with the patient.

Compliance Monitoring

G. Respondent failed to adequately or consistently monitor Patient B for compliance regarding the controlled substances he was using. Respondent failed to adequately investigate Patient B's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate).

Risk Stratification

H. Respondent failed to classify Patient B's risk during his care for the patient. He failed to undertake any risk assessment for his prescribing for long-term use of opioids such as the use of various screening tools (PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, and SOAPP-R). Risk stratification is an important tool to determine the level of risk and how to care for a patient based on the risk of harm. Patient B was at high risk of harm based on his medical comorbidities such as fall risk behavior comorbidities such as history of substance abuse and mental health; aberrant behaviors such as early refills, lost prescriptions, and multiple pharmacies; and

medication taken and dose such as morphine equivalent greater than 90 and combination of opioids and benzodiazepines.

Pain Management Agreement

I. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient B despite long-term use of controlled substances (greater than 90 days).

Medical Records

J. Respondent failed to maintain adequate and/or accurate medical records. His medical records failed to adequately document the rationale: for maintaining Patient B on controlled substances on a long-term basis; for dose changes; for dose increases; for the addition of a second controlled substance. His records failed to adequately document his discussions with the patient about the risks and benefits of his controlled substance use. Respondent's medical records for Patient B should have included adequate pertinent information, such as the patient's medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

Patient C.

52. On or about April 30, 2016 and thereafter, Respondent committed the following acts of gross negligence in connection with Patient C:

Excessive Prescribing

A. Respondent prescribed excessive amounts of opioids to Patient C well above guidance and continued to prescribe high-dose opiates in the face of multiple concerns, including severe side effects. This placed the patient at risk for cognitive impairment, motor impairment, respiratory depression and death. Higher doses of opioids are more likely to lead to abuse and also cause serious dose-related effects including cognitive impairment, motor impairment, respiratory depression, and death. During the time Respondent treated Patient C, Respondent frequently prescribed an amount of opioid medications that exceeded 420 MMEs daily.

Patient Evaluation

B. Respondent failed to adequately evaluate Patient C for long-term use of opioids for chronic non-cancer pain, given the potential risks associated with that type of opioid use, and failed to establish a diagnosis of medical necessity. There is a lack of evidence supporting the treatment of Patient C's headaches and trigeminal neuralgia (neuropathic conditions) with chronic opioids. There is a high-level of concern that high dose narcotics can exacerbate neuropathic conditions, including headaches.

Ongoing Assessment

C. Respondent failed to adequately evaluate Patient C's progress towards treatment objectives. He failed to utilize relevant objectives to comprehensively evaluate Patient C's controlled substances needs (analgesia, activity level, adverse effects, aberrant behaviors, and affect). Respondent's charting in Patient C's medical records is devoid of adequate use of a pain scale to assess the level of pain (analgesia) and failed to specifically describe the anatomical location of pain, quality of pain, the timing of pain, palliation, and provocation of pain. Additionally, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and patient's affect (changes to mood, depression or anxiety).

Treatment Plan and Objectives

D. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient C. Despite alleging at his Subject Interview that his goals were to reduce the patient's pain and improve his function, Respondent failed to specify measurable goals and objectives used to evaluate the progress of his treatment of Patient C. His documentation failed to show any discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy becomes necessary.

Patient Consent

E. Respondent failed to adequately perform and/or document the informed

consent process with Patient C. Respondent failed to elucidate the potential risks and/or side effects from long-term opioid use, and/or benefits of his treatment plan with the patient. The risks include risk of respiratory depression, motor impairment, cognitive impairment, and death. He also failed to adequately discuss and/or document his discussion about the risk of dependence, misuse, addiction, overdose, and death, with the patient. There was no discussion regarding potential side effects such as hypergonadism and hyperhidrosis.

Risk Stratification

F. Respondent failed to classify Patient C's risk during his care for the patient. He failed to undertake any risk assessment for his prescribing for long-term use of opioids such as the use of various screening tools (PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, and SOAPP-R). Risk stratification is an important tool to determine the level of risk and how to care for a patient based on the risk of harm. Patient C was at high risk of harm based on his medical comorbidities such as history of mental health issues; aberrant behaviors such as early refills; and medication taken and dose such as morphine equivalent greater than 90.

Pain Management Agreement

G. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient C despite long-term use of controlled substances (greater than 90 days).

Patient D.

53. On or about April 30, 2016 and thereafter, Respondent committed the following acts of gross negligence in his care and treatment of Patient D:

Prescribing Medications With Dangerous Interactions

A. Respondent prescribed to Patient D, for chronic use, three medications (opioids (hydrocodone), benzodiazepines (clonazepam) and sedatives (zolpidem)) that, when used concurrently, are synergistic for negative health outcomes. Respondent concurrently prescribed multiple medications to Patient D which could potentiate the individual medications' negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death, viz. opioids as well as benzodiazepines and a sedative hypnotic.

Patient Evaluation

B. Respondent failed to adequately evaluate Patient D for long-term use of opioids for chronic non-cancer pain, given the potential risks associated with that type of opioid use, and failed to establish a diagnosis of medical necessity. There is poor evidence supporting the treatment of Patient D's muscle-skeletal pain with chronic opioids.

Ongoing Assessment

C. Respondent failed to adequately evaluate Patient D's progress towards treatment objectives. He failed to utilize relevant objectives to comprehensively evaluate Patient D's controlled substances needs (analgesia, activity level, adverse effects, aberrant behaviors, and affect). Respondent's charting in Patient D's medical records is devoid of adequate use of a pain scale to assess the level of pain (analgesia) and failed to specifically describe the anatomical location of pain, quality of pain, the timing of pain, palliation, and provocation of pain. Additionally, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and patient's affect (changes to mood, depression or anxiety).

Treatment Plan and Objectives

D. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient D. Despite alleging at his Subject Interview that his goals were to reduce the patient's pain and improve his function, Respondent failed to specify measurable goals and objectives used to evaluate the progress of his treatment of Patient D, including with chronic opioids. His documentation failed to show any discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy becomes necessary.

Patient Consent

E. Respondent failed to adequately perform and/or document the informed consent process with Patient D. Respondent failed to elucidate the potential risks and/or side effects

from long-term opioid use, and/or benefits of his treatment plan with the patient. The risks include risk of respiratory depression, motor impairment, cognitive impairment, and death. He also failed to adequately discuss and/or document his discussion about the risk of dependence, misuse, addiction, overdose, and death, with the patient.

Compliance Monitoring

F. Respondent failed to adequately monitor Patient D for compliance regarding the controlled substances he was using. While Respondent did utilize drug screens for the patient, he failed to adequately follow up with the results, including when the patient tested negative for concurrent controlled substances. The patient showed inconsistent results on more than one occasion and inconsistent negative drug screens are a concern for controlled substance diversion.

Risk Stratification

G. Respondent failed to classify Patient D's risk during his care for the patient. He failed to undertake any risk assessment for his prescribing for long-term use of opioids such as the use of various screening tools (PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, and SOAPP-R). Risk stratification is an important tool to determine the level of risk and how to care for a patient based on the risk of harm. Patient D was at high risk of harm based on his medical comorbidities such as the history of mental health issues; aberrant behaviors such as early refills of prescriptions; lost medications; inconsistent drug testing; dose escalation; and medication taken such as opiates, benzodiazepines and sedative hypnotics.

Pain Management Agreement

H. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient D despite long-term use of controlled substances (greater than 90 days).

Medical Records

I. Respondent failed to maintain adequate and/or accurate medical records. His medical records failed to adequately document the rationale: for maintaining Patient D on controlled substances on a long-term basis; for dose changes; for dose increases; for the addition

of a second/third controlled substance. His records failed to adequately document his discussions with the patient about the risks and benefits of his controlled substance use. Respondent's medical records for Patient D should have included adequate pertinent information, such as the patient's medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

Patient E.

54. On or about April 30, 2016 and thereafter, Respondent committed the following acts of gross negligence in his care and treatment of Patient E:

Patient Evaluation

A. Respondent failed to adequately evaluate Patient E for long-term use of opioids for chronic non-cancer pain, given the potential risks associated with that type of opioid use, and his failure to establish a diagnosis of medical necessity. There is poor evidence supporting the treatment of Patient E's muscle-skeletal pain with chronic opioids, including at his dose levels. Respondent treated the patient with moderate-dose opioids for uterine fibroid pain. There is lack of sufficient evidence to support the use of opioids for the treatment of uterine fibroid pain. Instead, Respondent should have initiated appropriate treatment which would have included medications for uterine fibroids that target hormones that regulate the menstrual cycle or minimally invasive procedures through referral to gynecology.

Prescribing Medications with Dangerous Interactions

B. Respondent prescribed to Patient E, on multiple occasions, two medications (opioids and muscle relaxers) that, when used concurrently, are synergistic for negative health outcomes. Respondent concurrently prescribed multiple medications to Patient E which could potentiate the individual medications' negative effects, including opioids and Soma (a muscle relaxer which metabolizes to Meprobamate, a barbiturate). These medications, when used concurrently, potentiate the individual medications, with negative effects, such as motor impairment, cognitive impairment, and respiratory depression, which can lead to death.

Ongoing Assessment

C. Respondent failed to adequately evaluate Patient E's progress towards treatment objectives. He failed to utilize relevant objectives to comprehensively evaluate Patient E's controlled substances needs (analgesia, activity level, adverse effects, aberrant behaviors, and affect). Respondent's charting in Patient E's medical records is devoid of adequate use of a pain scale to assess the level of pain (analgesia) and failed to specifically describe the anatomical location of pain, quality of pain, the timing of pain, palliation, and provocation of pain. Additionally, Respondent failed to consistently evaluate other treatment goals such as the patient's activity level (functional goals), adverse effects (side effects), aberrant behaviors (signs of drug or alcohol use, unsanctioned dose escalation, and early refill requests), and patient's affect (changes to mood, depression or anxiety).

Treatment Plan and Objectives

D. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient E. Despite alleging at his Subject Interview that his goals were to reduce the patient's pain and improve his function, Respondent failed to specify measurable goals and objectives used to evaluate the progress of his treatment of Patient E. His documentation failed to show any discernible improvement in pain and associated symptoms during the treatment period. Respondent also failed to include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy becomes necessary.

Patient Consent

E. Respondent failed to adequately perform and/or document the informed consent process with Patient E. Respondent failed to elucidate the potential risks and/or side effects from long-term opioid use, and/or benefits of his treatment plan with the patient. The risks include risk of respiratory depression, motor impairment, cognitive impairment, and death. He also failed to adequately discuss and/or document his discussion about the risk of dependence, misuse, addiction, overdose, and death, with the patient. Although the patient's chart included an Opioid Fact Sheet, there is no evidence in the chart that the information discussed in the Fact Sheet was discussed with the patient

Compliance Monitoring

F. Respondent failed to adequately monitor Patient E for compliance regarding the controlled substances he was using. Respondent failed to adequately investigate Patient E's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate).

Risk Stratification

G. Respondent failed to classify Patient E's risk during his care for the patient. He failed to undertake any risk assessment for his prescribing for long-term use of opioids such as the use of various screening tools (PHQ-2, PHQ-9, CAGE-AID, Opioid Risk Tool, and SOAPP-R). Risk stratification is an important tool to determine the level of risk and how to care for a patient based on the risk of harm.

Pain Management Agreement

H. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient E despite long-term use of controlled substances (greater than 90 days).

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

56. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth, and represent repeated negligent acts.

Patient C

Compliance Monitoring

57. Respondent negligently failed to appropriately monitor Patient C for compliance regarding the controlled substances he was using. Respondent failed to adequately investigate Patient C's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate). While drug screens were utilized, there is no evidence of pill counting,

nor adequate use of CURES.

THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

58. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of medical services to Patients A, B, C, D and E. The circumstances are as follows:

59. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

60. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent excessively prescribed narcotic medications to Patients A, B, and C. The circumstances are as follows:

61. The allegations of the First through Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

62. Respondent prescribed excessive amounts of opioids for Patients A, B and C (and placed those patients at greater risk of harm).

FIFTH CAUSE FOR DISCIPLINE

(Offer of Opioid Reversal Drug)

63. Respondent is subject to disciplinary action under section 741 of the Code, in that Respondent failed to offer his patients a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression. The circumstances are as follows:

64. The allegations of the First through Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

Patient A

65. Respondent failed to offer Patient A a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or

partial reversal of opioid-induced respiratory depression despite the fact that the prescription dosage for Patient A was 90 or more MMEs of an opioid medication per day.

66. Beginning on or about October 4, 2019 through on or about April 8, 2020, Patient A received an average of at least 120 MME or more. Nevertheless, Respondent failed to offer the patient a prescription for naloxone hydrochloride or another drug for the complete or partial reversal of opioid-induced respiratory depression.

Patient D

67. Respondent failed to offer Patient D, a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression despite the fact that an opioid medication was prescribed within a year from the date a prescription for benzodiazepine had been dispensed to the patient.

68. On or about November 17, 2019, February 4, 2020, March 10, 2020, April 17, 2020, May 21, 2020 and May 22, 2020 Patient D filled a prescriptions for clonazepam. On or about each of October 16, 2019, November 15, 2019, November 25, 2019, December 12, 2019, December 30, 2019, January 16, 2020, January 30, 2020, February 24, 2020, March 13, 2020, April 8, 2020, May 18, 2020, June 9, 2020 and June 30, 2020, Respondent prescribed hydrocodone with acetaminophen to Patient D. Nevertheless, Respondent failed to offer the patient a prescription for naloxone hydrochloride or another drug for the complete or partial reversal of opioid-induced respiratory depression.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

69. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed drugs to Patients A, B, C, D, and E above, without appropriate prior examinations and/or medical indications. The circumstances are as follows:

70. The allegations of the First through Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

///

SIXTH CAUSE FOR DISCIPLINE

(Violation of Drug Statute; CURES; Patient Harm)

71. Respondent is subject to disciplinary action under sections 2228.1 and 2238 of the Code and 11165.4 of the Health and Safety Code, in that he failed to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and/or at least once every four months thereafter while the substances remained part of the treatment of the patient. In addition, Respondent's patients suffered harm as a result of his prescribing. The circumstances are as follows:

72. The allegations of the First through Fifth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

73. On or about October 2, 2018 and thereafter, with respect to Patients A, B, C, D and E, Respondent failed to periodically check the CURES database at least once every four months while the patients continued to be prescribed, and fill their prescriptions for controlled substances.

74. Respondent's prescribing resulted in harm to Patient A. Patient A had an admitted problem with drug abuse and requested assistance in treating his addiction. After completing treatment and after a short term period of opioid therapy after a surgical procedure, Respondent reinitiated long-term, high-dose narcotic therapy.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

75. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent has engaged in unprofessional conduct, generally. The circumstances are as follows:

76. The allegations of the First through Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth, and represent unprofessional conduct.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 78560,

issued to Respondent, Joel Ivan Sarachek, M.D.;

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

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

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

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

DATED: APR 28 2023

REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2022603437
65889253