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

In the Matter of the Accusation Against: **F. OMAR BRIONES TORDILLA, M.D.** **225 E Second Ave Ste 101** **Escondido, CA 92025** **Physician's and Surgeon's Certificate No. A 88578,** Respondent.	Case No. 800-2022-086193 **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 Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 13, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 88578 to F. Omar Briones Tordilla, 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 November 30, 2025, unless renewed.

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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 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> ...

5. 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 ...

6. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

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(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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STATUTORY PROVISIONS

7. 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.

...

8. Section 2266 of the Code states:

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

9. 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. ...

10. Section 4021 of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

11. Section 4022 of the Code states:

"Dangerous drug" ... means any drug ... unsafe for self-use in humans ... and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

...

(c) Any other drug ... that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

12. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

COST RECOVERY

13. 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

14. Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

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[1] *Shea v. Board of Medical Examiners*, (1978) 81 Cal.App.3d 564, 575.

15. Norco is a brand name for a hydrocodone-acetaminophen combination product, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I)(i), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Morphine milligram equivalents (MME) are values that represent the potency of an opioid dose relative to morphine. Using morphine as the standard, MME is a tool for doctors to compare different drugs in a simplified, unified measurement.

17. Ambien is a brand name for zolpidem tartrate, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used for the short-term treatment of insomnia.

18. Soma is a brand name for carisoprodol, a muscle relaxant. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022.

19. Flexeril is a brand name for cyclobenzaprine, a muscle relaxant. It is a dangerous drug pursuant to Code section 4022 but not a controlled substance.

STANDARD OF CARE

20. The standard of care for a provider in the state of California when transitioning a patient from acute opioid therapy to chronic opioid therapy (greater than 90 days) is to have a diagnosis of medical necessity.

21. The standard of care for a primary care provider in California, when considering long-term use of opioids for chronic non-cancer pain, given the potential risks of opioid analgesics, is to undertake risk stratification.

22. The standard of care for a primary care provider in the state of California, for patients who are continued on controlled substances after an initial trial, is to base care on outcomes such as making progress toward functional goals (activity level), presence and nature of side effects (adverse effects), pain status (analgesia), mental health status (affect), and any evidence of aberrant behavior such as patient misuse, abuse, or diversion. These are also often referred to as

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the five A's or five objectives in pain management: analgesia, activity level, adverse effects, affect, and aberrant behaviors.

23. The standard of care for a primary care provider in California is, when considering long-term use of opioids for chronic non-cancer pain, the provider and patient should develop treatment goals. The goals of treatment should include: improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance and anxiety/depression; and additionally should include an exit strategy in the event it becomes medically necessary.

24. There is poor evidence for the use of opioids for muscle-skeletal pain and greater risk for harm, especially when using chronic moderate-dose opioids when safer alternatives exist.

25. The standard of care when prescribing Soma is to use only for short periods, up to three weeks.

26. The standard of care for a primary care provider in California, when considering the long-term use of controlled substances, is that the physician discusses the risks and benefits of the treatment plan with the patient.

27. The potential risks of long-term opioid use or chronic Soma use – and the combined use of opioids and Soma – might include respiratory depression, motor impairment, cognitive impairment, and death, and may lead to dependence, misuse, addiction and overdose.

28. The standard of care for the contents of medical records in California is that medical records contain adequate documentation. Medical records serve as the basis for planning and maintaining the quality of patient care. When devoid of important medical information, illegible or unintelligible, the provider and other treating health professionals may remain unaware of important aspects of a patient's medical condition.

29. The standard of care for a primary provider in the state of California, when prescribing chronic opioids or other controlled substances, is to ensure appropriate compliance monitoring.

30. Since October 2, 2018, providers have been required to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance. The

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law has since been amended to include Schedule V controlled substances. Providers must consult CURES:

a. The first time[2] a patient is prescribed, ordered, administered, or furnished a controlled substance, unless one of the exemptions apply.

b. Within the twenty-four-hour period, or the previous business day, before prescribing, ordering, administering, or furnishing a controlled substance, unless one of the exemptions apply.

c. Before subsequently prescribing a controlled substance, if previously exempt. At least once every six months if the controlled substance remains a part of the patient's treatment plan.

FACTUAL ALLEGATIONS

31. At all relevant times, Respondent was a family practice physician in San Diego.

Patient 1:[3]

32. Patient 1 established primary care with Respondent on or about October 5, 2018, at the age of 62 years.

33. On or about October 21, 2018, following aortic valve replacement surgery, the provider concerned had prescribed Patient 1 a thirty-day supply of oxycodone 5 mg, to be taken one to two tablets every four hours for pain, as needed.

34. On or about January 26, 2020, Patient 1 presented to the Urgent Care for lower back pain at a level that was noted as "5/10." Patient 1 was given Toradol and Solu-Medrol (a nonsteroidal anti-inflammatory and a steroid) by injection and advised to follow up with his primary care physician ("PCP") or go to the Emergency Room ("ER") if needed.

35. On or about January 28, 2020, Patient 1 presented to Respondent for an urgent care follow up for his back pain. The injections had helped but Patient 1 reported that his pain had returned. Respondent prescribed 60 x Norco 325/5 mg tablets, a 30-day supply (representing 10 MME daily.)

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[2] "First time" is defined as the initial occurrence in which a health care practitioner intends to prescribe, order, administer, or furnish a controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

[3] Patient names are known to all parties but not disclosed for privacy reasons.

36. Patient 1 returned the following day. Patient 1's chart indicates that his lower back pain was continuing despite the medication. Respondent ordered an X-ray and doubled Patient 1's Norco dosage (20 MME), and noted that an MRI would be ordered if there was no improvement.

37. Patient 1's X-ray showed mild lumbar degenerative changes without significant disc space narrowing.

38. On or about January 31, 2020, Patient 1 reported continued pain with no relief from the increased Norco. On the same date, Respondent documented that he ordered an MRI without contrast of Patient 1's lumbar spine.

39. On or about February 3, 2020, Patient 1 filled a prescription from Respondent for 30 x Percocet 325/5 mg tablets, for a 10-day supply (26 MME).

40. On or about February 11, 2020, a chart note by Respondent indicates that Patient 1 was unable to work and still had back pain; he would be placed on disability.[4] The MRI had showed edema and possible osteomyelitis, and an MRI with contrast was ordered.

41. Also on or about February 11, 2020, Patient 1 signed a Controlled Substance Use Agreement.[5]

42. On or about February 12, 2020, Patient 1 filled a prescription from Respondent for 90 x Percocet 325/5 mg tablets, for a 30-day supply.

43. On or about February 18, 2020, Patient 1 presented for an office visit with reports of right foot pain. Respondent ordered X-rays and labs.

44. The X-ray report of Patient 1's right foot showed no acute findings. Patient 1's lab results dated February 18, 2020, were negative for markers of inflammatory arthritis such as gout, connective tissue disorders, or rheumatoid arthritis.[6]

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[4] Patient 1 was initially placed on two months' disability leave (starting January 29, 2020), which was later extended by a further two months, on or about March 26, 2020.

[5] A handwritten annotation, "Update 10/6/22" with an unknown set of initials appears on the first page of this agreement.

[6] There do not appear to be more general markers of inflammation completed on this date, such as C-Reactive Protein (CRP) or Erythrocyte Sedimentation Rate (ESR).

45. On or about February 20, 2020, Respondent prescribed steroids for Patient 1, who had reported continuing pain, now from his back, leg, and foot.

46. On or about February 21, 2020, the results of Patient 1's MRI with contrast (of his lumbar spine) were positive for osteomyelitis.[7]

47. On or about March 6, 2020, Patient 1 presented for an office visit. Respondent prescribed him Percocet 325/10 mg tablets, to be taken three times per day as needed (45 MME), for his acute bilateral lower back pain.

48. On or about May 22, 2020, Patient 1 was still on the same dosage of Percocet 325/10 mg. Patient 1 presented for an office visit, wanting to return to work. Patient 1 reported feeling good and that he had been cleared by infectious diseases and cardiology.

49. On or about May 26, 2020, Respondent again provided Patient 1 a refill for the Percocet 325/10 mg, three times daily.

50. On or about June 3, 2020, Patient 1's Percocet 325/10 mg dosage was decreased to twice daily (30 MME).

51. Patient 1 presented for an office visit on or about October 30, 2020. In Respondent's chart note for this visit, he states Patient 1 was negative for muscle-skeletal complaints. In his physical exam, Respondent describes Patient 1's muscle-skeletal and neurological systems as normal. In his assessment and plan, Respondent will refill Patient 1's pain medications for his low back pain and also for his inflammatory polyarthritis.

52. There is no indication in Patient 1's chart of how the diagnosis of inflammatory polyarthritis was made.

53. Patient 1 again presented for continuing refills in March, August, and December 2021, and April and August 2022.

54. In his chart note for Patient 1's office visit dated August 2, 2022, Respondent again states Patient 1 was negative for muscle-skeletal complaints and that his muscle-skeletal and

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[7] Osteomyelitis is inflammation or swelling that occurs in the bone.

neurological systems were normal. Respondent refilled Patient 1's pain medication for his inflammatory polyarthritis. Respondent states:

"[Patient 1] aware of risk. [C]onsider tapering down or pain management. ..."

55. Also on August 2, 2022, Respondent's assessment and plan for Patient 1 includes "acute pain of right shoulder," with an order for X-rays to be taken. It is unclear where this diagnosis originates as there is no discussion of Patient 1's shoulder in the history of present illness ("HPI"). The shoulder X-ray results show "no acute radiographic findings" and mild osteoarthrosis.

56. On or about August 31, 2022, Patient 1 asks for – and is given – a refill prescription for cyclobenzaprine, a non-controlled substance. It is unclear from Patient 1's chart why this medication is prescribed.[8]

57. On or about October 6, 2022, a one-year CURES report was pulled for Patient 1's controlled substance prescriptions and can be found in his chart.[9] There is no indication that Respondent reviewed this report and there is no reference to it in any chart notes. This is the only CURES report found in Patient 1's chart.

58. In a chart note dated October 13, 2022, Respondent states Patient 1 is negative for muscle-skeletal complaints. His physical exam showed low paraspinal tenderness bilaterally. Respondent documents that he and Patient 1 discussed, at length, the prolonged use of pain medication and that Patient 1 had agreed to tapering down the medication. A plan was made to decrease Percocet to one daily in November 2022.

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[8] In a note dated November 8, 2018, an employee documents a call from Patient 1, in which he said he had "a stiff neck and was wondering if he could get some muscle relaxers." A prescription (of an unidentified medication, presumably cyclobenzaprine) was apparently approved and sent to the pharmacy. Cyclobenzaprine 10 mg is listed as one of Patient 1's active medications on subsequent chart notes, reportedly stopped on September 25, 2019. The next (and final, until August 31, 2022) reference to cyclobenzaprine is in a chart note dated January 28, 2020, when Respondent prescribed Flexeril (a brand name for cyclobenzaprine), along with Norco and ibuprofen, for Patient 1's low back pain.

[9] Pages 2 and 3 of the three-page report are in Patient 1's chart. Page 1 is absent.

59. Patient 1 was prescribed two Percocet 325/10 mg tablets daily (30 MME) for a total of two years and five months, from June 2020 through November 2022. This was more than two years following resolution of Patient 1's osteomyelitis.

60. On or about November 5, 2022, Patient 1's Percocet 325/10 mg dosage was decreased to one per day (15 MME). Patient 1 remained on this medication and dosage for four months, until March 2023.

61. On or about March 16, 2023, Patient 1 presented for an office visit. Per Respondent's chart note of that date, Patient 1 was "trying to stop [P]ercocet. Trying to hold of[f] on pain meds." Respondent did not prescribe any further opioids to Patient 1.

62. In an interview with the Medical Board, Respondent stated that he did not do urine drug screens[10] because Patient 1 did not give him any indication for them. There is no evidence that Respondent utilized other compliance monitoring techniques, such as pill counting.

63. Respondent's records for Patient 1 do not show the use of any screening tools to evaluate Patient 1's potential risks of misuse of a controlled substance.

64. There is no evidence, from Respondent's records for Patient 1, that Respondent evaluated Patient 1's progress toward any treatment objectives. There is no indication of the use of a 1 to 10 pain scale, or any ongoing assessment that includes descriptions of the anatomical location of pain, quality of pain, timing of pain, palliation, and provocation of pain.

65. There is no evidence that Respondent consistently evaluated treatment goals such as Patient 1'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).

66. Respondent's chart for Patient 1 does not adequately demonstrate a discussion with Patient 1 regarding the potential risks of long-term opioid use, including the risk of respiratory depression, motor impairment, cognitive impairment, and death. There was also no clearly documented discussion of the risk of dependence, misuse, addiction, overdose, and death.

[10] Patient 1's chart contains lab results for one urinalysis conducted on or about November 13, 2018, along with a complete blood count ("CBC") and other labs.

67. Respondent's notes for Patient 1 almost uniformly do not include a detailed history, and lack information on the assessment and planning necessary to allow Respondent and other providers to determine if appropriate, adequate, and safe treatment was being provided to Patient 1.

68. Respondent did not specify measurable goals and objectives to evaluate Patient 1's treatment progress. His chart notes for Patient 1 fail to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also did not include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy became necessary.

Patient 2:

69. According to Respondent, Patient 2 established primary care with him in 2010.[11].

70. In January 2018, Patient 2 was a 56-year-old female whose chronic conditions included: chronic pain disorder, narcotic dependence, post inflammatory pulmonary fibrosis, insomnia, status post bariatric surgery, malignant lymphomas (unspecified site), paresthesia of foot (change in sensation), and lumbosacral radiculopathy. On or about January 2, 2018, Patient 2 filled prescriptions for 90 x Soma, 90 x Percocet 325/7.5 mg, and 30 x Ambien, in each case a thirty-day supply.

71. On or about February 1, 2018, Patient 2 presented for an office visit for medications. In Respondent's chart note for this visit, he notes no joint swelling and muscle weakness, and documents normal musculoskeletal system and normal neurologic system.

72. From February 2018 through July 2019, Patient 2 continued to receive Percocet 325/7.5 mg for a daily MME of 33.8.

73. In a chart note for a visit on or about August 13, 2019, Respondent documented that Patient 2 "needs increase in meds." There is no indication in the chart note of why Patient 2 needed a dose increase. The chart note stated, further, that the Percocet was to be increased to four times daily "for the next 2 months," then return to three times daily in October 2019.

[11] Records provided to, and reviewed by, the Board cover care and treatment provided to Patient 2 during the period January 1, 2018, through June 27, 2023.

74. Patient 2 remained on the increased dose of Percocet for three and a half years, until May 2023, when it was dropped back to three times daily.

75. Patient 2 had an X-ray of her left hip on or about August 20, 2019. The radiologist's impression was "normal left hip."

76. Patient 2 had X-rays of her left hip and her left shoulder on or about January 8, 2021. The radiologist's impression was "normal left hip" and "normal left shoulder."

77. Respondent's requests for an MRI for Patient 2 were denied and, on or about January 20, 2021, Respondent and Patient 2 agreed that she would try physical therapy for her left hip. There is no indication in the chart of whether Patient 2 ever received physical therapy or, if so, whether it had any effect on her reported condition.

78. Patient 2 filled prescriptions for ninety (90) Soma 350 mg tablets monthly (three per day) from at least February 2019 through March 2022. According to Patient 2's CURES report, in April 2022, Patient 2 started filling prescriptions from Respondent for one hundred twenty (120) tablets per month, or four per day. The reason for the increased prescription is not documented in Patient 2's chart.[12]

79. On or about July 6, 2022, X-rays were taken of Patient 2's right and left shoulders. Both showed mild tendinitis and mild degenerative changes "without acute osseous abnormality."

80. On or about August 21, 2022, Respondent received a letter from a major retail pharmacy about the dangers of prescribing a combination of Soma, Ambien, and Percocet to Patient 2. A handwritten (undated) annotation on the margin of the (typed) letter states, "no more Soma. Just Flexeril [cyclobenzaprine]."

81. On or about August 22, 2022, a one-year CURES report was pulled for Patient 2's controlled substance prescriptions and can be found in her chart. There is no indication that

[12] Patient 2 called the office on or about March 23, 2022, for a refill of her Soma prescription, three per day. On or about the same date, she filled her usual ninety tablets (for three per day). In the chart note for an office visit on or about April 21, 2022, Patient 2's medications are reported as including four Soma tablets per day. Respondent's plan and assessment is to "continue current treatment," and, starting April 21, 2022, Patient 2 fills prescriptions for four Soma tablets per day. No other mention of the increase in Soma dosage can be found in Patient 2's chart.

Respondent reviewed this report and there is no reference to it in any chart notes. This is the only CURES report found in Patient 2's chart.

82. On or about September 19, 2022, Patient 2 called Respondent's office and asked for refills for her Percocet and Ambien prescriptions, and asked for a prescription for Flexeril. It is unclear why she asked for Flexeril or whether the "no more Soma" was communicated to her at any time. The note, documenting the phone call, includes the word "Cures" without further elucidation.

83. On or about December 22, 2022, Respondent documented in his chart note that Patient 2 was aware of the risk of prolonged pain medication use and should taper down. Mention was made of a "poss[ible] pain management referral."

84. Patient 2 remained on Percocet 325/7.5 mg four times daily, for an approximate daily MME of 45, until May 2023.

85. On or about April 28, 2023, a certified letter was delivered to Patient 2, asking her to authorize the release of her medical records to the Division of Investigation. Patient 2 did not respond to the letter.

86. Respondent's chart for Patient 2 documents communications with her on or about May 15 and May 16, 2023, regarding medication refills. In the note dated May 16, 2023, Respondent documents:

> "discussed at length chronic pain med use. suggested tapering down. pt. agrees. will decrease from Percocet ... qid # 120 to Percocet ... tid #90, also consider pain management."

87. Respondent did not do any urine drug screens on Patient 2.

88. Respondent prescribed to Patient 2 a combination of Ambien, Soma, and Percocet for at least a period of five years. Following the August 2022 letter from the retail pharmacy regarding the dangers of this combination, Respondent switched from Soma to Flexeril in September 2022, and continued prescribing Percocet and Ambien until at least October 2023.

89. Respondent's records for Patient 2 do not show the use of any screening tools to evaluate Patient 2's potential risks of misuse of a controlled substance.

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90. There is no evidence, from Respondent's records for Patient 2, that Respondent evaluated Patient 2's progress toward any treatment objectives. There is no indication of the use of a 1 to 10 pain scale, or any ongoing assessment that includes descriptions of the anatomical location of pain, quality of pain, timing of pain, palliation, and provocation of pain.

91. There is no evidence that Respondent consistently evaluated treatment goals such as Patient 2'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).

92. Respondent's chart for Patient 2 does not adequately demonstrate a discussion with Patient 2 regarding the potential risks of long-term opioid use, including the risk of respiratory depression, motor impairment, cognitive impairment, and death. There was also no clearly documented discussion of the risk of dependence, misuse, addiction, overdose, and death.

93. Respondent's notes for Patient 2 almost uniformly do not include a detailed history, and lack information on the assessment and planning necessary to allow Respondent and other providers to determine if appropriate, adequate, and safe treatment was being provided to Patient 2.

94. Respondent did not specify measurable goals and objectives to evaluate Patient 2's treatment progress. His chart notes for Patient 2 fail to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also did not include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy became necessary.

95. During the roughly five and a half years of records reviewed, Patient 2 made fourteen (14) office visits to Respondent and had six (6) telehealth visits with Respondent. In Respondent's notes for each of these twenty (20) visits, under "Review of Systems," he documents that Patient 2 was negative for joint swelling and muscle weakness.

96. Respondent documents a normal musculoskeletal exam at each of nine (9) visits between January 2018 and November 2019. No physical exam or demonstration of movement is documented on any of the telehealth visits.

97. A single Narcotic Use Agreement was found in Patient 2's chart, dated October 3, 2017, and covering Patient 2's use of Percocet.

Patient 3:

98. Patient 3 is an adult female born in 1978.

99. Respondent's chart note for an office visit by Patient 3 on or about March 14, 2019[13], lists Patient 3's chronic conditions as: chondromalacia of the left knee, synovitis of the right knee, gastroesophageal reflux disease without esophagitis, morbid obesity, narcotic dependence, right adrenal mass, thyroid nodule, dysmenorrhea, chronic back pain, migraine, abnormal mammogram of right breast, and hypothyroidism.

100. From (at least) January 2019 through September 2023, Respondent treated Patient 3's muscle-skeletal pain (chronic low back pain and inflammatory polyarthritis) with Percocet 325/10 mg, to be taken three per day (for a daily MME of 45), decreasing on May 11, 2023, to two per day for a daily MME of 30. Patient 3's final prescription for narcotics was filled by the pharmacy on September 5, 2023, and sold on September 7, 2023.

101. In addition to the Percocet, Respondent prescribed Soma 350 mg tablets, three daily, for Patient 3 from (at least) January 2019 through July 2022.[14]

102. In the records reviewed for Patient 3, the first reference to the risks of prolonged opioid use is found in the chart note dated October 3, 2022. On the same date, Patient 3 signed a "Patient Agreement for Prescription Opioids (Narcotics)" in which potential side effects of opioids were described and initialed by Patient 3. [15]

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[13] The medical records reviewed for Patient 3 cover the period January 1, 2019, through December 31, 2023.

[14] On or about August 21, 2022, Respondent received a letter from a major retail pharmacy about the dangers of prescribing a combination of Soma, Ambien, and Percocet.

[15] Patient 3 signed a Controlled Substance Use Agreement on or about August 26, 2019, in which her duties and responsibilities with regard to her controlled substance medications are outlined.

103. Respondent did not do urinalysis on Patient 3. Patient 3's chart contains two CURES reports, one obtained on or about October 3, 2022, and a second one on or about September 5, 2023.

104. Respondent's records for Patient 3 do not show the use of any screening tools to evaluate Patient 3's potential risks of misuse of a controlled substance.

105. There is no evidence, from Respondent's records for Patient 3, that Respondent evaluated Patient 3's progress toward any treatment objectives. There is no indication of the use of a 1 to 10 pain scale, or any ongoing assessment that includes descriptions of the anatomical location of pain, quality of pain, timing of pain, palliation, and provocation of pain.

106. There is no evidence that Respondent consistently evaluated treatment goals such as Patient 3'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).

107. Respondent's chart for Patient 3 does not adequately demonstrate a discussion with Patient 3 regarding the potential risks of long-term opioid use or chronic Soma use and/or the combined use of opioids and Soma, including respiratory depression, motor impairment, cognitive impairment, and death. There was also no clearly documented discussion of the risk of dependence, misuse, addiction, overdose, and death.

108. Respondent's notes for Patient 3 almost uniformly do not include a detailed history, and lack information on the assessment and planning necessary to allow Respondent and other providers to determine if appropriate, adequate, and safe treatment was being provided to Patient 3.

109. Respondent did not specify measurable goals and objectives to evaluate Patient 3's treatment progress. His chart notes for Patient 3 fail to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also did not include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy became necessary.

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Patient 4:

110. Patient 4 is an adult male, born in 1964. He is the husband of Patient 3.

111. Respondent's chart note for an office visit by Patient 4 on or about April 4, 2019[16], lists Patient 4's chronic conditions: morbid obesity, localized osteoarthritis of right knee, inflammatory polyarthritis, arthritis and osteoarthritis of left knee, bilateral chronic knee pain, narcotic dependence, sleep apnea, nocturnal hypoxia, nocturnal hypoxemia.

112. The chart note for the April 4, 2019, visit states, under "History of Present Illness," that Patient 4 "needs refills." No additional information is provided. All the findings from the physical exam of Patient 4 are documented as normal, and Patient 4's muscle-skeletal system shows no joint swelling or muscle weakness.

113. On or about February 11, 2019, Patient 4 saw orthopedic surgeon, Dr. B., in a follow-up appointment for his left knee. According to the chart note for that visit, Patient 4 reported his pain level as 3 on a scale of 1 to 10.

114. On or about July 20, 2022, Patient 4 saw Dr. B. for a consult of his right hip. According to the chart note for that visit, Patient 4 reported his pain level as 1 to 2 out of 10. Patient 4 reported that his symptoms had decreased significantly over the prior couple of weeks. In comparing X-rays, Dr. B. found minimal progression in the arthritic changes in Patient 4's hip over a period of four years.

115. Like Patient 3, from (at least) January 2019 through September 2023, Respondent treated Patient 4's muscle-skeletal pain (bilateral knee pain and inflammatory polyarthritis) with Percocet 325/10 mg. Patient 4's dosage was approximately 60 MME until May 11, 2023, when it was decreased to 45 MME. Patient 4's final prescription for narcotics was filled by the pharmacy on September 5, 2023, and sold on September 7, 2023.

116. In addition, like with Patient 3, Respondent prescribed Soma 350 mg tablets, three daily, to Patient 4, from (at least) January 2019 through June 2022.

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[16] The medical records reviewed for Patient 4 cover the period January 1, 2019, through December 31, 2023.

117. With rare exceptions, for the entirety of the period reviewed, Patient 4's Percocet and Soma prescriptions were filled and/or sold on the same date as Patient 3's Percocet and Soma prescriptions.

118. Respondent did not do urinalysis on Patient 4.[17]

119. Patient 4's chart contains four CURES reports, two of which were obtained on or about the same date as Patient 3's CURES report(s), namely, October 3, 2022, and September 5, 2023. In addition, there are patient CURES reports for Patient 4 dated June 24, 2022, and August 26, 2023.

120. Like Patient 3, Patient 4 signed a Controlled Substance Use Agreement on or about August 26, 2019.

121. Like Patient 3, Patient 4 signed a Patient Agreement for Prescription Opioids (Narcotics) on or about October 3, 2022.

122. Respondent's records for Patient 4 do not show the use of any screening tools to evaluate Patient 4's potential risks of misuse of a controlled substance.

123. There is no evidence, from Respondent's records for Patient 4, that Respondent evaluated Patient 4's progress toward any treatment objectives. There is no indication of the use of a 1 to 10 pain scale, or any ongoing assessment that includes descriptions of the anatomical location of pain, quality of pain, timing of pain, palliation, and provocation of pain.

124. There is no evidence that Respondent consistently evaluated treatment goals such as Patient 4'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).

125. Respondent's chart for Patient 4 does not adequately demonstrate a discussion with Patient 4 regarding the potential risks of long-term opioid use or chronic Soma use and/or the combined use of opioids and Soma, including respiratory depression, motor impairment,

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[17] According to a note made following a phone call with Patient 4 on or about September 5, 2023 (the date of Patient 4's final prescription for narcotics), a urine drug screen was ordered. There is no indication in the chart of whether it was performed and, if so, its results.

cognitive impairment, and death. There was also no clearly documented discussion of the risk of dependence, misuse, addiction, overdose, and death.

126. Respondent's notes for Patient 4 almost uniformly do not include a detailed history, and lack information on the assessment and planning necessary to allow Respondent and other providers to determine if appropriate, adequate, and safe treatment was being provided to Patient 4.

127. Respondent did not specify measurable goals and objectives to evaluate Patient 4's treatment progress. His chart notes for Patient 4 fail to show discernible improvement in pain and associated symptoms during the treatment period. Respondent also did not include an exit strategy for discontinuing controlled substances therapy in the event that tapering or termination of controlled substances therapy became necessary.

Patient 5:

128. Patient 5, a male adult, was born in 1955. He was a patient of Respondent, who prescribed Patient 5 opioids from at least 2007 through February 2023.[18]

129. Respondent treated Patient 5's muscle-skeletal pain (chronic low back pain, inflammatory polyarthritis, and "chronic pain") with a combination of Norco 325/5 mg and Percocet 325/10 mg[19] continuously from at least January 2018 through August 2022, for a continuous, combined MME of approximately 90 to 102.

130. Respondent discontinued the Percocet in August 2022, but continued prescribing Norco 325/5 (13 MME) to Patient 5 until February 2023.

131. According to a patient CURES report for Patient 5, he filled his prescriptions at multiple pharmacies and paid by various methods, including commercial insurance, private pay, and "other." Patient 5 requested early refills of his opioids on multiple occasions.

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[18] Medical records were reviewed for Patient 5 covering the period January 2018 through March 2023.

[19] Respondent also prescribed Percocet 325/10 mg, four tablets per day (60 MME) to Patient 5's wife, continuously from at least January 2019 through April 2023, and to Patient 5's son continuously from at least January 2019 through July 2019, when he passed away due to acute fentanyl and oxycodone intoxication.

132. On or about October 5, 2018, a representative from CVS pharmacy called Respondent's office to confirm that Patient 5 was to receive both Percocet and Norco. According to the telephone message documented in Patient 5's chart, the CVS employee stated that since Patient 5, Patient 5's son and Patient 5's spouse were all getting opioid pain medications, it might be best for them to be referred to pain management instead of getting their medications from Respondent, their primary care provider.

133. On or about January 11, 2019, a representative from CVS pharmacy again expressed concern about dispensing both Percocet and Norco to Patient 5.

134. On or about February 11, 2019, Patient 5 reported further problems with filling prescriptions for both Percocet and Norco at CVS. Reportedly, the pharmacist insisted that Patient 5 would benefit from pain management and refused to refill more than a seven-day supply of Percocet to hold him over. Patient 5 requested that his future prescriptions be sent to Walgreens pharmacy.

135. On or about February 25, 2019, Patient 5 asked for his Norco prescriptions to be sent to Indian Health Pharmacy.

136. On or about March 1, 2019, a representative of Indian Health Pharmacy contacted Respondent's office for confirmation that Patient 5 was going to be on both Norco and Percocet simultaneously.

137. A patient CURES report for Patient 5 was pulled on April 30, 2019, and marked "Reviewed."

138. On or about October 2, 2019, Patient 5 signed a Controlled Substance Use Agreement.

139. On or about June 5, 2020, a representative from Walgreens pharmacy called Respondent's office to confirm that Patient 5 was receiving both Percocet and Norco medications.

140. On or about December 30, 2021, Patient 5 called Respondent's office and asked that his Norco refill be sent to Rite Aid pharmacy as he is no longer using Walgreens. On the same day, a representative from Rite Aid Pharmacy called Respondent's office saying they did not feel comfortable filling the Norco prescription since Patient 5 also had a prescription for Percocet.

141. Per a note in Patient 5's chart dated December 30, 2021, Patient 5 told Respondent's office staff that the Rite Aid pharmacist had declined to fill his medication because he did not have pharmacy benefits. He asked that the Norco prescription be sent to Indian Health Pharmacy.

142. On or about July 14, 2022, Patient 5 called Respondent's office and asked for his Percocet prescription to be transferred to Sav-On pharmacy. He called twice again on the same date, to follow up on the transfer request. On or about July 15, 2022, Patient 5 called again about transferring the refill order of his Percocet to Sav-On, and roughly an hour and a half later, Patient 5's son called about the same transfer request.

143. On or about July 21, 2022, Patient 5 told Respondent's office staff that the pharmacist at Sav-On would only give him a one-week's supply of Percocet at a time, until Patient 5 saw a pain management physician.

144. Patient 5 had a pain management appointment on August 11, 2022. On or about August 8, 2022, Patient 5 called and said it was imperative that he speak with Respondent before August 11, 2022. On or about August 9, 2022, Patient 5 again called to say that he was going to cancel his pain management appointment and would stop taking Percocet. He asked for a refill of his Norco prescription to be sent to Indian Health.

145. A note in Patient 5's chart dated September 12, 2022, states that Respondent spoke to Patient 5 "at length concerning his norco." Patient 5 had been sent to pain management but did "not want to see them." Patient 5 only wanted to see Respondent.

> "[Patient 5] already has stopped his percocet. [Patient 5] aware of risk with cont[inued] norco use. discussed the amount of norco he is taking #180. [Patient 5] is will[ing] to taper down and decrease amount of norco 5/325 #120. [Patient 5] is on contract. refill his norco 5/325 #120."

146. A patient CURES report for Patient 5 was pulled on September 12, 2022, and initialed.[20]

147. According to Patient 5's chart, Respondent discussed with him the risks associated with prolonged pain medication use on or about November 16, 2022. In a note dated February

[20] Patient 5's chart for the period reviewed contained two CURES reports, pulled April 30, 2019, and September 12, 2022. Besides these two reports, a further report dated August 27, 2015 (outside the period of review) was found in Patient 5's chart.

22, 2023, Respondent noted that Patient 5 was "aware of prolonged pain med[ication] use." Patient 5 "refused to go back [to pain management]. Consider tapering down."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

148. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5, as more particularly alleged hereinafter:

149. Paragraphs 14 through 147, above, are hereby realleged and incorporated by this reference as if fully set forth herein.

150. *Patient 1*:

a) Between approximately May 2020 through at least November 2022, Respondent used chronic opioid therapy on Patient 1 in the absence of a diagnosis of medical necessity and/or to treat muscle-skeletal pain.

b) Respondent failed to classify Patient 1's risk prior to initiating his long-term use of opioids.

c) Respondent failed to utilize any objectives to fully evaluate Patient 1's controlled substances needs.

d) Respondent failed to elucidate a coherent treatment plan and objectives when utilizing chronic opioid therapy on Patient 1.

e) Respondent failed to clearly elucidate to Patient 1 the long-term risks or side effects of opioids.

f) Respondent failed to conduct adequate compliance monitoring to ensure Patient 1's appropriate and/or safe use of controlled substances.

g) Respondent failed to keep adequate medical records of his care and treatment of Patient 1.

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151. *Patient 2*:

a) Respondent treated Patient 2 with chronic moderate-dose opioids without an appropriate medical indication.

b) Respondent prescribed to Patient 2 for chronic use Soma, Percocet, and Ambien – three medications that, when used concurrently, are synergistic for negative health outcomes.

c) Respondent failed to utilize the five objectives in pain management to fully evaluate Patient 2's controlled substance needs and/or determine the efficacy of the treatment.

d) Respondent prescribed to Patient 2 a sedative/hypnotic not indicated for long-term therapy, namely, Ambien, for a period of at least six and a half years.

e) Respondent failed to utilize treatment guidelines when prescribing Soma to Patient 2, when safer alternatives were available.

f) Respondent failed to elucidate clear treatment goals and objectives in his ongoing prescribing of controlled substances to Patient 2.

g) Respondent failed to clearly elucidate to Patient 2 the risks or side effects of opioids, sedative/hypnotics, and Soma, and their combined use.

h) Respondent failed to adequately undertake advised compliance monitoring of Patient 2 to meet patient safety goals and/or legal requirements.

i) Respondent failed to keep adequate medical records on his care and treatment of Patient 2.

152. *Patient 3*:

a) Respondent treated Patient 3 with chronic moderate-dose opioids without an appropriate medical indication.

b) Respondent prescribed to Patient 3 for chronic use Soma and Percocet – two medications that, when used concurrently, are synergistic for negative health outcomes.

c) Respondent failed to utilize treatment guidelines when prescribing Soma to Patient 3, when safer alternatives were available.

d) Respondent failed to develop any treatment plan or objectives when utilizing chronic opioid therapy in his care and treatment of Patient 3.

e) Respondent failed to utilize the five objectives in pain management to evaluate Patient 3's controlled substance needs and/or determine the efficacy of the treatment.

f) Respondent failed to clearly elucidate to Patient 3 the risks or side effects of opioids, sedative/hypnotics, and Soma, and their combined use.

g) Respondent failed to adequately undertake advised compliance monitoring of Patient 3 to meet patient safety goals and/or legal requirements.

h) Respondent failed to keep adequate medical records on his care and treatment of Patient 3.

153. *Patient 4*:

a) Respondent treated Patient 4 with chronic moderate-dose opioids without an appropriate medical indication.

b) Respondent prescribed to Patient 4 for chronic use Soma and Percocet - two medications that, when used concurrently, are synergistic for negative health outcomes.

c) Respondent failed to utilize treatment guidelines when prescribing Soma to Patient 4, when safer alternatives were available.

d) Respondent failed to develop any treatment plan or objectives when utilizing chronic opioid therapy in his care and treatment of Patient 4.

e) Respondent failed to utilize the five objectives in pain management to evaluate Patient 4's controlled substance needs and/or determine the efficacy of the treatment.

f) Respondent failed to clearly elucidate to Patient 4 the risks or side effects of opioids, sedative/hypnotics, and Soma, and their combined use.

g) Respondent failed to adequately undertake advised compliance monitoring of Patient 4 to meet patient safety goals and/or legal requirements.

h) Respondent failed to keep adequate medical records on his care and treatment of Patient 4.

154. *Patient 5:*

a) Respondent treated Patient 5 with chronic high-dose opioids without an appropriate medical indication.

b) Respondent failed to develop any treatment plan or objectives when utilizing chronic opioid therapy in his care and treatment of Patient 5.

c) Respondent failed to utilize the five objectives in pain management to evaluate Patient 5's controlled substance needs and/or determine the efficacy of the treatment.

d) Respondent failed to clearly and timely elucidate to Patient 5 the risks or side effects of opioids, sedative/hypnotics, and their combined use.

e) Respondent failed to adequately undertake advised compliance monitoring of Patient 5 to meet patient safety goals and/or legal requirements.

f) Respondent failed to keep adequate medical records on his care and treatment of Patient 5.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

155. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5, as more particularly alleged in paragraphs 14 through 154, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without Prior Examination and Medical Indication)

156. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed dangerous drugs as defined in Section 4022 of the Code without an appropriate prior examination and a medical indication, as more particularly alleged in paragraphs 14 through 155, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

157. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records

relating to his provision of services to Patient 1, Patient 2, Patient 3, Patient 4, and Patient 5, as more particularly alleged in paragraphs 14 through 155, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

158. Respondent is further subject to disciplinary action under 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 14 through 157, above, which are hereby realleged and incorporated by this reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 88578, issued to Respondent F. Omar Briones Tordilla, M.D.;

2. Revoking, suspending or denying approval of Respondent F. Omar Briones Tordilla, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent F. Omar Briones Tordilla, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 0 8 2025

Jenna Gomez for

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