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

In the Matter of the Accusation Against: Raymond John Dorio, M.D. Physician's and Surgeon's Certificate No. A 29371 Respondent.	Case No.: 800-2021-076569

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 20, 2025.

IT IS SO ORDERED: February 18, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

Michelle A. Bholat, M.D., Chair
Panel A

ROB BONTA
Attorney General of California
EDWARD KIM
Supervising Deputy Attorney General
COLLEEN M. MCGURRIN
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **RAYMOND JOHN DORIO, M.D.** **24237 Main Street** **Newhall, CA 91321-2907** **Physician's and Surgeon's Certificate Number A 29371** Respondent.	Case No. 800-2021-076569 OAH No. **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 Colleen M. McGurrin, Deputy Attorney General.

2. Raymond John Dorio, M.D. (Respondent) is represented in this proceeding by attorney Mark B. Guterman of La Follette, Johnson, De Haas, Fesler & Ames, whose address is: 701 North Brand Boulevard, Suite 600, Glendale, CA 91203.

3. On or about July 18, 1975, the Board issued Physician's and Surgeon's Certificate Number A 29371 to Raymond John Dorio, M.D., 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. 800-2021-076569, and will expire on September 30, 2026, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076569 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 March 27, 2024. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-076569 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. 800-2021-076569. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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

8. Respondent freely, 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. 800-2021-076569, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the Accusation, and that Respondent hereby gives up his right to contest those

charges.

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2021-076569, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate Number A 29371 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and 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. 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.

15. 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. 800-2021-076569 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.

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 Number A 29371 issued to Respondent RAYMOND JOHN DORIO, M.D. is revoked. However, the revocation is stayed, and Respondent is placed on probation for three (3) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act (Act), (a) except for those drugs listed in Schedules IV and V of the Act, and (b) provided that this restriction shall not apply to hospice care patients in a clinical setting.

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 in a clinical setting. 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.

2. 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.

3. 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, including but not limited to HIPPA regulations and requirements, evaluating and treating patients with past or current alcohol or drug abuse/misuse, prescribing to patients with current or past substance or alcohol abuse, and any other area deemed necessary, 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.

4. 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.

5. 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.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 program would have been approved by the Board or its designee had the program 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 program 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. 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.

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

10. 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.

11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, investigation, expert review, legal reviews, analysis and strategy, and other enforcement costs in the amount of $48,700 (forty-eight thousand seven hundred dollars). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

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

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

12. 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.

13. 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 or is in hospice care.

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.

14. 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.

15. 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' 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; and Quarterly Declarations.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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. 800-2021-076569 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, Mark B. Guterman. 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: _____

RAYMOND JOHN DORIO, M.D.
Respondent

I have read and fully discussed with Respondent Raymond John Dorio, 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: _____

Mark B. Guterman, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully

California and delivered to the Board or its designee no later than January 31 of each calendar year.

20. 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. 800-2021-076569 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, Mark B. Guterman. 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: 12-12-24

RAYMOND JOHN DORIO, M.D.
Respondent

I have read and fully discussed with Respondent Raymond John Dorio, 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: 12/12/24

Mark B. Guterman, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully

submitted for consideration by the Medical Board of California.

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California

Edward Kim Digitally signed by Edward Kim Date: 2024.12.18 10:10:34 -08'00'

EDWARD KIM
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-076569

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Attorneys for Complainant

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

In the Matter of the Accusation Against: **RAYMOND JOHN DORIO, M.D.** **24237 Main Street** **Newhall, California 91321-2907** **Physician's and Surgeon's Certificate Number A 29371,** Respondent.	Case No. 800-2021-076569 **ACCUSATION**

PARTIES

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

2. On July 18, 1975, the Board issued Physician's and Surgeon's Certificate Number A 29371 to Raymond John Dorio, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2024, 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 22 of the Code provides, in pertinent part:

> "Board" as used in any provisions of this code, refers to the board in which the administration of the provision is vested, and unless otherwise expressly provided, shall include . . . "department," "division," . . . and "agency."

5. Section 477 of the Code provides, in pertinent part: As used in this division:

> (a) "Board" includes . . . "department," "division," . . . and "agency."
>
> (b) "License" includes certificate, . . . or other means to engage in a business or profession regulated by this code.

6. Section 2220 of the Code provides, in pertinent part:

> 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 . . . other licensees, from health care facilities, . . . 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) . . . (c).

7. Section 2227 of the Code provides, in pertinent part:

> (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 . . . license revoked upon order of the board.
>
> (2) Have his . . . right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

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

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

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

8. Section 2234 of the Code, provides, in pertinent part:

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

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

(b) Gross negligence.

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

(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) . . . (g).

9. Section 2242, subdivision (a), of the Code provides, in pertinent part:

(a) Prescribing . . . 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 2263 of the Code states: The willful, unauthorized violation of professional confidence constitutes unprofessional conduct.

11. 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.

12. Section 4022 of the Code provides, in pertinent part: "Dangerous drug" . . . means any drug . . . unsafe for self-use in humans or animals, 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.

(b) . . . .

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

HEALTH AND SAFETY CODE

13. Health and Safety Code section 11165.4, subdivision (a) provided, in pertinent part, in October 2018:

> (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.

COST RECOVERY

14. Section 125.3 of the Code states that:

> (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
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> (b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.
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> (c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not

limited to, charges imposed by the Attorney General.

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

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

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

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

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

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

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

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

BACKGROUND INFORMATION

15. On or about August 11, 2016,[1] Respondent saw Patient A[2] for an initial visit in her home. She was a sixty-five-year-old female with many problems, and her blood pressure was

[1] This is the first visit documented in the patient's chart and when she was first seen by Respondent; however, according to the patient's CURES report, he had prescribed her temazepam and hydrocodone bitartrate/acetaminophen on an earlier date, August 5, 2016.

[2] For privacy, the patient is identified in this pleading as Patient A. The patient's full name will be disclosed upon a timely request for discovery per Government Code §11507.6.

110/80. He noted she had not seen a doctor for some time; however, according to the patient's Controlled Substance Utilization Review & Evaluation System (CURES) report, she had filled prescriptions for controlled substances by three other providers on or about May 18, June 20, and July 2, 2016. He noted she had Rheumatoid arthritis[3] all over her body since she was 18-years-old, had been to a pain management doctor who gave some medication that Medicare would not cover, and that oxycodone[4] was too strong, so she was ultimately given Norco.[5] He listed her current medications regimen as temazepam[6] 15 mg and lorazepam[7] 2 mg to calm her panic attacks. She stated she had gastrointestinal pain with attacks of diarrhea, and diverticulitis.[8] His plan was to continue the patient's temazepam, lorazepam, and Norco, to perform blood work

[3] Rheumatoid arthritis, abbreviated as RA, is a chronic inflammatory disorder that can affect more than just one's joints. In some people, the condition can damage a wide variety of body systems, including the skin, eyes, lungs, heart and blood vessels.

[4] Oxycodone is a Schedule II controlled substance, also known as OxyContin, Percocet, Endocet, Roxicodone, Roxicet and others, and is an opioid pain medication sometimes called a narcotic. It is used to treat moderate to severe pain and the extended-release form of oxycodone is for around-the-clock treatment of pain treatment and should not be used on an as-needed basis for breakout pain.

[5] Norco is a Schedule II controlled substance that contains a combination of acetaminophen and hydrocodone and is used to relieve moderate to moderately severe pain. Hydrocodone is an opioid pain medication that is sometimes called a narcotic and acetaminophen is a less potent pain reliever that increases the effects of hydrocodone.

[6] Temazepam is the generic name for the brand name Restoril which is a Schedule IV controlled substance, a benzodiazepine, that affects chemicals in the brain that may be unbalanced in people with sleep problems (insomnia) and works by slowing down the central nervous system (brain), causing drowsiness which helps patients fall asleep. Temazepam is used short term to treat insomnia (trouble falling or staying asleep).

[7] Lorazepam is the generic name for the Schedule IV controlled substance also known by the brand name Ativan that belongs to a class of medications called benzodiazepines. It is thought that benzodiazepines work by enhancing the activity of certain neurotransmitters in the brain and is used in adults and children at least 12 years old to treat anxiety disorders.

[8] Diverticulitis is the infection or inflammation of pouches (called *diverticula*) that can form in the intestines which, when inflamed, can result in pain, nausea and vomiting, fever, abdominal tenderness, constipation or diarrhea. In addition, cramping on the left or right side of the abdomen may be a sign of diverticulitis.

on the patient, and to add prescriptions for Zoloft,[9] and Methotrexate.[10]

16. On or about October 6, 2016, Respondent saw the patient for an office visit at IMAC Medical Group and Med Spa (IMAC), where he is an employee and sees patients there on Mondays. During that visit, Respondent stated in his Board interview, that BuSpar,[11] which had been prescribed for her anxiety, was not working so he crossed it out on the record. His plan was to prescribe mirtazapine[12] for her anxiety, depression and sleep, in addition to lorazepam, and Tylenol with codeine #3 for her pain.

17. Respondent continued to see the patient for home visits, telemedicine phone visits, and office visits at IMAC into March 2017.

18. On or about the March 2, 2017, Respondent saw the patient at IMAC. On that date, her blood pressure was recorded as 120/80, and her current medications were Percocet 10/325 for pain three times a day (t.i.d.)[13], temazepam 30 mg, lorazepam 2 mg two times a day (b.i.d.),

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[9] Zoloft is the brand name for the generic drug sertraline, an antidepressant that belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). It works by balancing serotonin levels in the brain and nerves. Zoloft is used to treat some types of depression, premenstrual dysphoric disorder (PMDD), social anxiety disorder (SAD), obsessive-compulsive disorder (OCD), panic disorder (PD), and post-traumatic stress disorder (PTSD).

[10] Methotrexate is a medication that interferes with the growth of certain cells of the body, especially cells that reproduce quickly, such as cancer cells, bone marrow cells, and skin cells, and is used to treat leukemia and certain types of cancer of the breast, skin, head and neck, lung, or uterus. It is also used to treat severe psoriasis and rheumatoid arthritis in adults. There is a caution to not use this medicine to treat psoriasis or rheumatoid arthritis if the patient has low blood cell counts, a weak immune system, alcoholism or chronic liver disease, or if one is breastfeeding. Methotrexate can cause serious or fatal side effects and the patient should tell the doctor if the patient has diarrhea, mouth sores, cough, shortness of breath, upper stomach pain, dark urine, numbness or tingling, muscle weakness, confusion, seizure, or skin rash that spreads and causes blistering and peeling.

[11] BuSpar is the brand name of the generic drug bupropion and is an anti-anxiety medicine that affects chemicals in the brain that may be unbalanced in people with anxiety. It is also used to treat anxiety disorders or the symptoms of anxiety, such as fear, tension, irritability, dizziness, pounding heartbeat, and other physical symptoms.

[12] Mirtazapine is the generic name for the brand name drug Remeron and Remeron SolTab, an antidepressant that is still not fully understood how it works, but it is thought to positively affect communication between nerve cells in the central nervous system and/or restore chemical balance in the brain and is used to treat major depressive disorder in adults.

[13] t.i.d. is a medical abbreviation for "*ter in die*" which, in Latin, means three times a day, b.i.d is the medical abbreviation for "*bis in die*" which, in Latin, means two times a day, and q.d. is the medical abbreviation for "*quaque die*" which, in Latin, means once a day.

Zoloft 200 mg once a day (q.d.), and Wellbutrin XL[14] 300 mg q.d. The patient was taking methotrexate for her RA, but had a lot of pain and he felt she needed to see a rheumatologist. He noted she had an allergic reaction to mirtazapine, which caused swelling. She filled month's supplies of prescriptions for Percocet, lorazepam, and temazepam from Respondent according to her CURES report.

19. On or about March 27, 2017, according to the patient's CURES report, she filled prescriptions from Respondent for 90 pills of 300 mg/30 mg acetaminophen/codeine phosphate,[15] and a month's supplies of temazepam, and lorazepam.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed acts of gross negligence in his care and treatment of Patient A. The circumstances are as follows:

21. On or about April 26, 2017, according to the patient's CURES report, she filled prescriptions for 30-days supplies of temazepam and lorazepam from Respondent.

22. On or about May 1, 2017, according to the chart, Respondent authorized a refill of Percocet; however, it is unclear who authored the document as it is not initialed or signed. According to the patient's CURES report, she obtained 90 tablets of Percocet 10/325 mg that day for a 30-day supply prescribed by Respondent.

23. On or about May 18, 2017, Patient A saw Respondent at the IMAC office; her blood pressure was recorded as 140/80. She complained of headaches and of not being able to sleep with no other information or details. Respondent noted "Hallucinations – one time – no more

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[14] Wellbutrin is the brand name for the generic drug bupropion, which is an antidepressant used to treat major depressive disorder and seasonal affective disorder. The XL version is for extended-release for round-the clock treatment.

[15] Acetaminophen/codeine phosphate is the generic name of the Schedule III controlled substance brand names Tylenol with Codeine #3, Tylenol with Codeine #4, EZ III, Pentaphene with Codeine, Tylenol with Codeine, Capital and Codeine Suspension, Tylenol with Codeine #2, Cocet, and Cocet Plus that is in the drug class of narcotic analgesic combinations. It is used to relieve moderate to severe pain.

after that," but failed to include any further information or explanation as to when and why she hallucinated. He noted she "did not keep her appointment & ran out of meds" but admitted, during his interview, he did not know what medications she ran out of. According to the patient's CURES report, however, she had refilled 30-day supplies of lorazepam and temazepam on April 26, and a 90-pill/30-day supply of Percocet on May 1, so it is impossible she ran out of these medications unless she was diverting or misusing them. Respondent, however, failed to document that he conducted a good faith examination of the patient or any findings from such an examination or the medical indication for the controlled substance prescription as the patient did not complain of pain on this visit. The standard of care (hereafter, the "standard") requires a physician to document with reasonable precision the history of the present illness, physical examination findings, if applicable, data upon which the assessment is relied, the diagnosis and/or assessment and plans. The standard further requires the physician to evaluate the patient for the appropriate indication for the chronic use of opiates/controlled substances and to re-evaluate for the continued use of them in non-malignant pain management.

On this visit, Respondent further failed to order a random urine drug screening of the patient especially since she "ran out of medications." The standard requires that random toxicology screens be conducted to assist in determining the presence or absence of the medications prescribed and/or any illicit drugs that may have adverse interactions with the medications prescribed or may have societal implications. He further failed to have the patient sign a Controlled Substance Agreement (CSA) requiring that she only obtain narcotics and controlled substances from him using one pharmacy, and failed to document informed consent in the chart. The standard requires a CSA and/or informed consent to be used for patients who are on or are anticipated to remain on controlled substances for a period of 90-days for controlling non-malignancy-related pain. On this visit, the patient filled 30-day prescriptions for temazepam, lorazepam, and promethazine with codeine cough syrup.[16]

[16] Promethazine with codeine cough syrup is a Schedule V controlled substance and is a combination medicine used to treat cold or allergy symptoms such as runny nose, sneezing, and cough. Codeine and promethazine contains an opioid (narcotic) cough medicine, and may be habit-forming.

24. On or about May 25, 2017, the patient filled prescriptions from Respondent for 90 pills of Percocet 10/325, according to her CURES report.

25. According to the patient's CURES report, on or about June 15, 2017, she filled prescriptions from Respondent for a month's supply of temazepam and lorazepam.

26. On or about June 23, 2017, the patient filled a prescription from Respondent for 90 tablets of Percocet, according to the CURES report.

27. On or about June 29, 2017, there is a status alert in the chart for the patient to undergo a mammogram; however, there is no evidence that the mammogram was ever ordered or took place, and there are no results in the chart. During his interview, Respondent stated he thinks they ordered one, but could not tell from the chart records.

28. On or about July 13, 2017, the patient again saw Respondent at IMAC and her blood pressure was recorded as 145/90. On this visit, he documented the patient was out of lorazepam, Percocet, Zofran, temazepam, Zoloft and Wellbutrin; however, she had filled a prescription for a month's supply of Percocet on June 23. Respondent failed to, however, inquire or document how she could have run out of Percocet unless she was misusing or diverting them. He failed to order or conduct a random urine screening on the patient who, at that time, had claimed she ran out of her medications twice already. He noted she had been in the "hospital 3 days – CT Scan[17] – red spot - Henry Mayo Hospital in June - July – records." His assessment and plan were to obtain the records from her hospitalization. He noted she had hypertension (HTN),[18] brain headache, and

[17] A CT scan, also known as CAT Scan or computerized tomography scan, combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside the body. CT scan images provide more-detailed information than plain X-rays do. A CT scan has many uses, but it's particularly well-suited to quickly examine people who may have internal injuries from car accidents or other types of trauma. A CT scan can be used to visualize nearly all parts of the body and is used to diagnose disease or injury as well as to plan medical, surgical or radiation treatment.

[18] Hypertension, abbreviated as HTN, also known as high blood pressure (HBP), is blood pressure that is higher than normal. One's blood pressure changes throughout the day based on your activities. Having blood pressure measures consistently above normal may result in a diagnosis of high blood pressure (or hypertension). The higher the blood pressure levels, the more risk one has for other health problems, such as heart disease, heart attack, and stroke.

blacked out stating "then she falls down" with no further explanation or information. He failed to document a physical examination of the patient or any findings thereof. The patient filled prescriptions for another 30-day supply of lorazepam and temazepam from Respondent that day.

Regarding this visit, Respondent stated during his interview that while the patient was at Valley Presbyterian Hospital[19] she had "PQ prolongation"[20] and the physician there concluded the combination of antidepressants Respondent had prescribed, mirtazapine, Zoloft and Wellbutrin, were causing the patient's heart arrhythmia abnormal conduction, which was causing her to faint. As a result, he changed her prescriptions according to what they said. When asked where the records from Henry Mayo Hospital were, Respondent stated he was unable to locate the ones for 2017, but had the records from her hospitalizations at Henry Mayo and Valley Presbyterian Hospital in 2018. The standard requires a physician to obtain and review medical records and/or directly communicate with prior and/or concurrent physicians involved in the direct care of the patient; however, Respondent failed to do this.

29. According to the patient's CURES report, on or about July 20, 2017, she filled a 30-day prescription for Percocet from Respondent.

30. On August 8, 2017, according to the patient's CURES report, she was prescribed one pill of temazepam from a Skilled Nursing Pharmacy; however, there is no information or documentation in the chart as to why the patient had been prescribed a controlled substance from a skilled nursing facility and no indication that Respondent was aware of such.

31. According to the patient's CURES report, on or about August 10, 2017, she filled a month's supplies of prescriptions from Respondent for lorazepam and temazepam.

32. On or about August 21, 2017, Respondent documented on the July 13 chart note, that the patient "ran out of medicine – Percocet 10/325 #90." On this date, she filled another month's

[19] Respondent, however, documented in the patient's chart that she was hospitalized in 2017 at Henry Mayo Hospital not Valley Presbyterian Hospital.

[20] There is no such thing as "PQ prolongation." It is assumed Respondent was referring to prolonged QT intervals, which is an irregular heart rhythm that can be seen on an electrocardiogram. It reflects a disturbance in how the heart's bottom chambers (ventricles) send signals. In a prolonged QT interval, it takes longer than usual for the heart to recharge between beats.

supplies of lorazepam and temazepam from Respondent even though she had just obtained a month's supply of both medications eleven days earlier, on August 10, 2017. The standard requires the physician to prescribe benzodiazepines in a safe manner, which Respondent failed to do. She also filled a 30-day supply of Percocet from Respondent according to the CURES report.

33. According to the patient's CURES report, on or about September 7, 2017, she filled another month's supplies of lorazepam and temazepam from Respondent, even though she had obtained a month's supplies on August 10 and 21.

34. On or about September 14, 2017, there are two notes for this visit – one is a handwritten IMAC progress record and the other is a typewritten note for the same date with additional entries not included in the handwritten note with no explanation. The handwritten IMAC note records the patient's blood pressure as 130/80, and her chief complaint as medications and pain control. On that record, he noted, "Percocet makes her nauseated" and she "does not take her [antidepressant] pills all the time." He also noted she had pain in her back, head, and shoulders and that he would try 4 mg of Dilaudid[21] t.i.d., instead of Percocet, as "she got [it] in the hospital it really helped her."

In the typewritten note for this visit, he documented that she had multiple problems and, "Percocet was ordered on 8-21, but it did not work," so he planned to increase her pain medicine to Dilaudid. He failed, however, to document where, when and why she was given Dilaudid, and any prior complaints or side effects of the Percocet he had prescribed her since March 2017. The note states the "opthamologist [sic] says that she has narrow angles to her eyes and need an opthamologist [sic]." He also prescribed her anal suppositories for hemorrhoids; however, there was no prior documentation of when the patient developed hemorrhoids or any reported rectal bleeding or discomfort. Both notes failed to include documentation that he conducted a good faith examination of the patient that day or any findings from such an examination justifying the medical indication for Dilaudid. Respondent further failed to conduct any imaging, diagnostic tests or studies to confirm the patient conditions and complaints. The standard requires a

[21] Dilaudid is the brand name for the Schedule II controlled substance generic drug hydromorphone, which is an opioid (narcotic analgesic) used to treat moderate to severe pain.

physician to verify diagnosis by determining a differential diagnosis, follow up on tests, studies, imaging, and referrals, and have sufficient knowledge, skills and experience to treat patients within one's scope of practice.

35. According to the patient's CURES report, on or about October 9, 2017, she filled a prescription for 90 pills of 300 mg/30 mg Tylenol with codeine, and a month's supplies of temazepam and lorazepam from Respondent.

36. According to the patient's CURES report, on or about October 11, 2017, she filled a prescription for promethazine HCL/codeine phosphate syrup prescribed by Respondent; however, it is unknown how the patient could have received this prescription before she called him the following day for her complaints, as documented in the chart.

37. On or about October 12, 2017, Respondent documented a telemedicine phone visit with the patient, noting she has been coughing for 2-days, sounded very sick, "cannot make it in to the office until next week," and that a helicopter was "flying overhead and kicked up a lot of dirt in her house." His assessment was "possible pneumonia" and "it is dangerous not to treat her." His plan was to prescribe "Augmentin 875 125 bid"[22] and promethazine with codeine cough syrup; however, the patient had already filled the promethazine with codeine prescription the day before with no documented explanation or telemedicine note. Respondent stated, in his Board interview, that he thought it was "possible [she] had some kind of lung infection," which is why he prescribed Augmentin; however, he failed to properly assess and evaluate her by ordering laboratory tests or conducting other diagnostic tests or studies to determine the cause of her condition, including environmental or otherwise. He confirmed the patient did not come for an office visit the following week.

38. According to the patient's CURES report, on or about November 6, 2017, she filled prescriptions for lorazepam, temazepam and Tylenol with codeine from Respondent.

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[22] Augmentin contains a combination of amoxicillin and clavulanate potassium. Amoxicillin is a penicillin antibiotic that fights bacteria in the body and clavulanate potassium is a beta-lactamase inhibitor that helps prevent certain bacteria from becoming resistant to amoxicillin. Augmentin is a prescription antibiotic used to treat many different infections caused by bacteria, such as sinusitis, pneumonia, ear infections, bronchitis, urinary tract infections, and infections of the skin.

39. On or about November 20, 2017, Respondent saw the patient at IMAC, and her blood pressure was recorded as 140/60. He noted she had back pain since the age of nineteen, and the Dilaudid he prescribed two months earlier made her confused so he switched to Norco instead. He again failed to document that he conducted a good faith examination of the patient that day or record any positive or negative findings obtained during such an examination. Respondent referred her to a psychiatrist, but failed to document why. He prescribed her lorazepam, temazepam, mirtazapine, Wellbutrin, Zoloft and Zofran. When asked, during his interview, what happened with the psychiatric referral and if he ever spoke with the psychiatrist, Respondent stated he never spoke with the psychiatrist and did not know if there were other records in this regard.

40. On or about December 28, 2017, the patient appears to have seen Respondent at IMAC, presumably to get refills of her medications. He noted to refill her lorazepam, Percocet and presumably, temazepam, but the chart repeats lorazepam. It also includes BuSpar; however, this medication did not work, according to Respondent in October 2016.

41. On or about February 1, 2018, Respondent saw the patient at IMAC. She was noted to suffer from depression while on mirtazapine so his plan was to increase it from 30 mg to 45 mg. He continued to prescribe Wellbutrin, Zoloft, Ativan, temazepam, BuSpar, and Percocet, which she previously reported to be "too strong," "did not work" and made her "nauseous," but he documented it is better now with no further explanation or information. According to the patient's CURES report, she obtained a month's supplies of lorazepam, temazepam and 90-pills of Percocet; however, Respondent failed to document that he conducted any good faith examination of the patient that day or record any positive or negative findings obtained during such an examination. He further failed to follow-up on his referral for her to see a psychiatrist.

42. According to the patient's CURES report, on or about February 19, 2018, she filled a prescription for acetaminophen/codeine 300 mg/30 mg from another physician; however, the patient had just filled a 30-day supply of Percocet from Respondent on February 1, 2018.

43. On or about March 12, 2018, the patient was seen at IMAC for a follow-up on her medications with no vitals recorded. Her medications are listed as lorazepam, sleeping pills, and

Percocet. He noted she was throwing up, with no further explanation or information as to when, why and for how long. No good faith examination is documented nor were any positive or negative findings obtained during this examination. Respondent failed to conduct or order any tests or studies to determine the cause of the patient's sleep problems or vomiting, and further failed to follow up regarding his referrals for a psychiatrist and rheumatologist.

44. On or about March 26, 2018, the patient was admitted to Henry Mayo Newhall Memorial Hospital (Henry Mayo) for bright red blood from her rectum according to the records contained in IMAC's certified chart. In the Henry Mayo records, the patient's history of present illness included chronic hepatitis C,[23] a social history of "significant substance abuse history with opiates and benzodiazepines," and alcoholic gastritis.[24] It was further noted she had an alcohol abuse and amphetamine abuse problem. During his interview, Respondent stated he had never reviewed the Henry Mayo records before. When asked how did IMAC obtain the hospital records, Respondent said they're "faxed to the office, but very often, I don't review those. So I did not review those beforehand." He stated IMAC's office protocol is that when a patient is seen and there are records, "we print them out and review them", but "it didn't happen" in this case. When asked if the patient had an alcohol abuse problem, he stated her family would not give him an answer, and the patient "never said [she had] an alcohol problem" so he never investigated to determine if she had an alcohol problem or not.

45. On or about April 16, 2018, there are two handwritten IMAC progress notes for this visit in the records. The first record records the patient's blood pressure as 120/80 and states the patient was there for a "Hospital follow up Rx refill." The second handwritten progress note has different writing, does not include any vitals at all, and states the patient was there for "Headaches, [some type of illegible] 'feeling,' inability to sleep." In that note there appears to be a post-it note with the same handwriting listing, among other things, that the patient was currently

[23] Hepatitis C is a viral infection that causes liver swelling, called inflammation, and can lead to serious liver damage. The hepatitis C virus (HCV) spreads through contact with blood that has the virus in it.

[24] Alcoholic gastritis is when the stomach inflammation is caused by alcohol use.

on 3 antidepressants and lists them as "merlazapine[25] 45 mg, Zoloft 200 mg, and mobutrine[26] 300 mg, and adds "Percoset [sic] 3x/day (*diloted [sic] causes pain)." The assessment/plan was psychiatric referral, refill prescriptions, the "rheumatologist must be notified of potential fibromialgia [sic]," "fibromialgia [sic] (depression, wide spread pain)," and "sleep disorder, anxiety disorder." The record appears to be signed by Respondent, but the handwriting on the record itself is not his writing. According to the patient's CURES report, she filled prescriptions that day for Percocet, lorazepam and temazepam from Respondent. However, he failed to conduct and document a good faith examination or the findings thereof. He further failed to order any tests or studies to determine the cause of her sleep problems or if she had fibromyalgia, and failed to correspond her care and treatment with her rheumatologist and other providers.

46. On or about May 6, 2018, the patient was hospitalized in Valley Presbyterian Hospital for syncope,[27] which had been ongoing for quite a long time, according to the patient. She reported occasional syncopal episodes, the last one of which was two weeks previously with no preceding light-headedness, chest pain, shortness of breath, or palpitations. The fainting spells always occur when she is standing. No cardiovascular complaints were documented in the hospital records contained in the IMAC chart. The hospital records state the patient suffered from alcohol abuse, pancreatitis, depression, anxiety, and a history of drug-seeking behavior. The hospital personnel documented the patient stated she "stopped drinking 20 years ago," but was "admitted [to the hospital] 7 years ago for pancreatitis and noted alcohol use." The patient's electrocardiogram (ECG or EKG)[28] revealed prolonged QTc intervals, so she was admitted

[25] There is no known medication by this name. It is presumed the author of the note meant mirtazapine as the patient had been prescribed 45 mg of this antidepressant medication.

[26] There is no known medication by this name. It is presumed the author of the note meant bupropion (Wellbutrin) as the patient had been prescribed 300 mg of this antidepressant medication.

[27] Syncope is another word for fainting or passing out. Someone is considered to have syncope if they become unconscious and go limp, then soon recover. For most people, syncope occurs once in a great while, if ever, and is not a sign of serious illness. However, in others, syncope can be the first and only warning sign prior to an episode of sudden cardiac death. Syncope can also lead to serious injury.

[28] An electrocardiogram (ECG or EKG) records the electrical signals from the heart and

overnight for observation. The hospital doctor advised the patient to avoid QT prolonging medication, such as Zofran and sertraline (Zoloft), and switched her sertraline to Paxil[29], that seems to have less QTc effects. They also placed her on a low dose of Coreg[30] for her untreated hypertension. In his interview, the Respondent stated this was the first time he saw the records from Valley Presbyterian. He said the patient "was having fainting because of her heart problems" and the hospital "helped us a lot so we could modify her treatment so she would stop falling down." The hospital records, however, do not list a history of heart problems, but only that the EKG, which was mostly negative, showed some prolonged QTc intervals that hospital personnel believed were related to the combination of antidepressants Respondent had prescribed her.

47. On or about May 10, 2018, there are three separate records on this day, two for this visit and a note regarding a call received from the patient's daughter. The first is an IMAC handwritten progress note that records the patient's blood pressure as 110/70; however, the rest of the note is blank except for the patient's name, date of birth and date of the office visit.

The second is a typewritten record for this visit that noted the patient "has been blacking out for the last three or four months," "she is in the house when she falls," "does not get any warning," she just "finds herself on the floor." He noted she went to the ER and "they suggested it could be an interaction between the ondansetron (Zofran) and Zoloft – these could cause QT prolongation" and that since "she stopped the Zoloft, she did not have any more falling problems." He noted she was hospitalized at Valley Presbyterian a week ago and "had hypertension." Respondent lists her medications as "Sertarline [Zoloft] 100 mg, Mirtazapine 45

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shows how the heart is beating. Sensors, called electrodes, are placed on the chest to record the heart's electrical signals and the signals are shown as waves on an attached computer monitor or printer.

[29] Paxil is the brand name for the generic drug paroxetine, an antidepressant that belongs to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be unbalanced in people with depression, anxiety, or other disorders.

[30] Coreg is the brand name for the generic drug carvedilol, a beta-blocker. Beta-blockers affect the heart and circulation (blood flow through arteries and veins). Coreg is used to treat heart failure and hypertension (high blood pressure) and is also used after a heart attack that has caused your heart not to pump as well.

mg, Wellbutrin 300 mg q.d., Paxil 20 mg q.d., Temazepam 30 mg q.d., Lorazepam 2 mg," Percocet 10/325 mg t.i.d., that Buspar did not help her, and "Dilaudid made her sick." He had already documented, however, in the same note that after "she stopped the Zoloft, she did not have any more falling problems" and they "changed Zoloft 200 mg" to Paxil so it is unclear why he listed that as one of her current medications. In addition, he had previously documented on March 2, 2017, that the patient had an allergic reaction to mirtazapine, which caused swelling, so he switched it to Zoloft; however, he failed to document any explanation why he listed both Zoloft and mirtazapine in the patient's medications. He further failed to document that he conducted any examination of the patient that day or record any positive or negative findings obtained during such an examination and failed to properly evaluate her. He further failed to follow-up on his referral for her to see a psychiatrist.

The third document on this visit, a phone call note from the patient's daughter, stated the patient was having swallowing problems, was "blacking out most of the time," "cannot be left alone" and is "very forgetful" so that her medications need to be monitored as the patient's "mind [is] very cloudy, foggy" and she "cannot drive anymore." She continued that her mother has "constant headaches, body pains, RA, very painful" and "needs a walker." She also stated her mother needs "to be seen by neurologist as soon as possible." Respondent, however, failed to order or conduct any tests or studies on the patient and failed to follow-up regarding the daughter's complaints or refer the patient to a neurologist or other specialist on this visit.

48. On or about May 11, and June 12, 2018, according to the patient's CURES report, she filled a month's supplies of prescriptions from Respondent for Percocet, temazepam and lorazepam.

49. On or about June 21, 2018, Respondent appears to have had an office visit with the patient. The typewritten note states she "Stopped the antidepressants" "Do hepatitis C" "She has a lot of gas." "She has trouble sleeping and is tired in the morning." His plan was to refer her to a pain management doctor because the one left the insurance company and to order a sleep study.

He prescribed Reglan[31] as the patient says, "she cannot take Zofran because of the antidepressants and the heart valve problem"; however, there is no documented evidence in the chart that the patient suffered from a heart valve problem, only that she had prolonged QT intervals due to the antidepressant combination Respondent had prescribed her. Respondent failed to document that he conducted any type of examination of the patient or any findings from such an examination, and none of the patient's vitals, including her blood pressure, were recorded. Respondent further failed to conduct or order any testing, imaging or studies to confirm the patient's conditions, including, but not limited to, a test for hepatitis C, blood or other laboratory work, a sleep study, or any other test or study. He further failed to treat the patient's hypertension identified during her hospitalization the prior month.

50. According to the patient's CURES report, on or about July 17, 2018, she filled a month's prescriptions for temazepam and lorazepam from Respondent, and Percocet from another physician.

51. According to the patient's CURES report, on or about August 2 and 5, 2018, she filled prescriptions for lorazepam from two different Kaiser doctors, even though she had filled a month's prescription of lorazepam from Respondent on July 17.

52. On or about August 6, 2018, the patient was seen by Respondent at IMAC, but none of her vital signs were recorded. He continued to prescribe her Percocet for "widespread pain" three times a day, lorazepam for anxiety three times a day, if needed, temazepam to help her sleep, and Paxil. He failed to consult the CURES report as if he had, he would have seen that the patient received controlled substances, including Percocet and lorazepam, from other providers

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[31] Reglan is the brand name for the generic drug metoclopramide, which increases muscle contractions in the upper digestive tract. This speeds up the rate at which the stomach empties into the intestines and may help with nausea. It is used for 4 to 12 weeks to treat heartburn caused by gastroesophageal reflux in people who have used other medications without relief. It is also used to treat gastroparesis (slow stomach emptying) in people with diabetes, which can cause heartburn and stomach discomfort after meals.

that month and previously. He further failed to conduct a random urine screening to determine the presence or absence of the medications he prescribed. He also failed to follow-up regarding the psychiatric referral, the hepatitis C testing and the sleep study, and it is unknown if either test or study was ever ordered or performed. Respondent further failed to document that he conducted any type of good faith examination or the findings thereof, and failed to properly re-evaluate the patient as required for the continued prescribing of controlled substances to a non-malignant pain patient.

53. According to the patient's CURES report, on or about August 20, 2018, she filled a prescription for a 20-day supply of lorazepam from a different Kaiser doctor; however, she had filled a month's prescription for that medication on July 17 from Respondent, and obtained additional pills of this medication from two separate Kaiser doctors on August 2 and 5, so it is impossible that she needed additional lorazepam unless she was misusing or diverting them.

54. Two days later, on or about August 22, 2018, she filled prescriptions for a month's supplies of lorazepam, temazepam and Percocet from Respondent, according to the CURES report. When asked if he was aware the patient had been prescribed lorazepam a few days earlier by a Kaiser doctor, Respondent stated "I did not know that." He said the Kaiser doctor had prescribed a lower dose of lorazepam and he changed it to a higher dose, but admitted that he did not "have a note" for that change. It is unclear, however, how he could have changed the dose of lorazepam from the Kaiser doctor when he stated he did not know they prescribed it to her, she did not tell him about it, he did not speak with the Kaiser doctors regarding this, never obtained her Kaiser records, and failed to review her CURES.

55. According to the patient's CURES report, on or about September 16, 2018, she filled another prescription for a 20-day supply of lorazepam from a different Kaiser doctor; however, she had just obtained a 30-day supply from Respondent on August 22, which does not include the additional lorazepam she obtained from the Kaiser doctors on August 2 and 5, 2018.

56. On or about September 20, 2018, Respondent saw the patient at IMAC. Her blood pressure was recorded as 160/90 and her chief complaint was "pain." He noted she had "fibromyalgia" and "switched to Kaiser;" however, he failed to conduct any tests or studies on the

patient to determine if she did, in fact, have fibromyalgia, and never followed up with the sleep study, hepatitis C testing or the psychiatric referral. He prescribed lorazepam, temazepam, Paxil, and Percocet 10/325 four times a day (q.i.d.)[32] for her back pain. He failed, however, to document that he conducted a good faith examination of the patient or any findings of such an examination and failed to document any medical indication as to why the patient's pain justified an increase in the Percocet to four times a day. He also failed to address her continuing hypertension. On this date, she filled prescriptions for a month's supplies of lorazepam and temazepam, and 110 pills of Percocet 325 mg/10 mg from Respondent.

On this same visit, Respondent signed a letter from IMAC. The letter informed her that IMAC "will be no longer able to provide you service. According to new DEA regulations all narcotic patients must first be seen by a Pain Management Specialist and to be placed on a regimen as well as assigned to our office before returning to us for narcotic prescriptions. As of 09/20/2018 we will no longer be able to accept you as a patient until all conditions have been met in accordance with DEA rules and regulations." When asked about the letter during his Board interview, Respondent stated this was just an "office decision" and he was just "an employee" there. When asked if the "office are non-medical staff deciding what should happen with his patient," he replied, "Yes. Correct."

57. According to the patient's CURES report, on or about September 24, 2018, she obtained another 10 pills of Percocet prescribed by Respondent.

58. After the September 20, 2018, visit and letter there are no corresponding chart notes from Respondent until almost a year later on September 16, 2019; however, there is evidence in the patient's CURES report reflecting that she obtained further controlled substances prescribed by Respondent during this period.

59. According to the patient's CURES report, on or about October 31, 2018, she filled a 90 pills a month's supply of Percocet from another physician. On the same date she filled prescriptions from Respondent for temazepam and lorazepam. After this date, the patient did not

[32] q.i.d. is a medical abbreviation indicating a medicine is to be take four times a day. It abbreviates the Latin, *qua'ter in di'e* (four times a day).

receive any further prescriptions for lorazepam for approximately five months until April 2019, and did not receive further prescriptions for temazepam for approximately eleven months until September 2019, when she resumed treating with Respondent.

60. According to the patient's CURES report, on or about December 14, 2018, she filled another prescription for Percocet from the same physician who prescribed her Percocet in October 2018.

61. According to the patient's CURES report, on or about February 13 and March 12, 2019, she filled prescriptions for Percocet from the same physician identified in paragraph 60.

62. According to the patient's CURES report, on or about April 15, 2019, she filled prescriptions for lorazepam from Respondent; however, there is no corresponding chart note for this prescription as she had not seen him since September 2018, and there is no evidence he examined the patient or consulted her CURES report prior to prescribing it.

63. According to the patient's CURES report, on or about May 7, 2019, she filled a prescription for 90 pills of Percocet from the same physician identified in paragraph 60.

64. According to the patient's CURES report, on or about June 11, 2019, she filled prescriptions for 90 pills of Percocet from the same physician identified in paragraph 60, and a month's supply of lorazepam from Respondent; however, there is no corresponding chart note for this prescription, as she had not been seen since September 2018, and no examination of the patient was documented or that he consulted her CURES.

65. According to the patient's CURES report, on or about July 9, 2019, she filled a prescription for 90 pills of Percocet from the physician identified in paragraph 60.

66. According to the patient's CURES report, on or about July 22, 2019, she filled a prescription for 12 lorazepam from a Kaiser doctor.

67. According to the patient's CURES report, on or about August 6, 2019, she filled a 90 pill/90-day prescription for hydrocodone/acetaminophen (Norco) 325 mg/10 mg from the physician identified in paragraph 60.

68. According to the patient's CURES report, on or about September 5, 2019, she filled 90 pill/30-day prescriptions for Norco 325 mg/10 mg from the physician identified in paragraph

60.

69. On or about September 16, 2019, Respondent saw the patient at IMAC for the first time in almost a year; however, no chief complaint is listed. He noted the patient had been on "lorazepam for a long time" and was not sleeping, yet he failed to obtain the specifics of her sleep problem. No pain or physical discomfort was noted on this visit. He prescribed her temazepam at the same dosage despite the patient not having received the medication in almost a year with no dosing escalation titration process. He also prescribed lorazepam and Zofran, which were filled that day; however, the patient had not been taking temazepam and lorazepam together regularly for almost a year. Respondent failed to prescribe the two benzodiazepines to her in a safe manner, failed to document a good faith examination of and the findings thereof of a patient he had not seen in almost a year, failing to properly evaluate her as required. He further failed to document if the requirements of the IMAC September 18, 2018 letter had been complied with prior to the patient returning to the clinic. During his interview, he stated he did not know what happened, how the patient was accepted back into the clinic, and did not know if the patient had been referred to or had seen a pain management specialist as required by the clinic. Respondent also failed to consult the patient's CURES report as mandated and if he had, he would have seen the patient had received controlled substances from other providers. In October 2018, physicians were mandated to consult with the CURES database prior to prescribing controlled substances to a patient, and periodically thereafter every four months, while continuing to prescribe controlled substances to the patient. He further failed to have the patient sign a Controlled Substance Agreement (CSA) that she would only use one pharmacy for all controlled substances/narcotics and only obtain them from him, and/or documented informed consent. Additionally, in the diagnosis portion of the progress note, Respondent wrote "10-7-19" with no other information or explanation as to what may have happened on that date.

70. According to the patient's CURES report, on or about October 9, 2019, she filled a prescription from Respondent for 120 pills/30-day supply of Percocet 325 mg/10 mg; however, this medication is not listed as one he prescribed her on September 16. Additionally, he failed to document any evidence that he performed a good faith physical examination of the patient prior

to prescribing this medication and failed to document any medical indication for this controlled substance.

71. According to the patient's CURES report, on or about October 15, 2019, she filled a month's prescription for temazepam prescribed by Respondent.

72. On or about November 11, 2019, Respondent saw the patient at IMAC for a medication refill and follow-up. He documented he was switching her pain medication to Norco 10 mg/325 mg #12, and wanted to "try to ↓ [decrease] narcotics" with no further explanation or information as to why he wanted to decrease her narcotics. He noted back and leg pain with no further information or details. He again failed to document that he conducted any type of examination of the patient and any pertinent findings from such examination. Respondent also failed to consult with CURES as mandated prior to continuing to prescribe her controlled substances.

73. According to the patient's CURES report, on or about November 12, 2019, she filled prescriptions from Respondent for a month's supplies of lorazepam and temazepam. She also filled a prescription for 120 pills of oxycodone/acetaminophen from the physician identified in paragraph 60; however, there are no records from this physician in the IMAC chart nor any evidence that Respondent was aware of or communicated with the patient's other physicians.

74. On or about December 12, 2019, the patient filled a prescription for 20 pills of Oxycodone HCL from a Kaiser doctor and on December 17, 2019, she filled another prescription for 10 pills of Oxycodone HCL from a different Kaiser doctor. She also filled a 30-day prescription for temazepam from Respondent that day. Respondent admitted that he failed to check the patient's CURES report to determine if she was obtaining narcotics or controlled substances from other providers.

75. According to the patient's CURES report, on or about December 23, 2019, she filled a prescription for 45 pills of acetaminophen/hydrocodone and 45 pills of lorazepam from a Kaiser doctor.

76. On or about December 31, 2019, Respondent saw the patient at IMAC who stated she had surgery on December 12, felt she needed antibiotics, and "needs medication for pain."

Respondent listed her medications as lorazepam, Percocet, temazepam and Zoloft, and that she has a sleep disorder, depression and back pain; however, he had failed to follow-up if a sleep study had ever been performed and what the results were. He also failed to document that he conducted a good faith examination of the patient on that visit and failed to document any findings of any such examination. During his Board interview, when asked if he conducted a physical examination of the patient that day, he stated he "listened to her lungs and talked to her," but failed to document it. This is not an adequate examination. He further failed to consult the patient's CURES report as required and said, "if you look at CURES [the Kaiser doctors] never gave her any narcotics and didn't give her anything that would appear on CURES." This statement is untrue and Respondent would have known this if he had consulted the CURES database as mandated that clearly shows the patient was receiving controlled substances from other providers, including from Kaiser.

77. According to the patient's CURES report, on or about January 3, 2020, she filled prescriptions for 120 pills of Percocet, and a month's supplies of lorazepam and temazepam from Respondent; however, he failed to perform a good faith examination of the patient and failed to document the medical indication for the continued prescribing of controlled substances on the December 31 visit. He further admitted he failed to consult the patient's CURES report as mandated and stated he "did not [check CURES] because I did not know the Kaiser doctors were giving her anything – she did not tell me."

78. On or about January 20, 2020, Respondent saw the patient at IMAC for a medication refill, left shoulder pain and head and neck pain with no further information. He noted "Percocet too strong" and listed Norco 10/325 q.i.d., lorazepam and temazepam as her medications. He again failed to document an examination of the patient on that visit or any findings of such examination. He further failed to adequately re-evaluate her, and to consult the patient's CURES report as mandated.

79. According to the patient's CURES report, on or about February 3, 2020, she filled a prescription for 120 pills of Norco from Respondent.

80. On or about February 24, 2020, Respondent saw the patient at IMAC, and her blood

pressure was noted to be 141/101. Her chief complaint was "left shoulder pain following down to wrist, anxiety attacks," and the "pain keeps her up at night." Respondent noted she "needs refill on Norco 10/325;" however, he failed to document that he conducted a good faith examination of the patient on that visit or any findings of such examination prior to continuing to prescribe her controlled substances. He further failed to consult the patient's CURES report as mandated. On this visit, she filled a month's supply of temazepam. When asked who treated her for shoulder pain or if he ordered X-rays, he said he did not know who treated her, but "thought it was long standing pain" so he did not conduct or order any tests or diagnostic imaging to determine the cause of her shoulder pain.

81. According to the patient's CURES report, on or about March 4, 2020, she filled prescriptions for 120 pills of Norco and a month's supply of lorazepam from Respondent. On or about March 20, 2020, she filled a month's prescription for temazepam from Respondent.

82. On or about April 3, 2020, Respondent documented a telemedicine phone call with the patient who "called for refills;" however, it is unknown what medications she was requesting a refill for as she had filled a month's prescription for temazepam on March 20. He prescribed lorazepam 2 mg t.i.d., temazepam 15 mg at hour of sleep (h.s.),[33] and Zofran was called into the pharmacy, with no documented medical indication for the Zofran. He also lists Ativan 2 mg t.i.d.; however, this medication is the same as lorazepam so it is unclear why Respondent repeated Ativan in the note.

83. According to the patient's CURES report, on or about April 8, 2020, she filled a prescription for 98 pills of Percocet from Respondent even though she told him, several months earlier, that Percocet was too strong and made her nauseous. Additionally, he documented that he was trying to decrease the patient's narcotic medications in November 2019 not increase them, and prescribed Norco instead; however, he failed to document a medical indication for Percocet in the patient's chart. He also failed to document when and why he prescribed her Percocet again as it is not listed as one of the medications he prescribed in the last few visits.

[33] h.s. is the medical abbreviation for the Latin phrase "*hora somni*" ("at bedtime") or hour of sleep.

84. On or about April 27, 2020, Respondent noted, on the February 24, 2020, progress note, that the patient has "chronic back pain – shoulder pain" and he prescribed her 120 pills of Percocet; however, he failed to document he conducted any examination of the patient on that visit or any findings of such an examination for the continued use of controlled substances. He further failed to consult the patient's CURES report as mandated, and failed to adequately re-evaluate the patient on this visit.

85. According to the patient's CURES report, on or about April 28, 2020, she filled a month's prescription for temazepam from Respondent.

86. On or about May 1, 2020, according to the patient's CURES report, she filled a prescription for 120 pills of Percocet from Respondent; however, there is no evidence that he conducted a good faith examination on April 27.

87. On or about May 4, 2020, there are two separate notes for this visit – the first one is an IMAC handwritten note with only the patient's name, and the date and time of her visit, with no other information. The other is a typewritten telemedicine note where he states "refilled her lorazepam 2 mg t.i.d." a medication she has been taking "for a long time," and had generalized anxiety, but he never followed up on his psychiatric referral.

88. According to the patient's CURES report, on or about June 4, 2020, she filled a prescription from Respondent for 120 pills of Norco; however, the last time he had prescribed Norco was February 24, and after that he had prescribed Percocet instead. In addition, he failed to list Norco in the May 4 chart note.

89. On or about June 5, 2020, Respondent had another telemedicine visit note that is included in the telemedicine note of May 4. He refilled the temazepam, and documented in the patient's chart that one of the patient's adult family members "[first name] has not starting [sic] to start to work" and they "did not give him the letter to start work." When asked during his interview why he had included the adult family member's personal information in the patient's chart, he stated because it "could be a triggering event for her needing lorazepam." On this visit, the patient filled prescriptions for a month's supplies of lorazepam and temazepam. (#2, p. 6/31)

90. On or about June 27, 2020, according to the patient's CURES report, she filled a

prescription from a Kaiser doctor for 12 pills of 325 mg/5 mg of acetaminophen/hydrocodone.

91. On or about July 6, 2020, Respondent saw the patient at IMAC for right shoulder pain and anxiety. He noted, "I have spoken to her many times on the phone. She is very anxious and she sounds depressed. Last month I increased her medicine from Norco to Percocet. Refill Percocet 10.325 q.i.d. She had an accident hand [sic] has a bruise around her left eye." He failed, however, to document what type of accident she had, the circumstances and mechanisms of it, or the etiology for it. He further failed to document a good faith examination of the patient on that visit or any findings of such an examination, and failed to adequately re-evaluate her. He also failed to consult the patient's CURES report as mandated as if he did, he would have seen the patient had received controlled substances from a Kaiser doctor only a few days earlier. Respondent stated, during his interview, he did not believe her accident was due to a drug overdose, but acknowledged that was pure speculation, as he had failed to order or conduct any tests or studies to determine the cause. He also failed to have the patient submit to a urine screening.

92. On or about July 7, 2020, she filled a prescription from Respondent for 120 pills of Percocet, according to the patient's CURES report.

93. On or about July 27, 2020, there are two records for this visit – one is a blank IMAC note except for the patient's name and date and time of the appointment and the other is a typewritten note where he documents that her adult family member, previously named in an earlier note, "does not take blood test." He noted the patient had pain in her head and neck with no further explanation or information. He noted "Percocet was too strong. It is too much. Pain in her legs se [sic] can hardly walk," but he had known this about the Percocet previously and that it reportedly made her nauseous. His typewritten note continued "[s]witch back back [sic] to Norco" followed by the patient's name, the date of 5-4-20, and her date of birth. He lists her medications as 30 mg of temazepam, 2 mg of lorazepam t.i.d., Zoloft 100 mg q.d., and mirtazapine 15 mg for sleep; however, she was already receiving 30 mg of temazepam for sleep and he failed to document why he added mirtazapine for her sleep on this visit. He further noted "She is falling. She was in the kitchen no headache dizziness, she just falls. No chest pain. She

might black out for a minutes [sic]. The etiology is not clear." His diagnosis was anxiety and depression; however, he failed to document that he conducted any type of examination of the patient on this visit or the findings of such an examination. He further failed to order or conduct any testing, imaging or studies to determine the cause of her falls, which had previously been related to his antidepressant prescribing practices. He also failed to adequately re-evaluate her and failed to consider that the falls/fainting could be a side effect of the combinations of benzodiazepines (lorazepam and temazepam) and opiates (Norco and Percocet) he was prescribing. He further failed to consult the patient's CURES report as mandated.

94. According to the patient's CURES report, on or about August 4, 2020, she filled prescriptions from Respondent for 90 pills of Norco, and a month's supplies of lorazepam and temazepam.

95. According to the patient's CURES report, on or about September 29, 2020, she filled a prescription from Respondent for 90 pills of Norco.

96. According to the patient's CURES report, she continued to fill prescriptions for lorazepam and temazepam from Respondent.

97. On or about December 14, 2020, according to her CURES report, she filled a prescription from Respondent for 120 pills of Percocet; however, there is no corresponding chart note that he saw the patient after the July 2020 visit, at which she told him Percocet was "too strong" yet he continued to prescribe it with no explanation. He further failed to document a good faith examination of the patient, the findings of such an examination, or any medical justification for continuing to prescribe controlled substances to a patient he had not seen in almost 4 months.

98. On or about February 1, 2021, there are two records for this visit - one is a typewritten IMAC office progress note and the other is a typed telemedicine visit. The IMAC progress note states a history of present illness as "Out of energy For [sic] energy help her clean the house test her for possible testosterone injections. She is already taking Zoloft 100 mg and Mirtazapine 15 mg HA for depression." No vital signs are recorded in this record. The other typewritten record references a telemedicine visit where the patient "called and asked if I could

help her get more energy, to help with energy and to help her clean the house. She is on a lot of antidepressants. We can test her for possible testerone [sic] deficiency which can be treated with injections. We can try to see if it helps. Already tried Zoloft 100 mg and mirtazapine 15 mg." He lists temazepam, lorazepam and Percocet as the patient's other medications. He attributed her weakness to deficient testosterone without conducting or ordering any tests. Both records failed to document any examination or findings or any plan to conduct or order any testing, imaging or studies to determine the cause of her weakness.

99. On or about February 15, 2021, there is another typewritten telemedicine record noting the patient, "called for her [adult family member's] medication." Respondent specifically lists two of her adult family members by their first and last names, dates of birth, medications, and medical conditions in her chart in violation of their personal and confidential health care information and privacy. The standard is to maintain a patient's privacy and confidentiality of their HIPPA protected information. When asked in his interview if he was familiar with HIPPA regulations and if he had obtained her adult family members' permission to discuss their confidential medical information, Respondent said he was not familiar with the HIPPA regulations and had not obtained their permission. The record also noted the patient "asked for something for energy" and "wanted something to help her clean her house" and he thought they could try testosterone injections. He listed her medications as Restoril 30 mg, Vitamin D, lorazepam 2 mg, gabapentin[34] 100 mg bid, and testosterone cypionate 200 mg/ml inject 0.2 cc q 2 weeks. He had, however, failed to check her testosterone levels or conduct any tests to determine the cause of her lack of energy prior to prescribing her testosterone injections. In addition, he failed to document why he prescribed her gabapentin when there is no evidence in the chart that she suffered from a partial seizure, nerve pain from shingles or restless leg syndrome.

100. In March and April 2021, the patient sent numerous text messages to Respondent begging him to go to his office and leave prescriptions for her and her adult family members and

[34] Gabapentin is the generic name for the brand name drug Neurontin, Gralise, Horizan, a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome. It works on the chemical messengers in the brain and nerves and is from a group of medicines called anticonvulsants.

about their medical conditions, among other things. In some of the texts, the patient appears to be confused regarding which adult family member needed a referral.

101. On or about April 4, 2021, the patient filled a prescription from Respondent for 120 pills of Percocet; however, it does not appear from the chart notes, that he had physically seen the patient since the July 2020 visit. In addition, there is no documented medical indication or justification for continuing to prescribe controlled substances to a patient who had not been seen for an extended time.

102. On or about April 15, 2021, Respondent documented another telemedicine visit, stating the patient "was admitted to Kaiser Hospital. I do not know what she was admitted for. The Kaiser doctor called me. I did not get her name, but I did give her information. I will contact the family." (#17, p. 3) During his Board interview, he stated he did not recall if he requested information from the Kaiser doctor as to why she was admitted, and did not request records from Kaiser to determine why she was hospitalized.

103. On or about May 13, 2021, Respondent documented another telemedicine visit, stating she "was in the hospital for some GI problem. She did not remember what it was." He noted she "last filled her Norco on 4/5/21," but according to the CURES report, she actually filled a prescription from Respondent for 120 pills of Percocet, and had not obtained Norco from him since September 2020. He provided prescriptions for Percocet, lorazepam and temazepam; however, according to the chart, he had not physically seen her for an extended time, and he failed to document any medical justification or indication for the continued prescribing of controlled substances to the patient.

104. On or about May 24 and 25, 2021, she filled prescriptions for a total of 120 pills of Percocet and months supplies of lorazepam and temazepam from Respondent.

105. On or about May 28, 2021, Respondent documented another telemedicine visit, stating she "called for pain medications. She complained of wide-spread pain and depression, probably fibromyalgia. I told her I would prescribe Percocet 10.325 q.i.d., as she had in the past." Respondent, however, had not physically seen the patient since July 2020, as the rest of the chart notes appear to be telemedicine phone visits and not in-person visits. He failed to document that

he conducted any good faith examinations of the patient or document the results or findings of any such examinations or any objective medical indication or justification for continuing to prescribe controlled substances to a patient he had not seen for an extended time. He further failed to order or conduct any tests or studies on the patient to verify or confirm her conditions and failed to follow up on referrals, tests and studies.

106. On or about July 15, 2021, Respondent documented another telemedicine visit, stating she "continues to call me in a panic about her [adult family member]. She has chronic pain, anxiety and sleep disturbances." He continued, "I cannot understand what she is saying. I was afraidn [sic] she had a stroke, but I talked to her [adult family member], [first name] who told me she lost her lower dentures and cannot pronounce words." Instead of insisting the patient be seen in the clinic or making a home visit to confirm the reason for her slurred words and condition, Respondent relied on a non-medical adult family member's opinion for her condition and continued to prescribe her Percocet without having physically seen or examined her in an extended period. This was inadequate and not a proper evaluation of the patient. He failed to consider that the combinations of two benzodiazepines and opiates he prescribed were causing her to have side effects of those medications that can cause fatigue, fainting and slurred speech. He further failed to document that he had conducted a good faith examination of the patient and any objective medical justification for continuing to prescribe her controlled substances. He further failed to consult the patient's CURES report as mandated to determine if she was obtaining prescriptions from other sources or order a urine screening to determine if she was diverting the medications or had other substances in her system, especially in a patient who was slurring her words.

107. During his interview with the Board, when asked if he conducts and documents physical examinations of the patient, he stated he examined her, but did not document it. He said, "I was not so good about that. I must admit. I asked her about her pain." He further said, "I'm just lazy. I just don't do it."

When asked if he kept copies of the prescriptions he provides to the patient in their chart, he stated he did not. He stated they only performed one urine screening on the patient throughout

his care and treatment of her, on an unknown date in 2021, and it was "completely negative." Respondent, however, failed to document this in the chart and there is no order, laboratory report or evidence regarding this alleged urine test in the chart. In addition, he said the test was completely negative; however, he had been prescribing her controlled substances, which should have showed up in the test results unless she was diverting the medication.

When asked about checking the CURES reports, he stated that when IMAC gives a prescription the secretaries in the office (non-medical staff) access and look at the CURES report, but they do not always print them out, put them in the chart, or tell him. He admitted that he did not consult her CURES report as required. He stated he called the patient's pharmacist to ask if she was sleepy, druggy or disoriented, and they said she was not; however, he failed to document when this occurred in the chart. In addition, he stated he recently, in 2023, called the pharmacy about the patient, but they would no longer fill her prescriptions from him or any other provider because they were worried she was an addict.

During the interview, Respondent spoke about the patient's adult family members' confidential personal health information, some of which he had recorded in the patient's chart. He admitted that he was not familiar with the HIPPA regulations and did not obtain the adult family members' permission to speak with the patient regarding their confidential health care or treatment information.

108. In Respondent's care and treatment of Patient A, he committed acts of gross negligence, collectively and individually, when he:

A. Failed to have a Controlled Substance Agreement with the patient and/or document informed consent for a patient who is on or is anticipated to be on controlled substances for a period of greater than 90-days for non- malignancy related pain;

B. Failed to use and document the use of random toxicology screenings to determine the presence or absence of diversion and in determining the patient's exposure to illicit drugs or other substances;

C. Failed to properly evaluate her for the appropriate indication for the chronic use of opiates in a non-malignant pain management patient when he failed to document examinations or

their findings or any other alternatives to medications and no imaging or past record confirmation of her complaints;

D. Failed to adequately re-evaluate the patient for the continued use of opiates in the management of a non-malignant related pain based on evidence of the patient's progress toward treatment objectives;

E. Failed to prescribe benzodiazepines simultaneously in a safe manner;

F. Failed to consult CURES during the patient's care and treatment while he prescribed and continued to prescribe controlled substances;

G. Failed to maintain patient privacy and confidentiality of the patient's adult family members' information when he placed their names, dates of birth, medication and health condition information in the patient's chart;

H. Failed to independently verify the patient's diagnoses, follow-up on tests and referrals, and have sufficient knowledge, skills and experience to treat patient;

I. Failed to review and obtain medical records from other providers and/or directly communicate with prior and/or concurrent physicians involved in direct patient care; and

J. Failed to maintain adequate and accurate records in this care and treatment.

SECOND CAUSE FOR DISCIPLINE

(Prescribing Narcotics or Dangerous Drugs without a Good Faith Physical Examination)

109. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2246, subdivision (a), in that he prescribed Patient A dangerous drugs without an appropriate good faith prior (physical) examination and medical indication. The circumstances are as follows:

110. Paragraphs 21 through 107, above, inclusive, are incorporated herein by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

111. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and

treatment of Patient A. The circumstances are as follows:

112. Paragraphs 21 through 107, above, inclusive, are incorporated herein by reference as if fully set forth.

113. Respondent committed repeated negligent acts, collectively and individually, in his care and treatment of Patient A when he:

A. Failed to have a Controlled Substance Agreement with the patient and/or document informed consent for a patient who is on or is anticipated to be on controlled substances for a period of greater than 90-days for non- malignancy related pain;

B. Failed to use and document the use of random toxicology screenings to determine the presence or absence of diversion and in determining the patient's exposure to illicit drugs or other substances;

C. Failed to properly evaluate her for the appropriate indication for the chronic use of opiates in a non-malignant pain management patient when he failed to document examinations or their findings or any other alternatives to medications and no imaging or past record confirmation of her complaints;

D. Failed to adequately re-evaluate the patient for the continued use of opiates in the management of a non-malignant related pain based on evidence of the patient's progress toward treatment objectives;

E. Failed to prescribe benzodiazepines simultaneously in a safe manner;

F. Failed to consult CURES during the patient's care and treatment while he prescribed and continued to prescribe controlled substances;

G. Failed to maintain patient privacy and confidentiality of the patient's adult family members' information when he placed their names, dates of birth, medication and health condition information in the patient's chart;

H. Failed to independently verify the patient's diagnoses, follow-up on tests and referrals, and have sufficient knowledge, skills and experience to treat patient;

I. Failed to review and obtain medical records from other providers and/or directly communicate with prior and/or concurrent physicians involved in direct patient care; and

J. Failed to maintain adequate and accurate records in this care and treatment.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Patient Confidentiality)

114. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2263, in that he documented two of the patient's adult family members' confidential medical information in the patient's medical chart and discussed their medical information with the patient without proper authorization and authority. The circumstances are as follows:

115. Paragraphs 89, 93, 99 through 100, and 106 through 107, above, inclusive, are incorporated herein by reference as if fully set forth.

116. Respondent violated the patient's adult family members' confidentiality and privacy when he spoke about their health care information and placed their names, dates of birth, medication and health condition information in the patient's chart.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence - Lack of Knowledge)

117. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2234, subdivision (d), in that he displayed a lack of knowledge regarding HIPPA requirements and patient confidentiality and privacy and when he failed to have sufficient knowledge, skills and expertise to treat Patient A for her conditions based on the clinical presentation, differential diagnosis, appropriate testing and studies in the treatment and management of numerous conditions. The circumstances are as follows:

118. Paragraphs 21 through 107, above, inclusive, are incorporated herein by reference as if fully set forth.

119. Respondent displayed a lack of knowledge when he:

A. Admitted that he was not familiar with HIPPA regulations and patient privacy and confidentiality when he placed the names, dates of birth, medication and health condition information of the patient's adult family members in the patient's chart;

B. Failed to verify and coordinate treatment with the patient's Rheumatologist, if any;

C. Failed to test and verify the patient's hepatitis C diagnosis and the circumstances

surrounding it;

D. Failed to verify the patient's "heart valve problem;"

E. Failed to verify or conduct any tests or work-up of the patient's syncope;

F. Failed to conduct any tests, studies or work-ups concerning the patient's fatigue;

G. Failed to follow-up on the patient's hematochezia (blood in stool) that was later attributable to rectal prolapse and failed to order a follow-up colonoscopy;

H. Failed to follow up on the MRI of the patient's right shoulder;

I. Failed to order or conduct any X-rays on the patient;

J. Failed to rule out stroke and to conduct or order any tests or studies on the patient to determine the cause of her condition, but instead relied on the opinion of an adult family member who was not a physician or health care practitioner;

K. Failed to conduct or order any test or studies to verify the patient had fibromyalgia and;

L. Failed to address the patient's hypertension.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

120. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate medical records in his care and treatment of Patient A. The circumstances are as follows:

121. Paragraphs 21 through 107, above, inclusive, are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct – Violation of the Medical Practice Act)

122. Respondent Raymond John Dorio, M.D. is subject to disciplinary action under Code section 2234, subdivision (a), in that he violated the terms of the Medical Practice Act. The circumstances are as follows:

123. Paragraphs 21 through 120, above, inclusive, are incorporated herein by reference as if fully set forth.

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 29371, issued to Respondent Raymond John Dorio, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Raymond John Dorio, 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: MAR 27 2024

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

Complainant

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