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

In the Matter of the Accusation Against: Richard Jeffrey Kroop, M.D. Physician's and Surgeon's Certificate No. G 36316 Respondent.	Case No.: 800-2021-076384

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 24, 2025.

IT IS SO ORDERED: February 21, 2025.

MEDICAL BOARD OF CALIFORNIA

Michelle A. Bholat, MD

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

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
E-mail: Rebecca.Smith@doj.ca.gov
Attorneys for Complainant

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

In the Matter of the Accusation Against: **RICHARD JEFFREY KROOP, M.D.** **2701 W. Alameda Avenue, Suite 202** **Burbank, CA 91505-4406** **Physician's and Surgeon's Certificate No. G 36316,** Respondent.	Case No. 800-2021-076384 OAH No. 2024050963 **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 Rebecca L. Smith, Deputy Attorney General.

2. Respondent Richard Jeffrey Kroop, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-5162.

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3. On or about April 24, 1978, the Board issued Physician's and Surgeon's Certificate No. G 36316 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2021-076384, and will expire on November 30, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2021-076384 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 22, 2024. Respondent filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2021-076384 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. 800-2021-076384. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2021-076384, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. 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. 800-2021-076384, 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, No. G 36316 to disciplinary action.

11. 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

12. 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.

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this matter.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2021-076384 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

15. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 36316 issued to Respondent Richard Jeffrey Kroop, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If Respondent forms the medical opinion, after an appropriate prior examination and a 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 a 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 - SURRENDER OF DEA PERMIT. Respondent is prohibited from practicing medicine until Respondent provides documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, Respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

3. EDUCATION COURSE. Within sixty (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 forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

4. MEDICAL RECORD KEEPING COURSE. Within sixty (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 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (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 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 fifteen (15) calendar days after successfully completing the program or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

6. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (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 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. 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 Respondent did not successfully complete the clinical competence assessment program, 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.

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

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

If, during the course of the probation, Respondent's practice setting changes and Respondent is no longer practicing in a setting in compliance with this Decision, Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within sixty (60) calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume practice until an appropriate practice setting is established.

8. NOTIFICATION. Within seven (7) days of the effective date of this Decision, 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 fifteen (15) calendar days.

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

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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, in the amount of $27,681.15 (Twenty-Seven Thousand Six Hundred Eighty-One Dollars and Fifteen Cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within thirty (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.

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 ten (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.

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 thirty (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 fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (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 forty (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; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one hundred twenty (120) calendar days prior to the completion of probation. This term does not include cost recovery, which is due within thirty (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. 800-2021-076384 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.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. 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: 11/13/2024

RICHARD JEFFREY KROOP, M.D.
Respondent

I have read and fully discussed with Respondent Richard Jeffrey Kroop, 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: 11/18/2024

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/18/2024

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2021-076384

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **RICHARD JEFFREY KROOP, M.D.** **2701 W. Alameda Avenue, Suite 202** **Burbank, CA 91505-4406** **Physician's and Surgeon's Certificate No. G 36316,** Respondent.	Case No. 800-2021-076384 **ACCUSATION**

PARTIES

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

2. On or about April 24, 1978, the Board issued Physician's and Surgeon's Certificate Number G 36316 to Richard Jeffrey Kroop, M.D. (Respondent). The Physician's and Surgeon's Certificate expired on November 30, 2023, and has not been 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 118 of the Code states:

> (a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.
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> (b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.
>
> (c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

5. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> (f) Approving undergraduate and graduate medical education programs.
>
> (g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).
>
> (h) Issuing licenses and certificates under the board's jurisdiction.

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(i) Administering the board's continuing medical education program.

6. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

7. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

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

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

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations,

continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

8. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

9. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

10. Section 725 of the Code states:

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

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

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

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

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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 2228.1 of the Code states.

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

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

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

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

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

13. Section 4021 of the Code states:

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

14. Section 4022 of the Code provides:

"Dangerous drug" or "dangerous device" means any drug or device 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) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

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

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COST RECOVERY

15. Section 125.3 of the Code states:

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

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

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

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

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

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

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

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

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

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

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(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.

DRUG DEFINITIONS

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

"Adderall" is a brand name of a combination of two stimulant drugs, amphetamine and dextroamphetamine. It is generally used to treat attention deficit hyperactivity disorder, but also has a high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d)(1), and a dangerous drug as defined in Code section 4022.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestions of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. It is also sold under various brand names including, Intensol, Xanax, and Xanax XR. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Code section 4022.

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

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

"CURES" means the California Department of Justice, Bureau of Narcotic Enforcement's Controlled Substance Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to

assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Cymbalta" is a brand name for duloxetine, an antidepressant and nerve pain medication used to treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain. Cymbalta is also used to treat a chronic pain disorder called fibromyalgia, treat pain caused by nerve damage in people with diabetes (diabetic neuropathy) and to treat chronic musculoskeletal pain, including discomfort from osteoarthritis and chronic lower back pain. It is from a group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SNRI). It is a dangerous drug as defined in Code section 4022.

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

"Gabapentin" is an anticonvulsant medication used to treat partial seizures, neuropathic pain, hot flashes, and restless legs syndrome. It is recommended as one of a number of first-line medications for the treatment of neuropathic pain caused by diabetic neuropathy, postherpetic neuralgia, and central neuropathic pain. It is sold under the brand name Neurontin, among others. It can have potentially harmful effects when combined with opioids. It is a dangerous drug as defined in Code section 4022.

"Hydrocodone," also known by the brand names Norco and Vicodin, is a semisynthetic opioid analgesic similar to but more potent than codeine. It is used as the bitartrate salt or polistirex complex, and as an oral analgesic and antitussive. Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Hydrocodone acetaminophen," also known by the brand name Norco, is an opioid pain reliever. It has a high potential for abuse. In 2013, hydrocodone-acetaminophen was a Schedule III controlled substance. Commencing on October 6, 2014, hydrocodone-acetaminophen became classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Code section 4022.

"Morphine milligram equivalents" (MME), developed by the Centers for Disease Control and Prevention (CDC), are values that represent the potency of an opioid dose relative to morphine. MME is intended to help clinicians make safe, appropriate decisions concerning opioid regimens. It is used as a gauge of the overdose potential of the amount of opioid prescribed. Higher dosages of opioids are associated with higher risk of overdose and death. Calculating the total daily dosage of opioids assists in minimizing the potential for prescription drug abuse/misuse and reducing the number of unintentional overdose deaths associated with pain medications. It is recommended that physicians proceed cautiously once the MME reaches 80 mg per day and to generally limit the MME to less than 90 MME per day.

"Naloxone" is a medication used to reverse the effects of opioids. It is commonly used to counter decreased breathing in opioid overdose. It can treat narcotic overdose in an emergency situation. It is sold under the brand names Narcan and Evzio. It is a dangerous drug as designated in Health and Safety Code section 4022.

"Opioids" are a class of drugs used to reduce pain, including anesthesia, and include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription. Many prescription opioids are used to block pain signals between the brain and the body and are typically prescribed to treat moderate to severe pain. Side effects can include slowed breathing, constipation, nausea, confusion, and drowsiness. Opioids are highly addictive, and opioid abuse has become a national crisis in the United States. Combining opioids with other drugs or alcohol can be fatal, therefore patients should be cautioned about the simultaneous ingestion of alcohol, benzodiazepines, or other CNS depressant drugs during treatment with opioids.

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

"Phentermine" is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Code section 4022.

"SNRI" and "SSNRI" means selective serotonin and norepinephrine reuptake inhibitors, which are a class of medications that are effective in treating depression. SNRIs are also sometimes used to treat other conditions, such as anxiety disorders and long-term (chronic) pain, especially nerve pain. SNRIs work by ultimately effecting changes in brain chemistry and communication in brain nerve cell circuitry known to regulate mood, to help relieve depression. SNRIs block the reabsorption (reuptake) of the neurotransmitters serotonin and norepinephrine in the brain. They are sold in several formulations, including desvenlafaxine (Pristiq), dloxetine (Cymbalta), levomilnacipran (Fetzima), and venlafaxine (Effexor XR). They are dangerous drug as defined in Code section 4022.

"SSRI" means Selective Serotonin Reuptake Inhibitor. SSRI antidepressants are a type of antidepressant that work by increasing levels of serotonin within the brain. Serotonin is a neurotransmitter that is often referred to as the "feel good hormone."

"Temazepam" is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is sold under the brand names Restoril among others. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Code section 4022.

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"Tuzistra" is an opioid cough suppressant consisting of codeine and chlorpheniramine. It is used to treat cough and respiratory symptoms associated with allergies and the common cold. This medication has a risk for abuse and addiction, which can lead to overdose and death. This medication may also cause severe, possibly fatal breathing problems. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (b)(3), and a dangerous drug as defined in Code section 4022.

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he engaged in gross negligence in the care and treatment of Patients 1, 2, 3, 4, and 5.[1] The circumstances are as follows:

Patient 1:

18. Patient 1 was documented to have been seen by Respondent from June 9, 2017, until March 19, 2020. During that timeframe, Patient 1 saw Respondent regularly every one-to-three months.

19. The first available chart entry reflects that on or about June 9, 2017, Patient 1, a then 50-year-old male, was being seen for "back pain and diabetes." Patient 1's back pain was described as an ache with symptoms aggravated by activity and relieved by pain medications. Patient 1's pain was noted to be controlled on medications. Patient 1 was also noted to have diabetes. Respondent noted that Patient 1 was compliant with his diabetes medication, and was also being managed with diet, insulin and fingerstick blood sugars. Patient 1's blood pressure at the time of the visit was 139/62. Respondent did not address the elevated blood pressure reading.[2] Patient 1's medications included Humalog and Lantus for his diabetes and oxycodone,

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1, 2, 3, 4, and 5.

[2] A normal blood pressure reading is less than 120 systolic and less than 80 diastolic. An elevated blood pressure is systolic reading of 120 to 129 systolic and less than 80 diastolic. Stage 1 hypertension is a systolic reading of 130 to 139 or diastolic reading of 80 to 89. Stage 2 hypertension is a systolic reading of at least 140 or diastolic reading of at least 90.

20 mg, 1 tablet every 5-6 hours, and OxyContin, 80 mg, 1 tablet every 6 hours.

20. On or about July 14, 2017, Patient 1 was seen by Respondent for diabetes, back pain, and multiple sclerosis. Patient 1's blood pressure was noted to be 170/85. Respondent did not address the elevated blood pressure reading. Respondent's assessment was diabetes, lumbar disc degeneration and multiple sclerosis. Respondent noted that Patient 1 was compliant with his medications. Respondent continued Patient 1's medications at the same dose as the prior visit.

21. On or about August 14, 2017, Patient 1 was seen by Respondent for diabetes, back pain, and hypertension. Patient 1's blood pressure was noted to be 152/79. With respect to Patient 1's history of present illness, Respondent noted that Patient 1's diabetes was being managed with diet, insulin, and fingerstick blood sugars and that Patient 1 was compliant with medications and diet. With respect to the back pain, Respondent noted that Patient 1 reported that his back pain is rated an 8 out 10 in severity, is worse with activity, and medication is necessary for activities of daily living. Respondent noted that Patient 1 is compliant with his pain medication. With respect to hypertension, Respondent noted that Patient 1 denies taking blood pressure medication. Respondent's assessment was intervertebral disc degeneration, diabetes and hypertension. Respondent's diabetes and pain medications were continued and Respondent restarted Patient 1's blood pressure medication, Lisinopril. There is no indication as to when Patient 1 was previously taking blood pressure medication. The blood pressure medication was not added to Patient 1's medication list and there are not any further references to blood pressure medication in Patient 1's chart.

22. Patient 1 continued to see Respondent regularly every one-to-three months in follow up for his diabetes, back pain, and various other complaints. From March 16, 2018, to March 19, 2020, Patient 1 was noted to have a past medical history of seasonal allergies, diabetes, and chronic obstructive pulmonary disease (COPD). At approximately every visit, Respondent documented risk factors for diabetes and hypertension, even though Patient 1 already had a diagnosis of diabetes, as of June 9, 2017, and hypertension, as of August 14, 2017. Respondent noted that Patient 1 performed fingerstick blood sugar readings but did not document any actual fingerstick blood sugar readings in Patient 1's chart. Respondent did not document any visual or

urinary symptoms associated with diabetes. Respondent did not address the elevated blood pressure readings documented on or about June 9, 2017, July 14, 2017, February 16, 2018, March 16, 2018, May 18, 2018, June 15, 2018, July 13, 2018, August 10, 2018, October 12, 2018, November 14, 2019, February 18, 2019, March 18, 2019, April 15, 2019, May 13, 2019, September 25, 2019, October 21, 2019, and December 2, 2019. Respondent did not address Patient 1's depression noted on June 15, 2018, and September 25, 2019. Respondent did not address Patient 1's shortness of breath noted on April 15, 2019.[3]

23. Despite assessing Patient 1 with hypertension on August 14, 2017, Respondent only noted that Patient 1 had hypertension on November 13, 2017, and March 19, 2020. On August 14, 2017, Respondent set forth the plan to restart blood pressure medication, Lisinopril, in his assessment section of the note. Lisinopril is not included in Patient 1's medication list despite a notation at every visit that Patient 1's medications had been reconciled. Likewise, Respondent ordered Lasix for edema on May 13, 2019, and March 19, 2020, and this medication was not added to Patient 1's medication list.

24. On a monthly basis from June 2017, through March 2018, Patient 1 filled prescriptions for approximately 120 tablets of OxyContin (80 mg) and 240 tablets of oxycodone (20 mg), prescribed by Respondent.[4] On a monthly basis from April 2018, through August 2018, Patient 1 filled prescriptions for approximately 90 tablets of OxyContin (80 mg) and 120 tablets of oxycodone (20 mg), prescribed by Respondent. On a monthly basis from September 2018, through May 2019, Patient 1 filled prescriptions for approximately 120 tablets of OxyContin (80 mg) and 180 tablets of oxycodone (20 mg), prescribed by Respondent.

25. Respondent's documentation of the opioid medications that he prescribed to Patient 1 do not reflect the actual quantities prescribed by Respondent and filled by Patient 1.

26. Respondent did not document any discussions with Patient 1 regarding the risks of

[3] On or about April 15, 2019, Respondent noted that Patient 1 presented for diabetes, bilateral lower extremity edema, back pain, and shortness of breath. Respondent noted that Patient 1 denied shortness of breath but had moderate dyspnea on exertion, relieved with an inhaler.

[4] In July 2017, Patient 1's OxyContin (80 mg) prescription was for 90 tablets. In November 2017, Patient 1 also filled an additional prescription for 40 tablets of OxyContin (80 mg), prescribed by Respondent.

opiate therapy, including the risks of drug overdose, death, and adverse effects. Respondent did not document discussing the high risk of respiratory compromise given Patient 1's past history of COPD. There was no documentation of the reasons for the high opioid doses. Respondent did not document the reason for the increase in medication from late-2017, through mid-2018. Respondent did not maintain a pain agreement with Patient 1 nor did Respondent document discussing the elements of a pain agreement with Patient 1. Likewise, Respondent did order any drug screening tests for Patient 1.

Medical Record Keeping

27. The standard of care requires that physicians maintain timely, legible and accurate medical records. The history of present illnesses and review of systems should be detailed in the notes. An accurate recording of the physical findings should be documented in every visit. Medication reconciliation is necessary to ensure patient safety and quality of care.[5] There should be clear documentation of impressions and plans. Keeping clear and concise medical record documentation is also critical to maintaining the continuum of care.

28. Respondent failed to document relevant negative and positive findings in Patient 1's medical records. Respondent repeatedly documented risk factors for diabetes and hypertension though Patient 1 already been diagnosed with diabetes and hypertension. With respect to Patient 1's diabetes, Respondent failed to document finger stick blood sugar readings and visual or urinary symptoms associated with diabetes. Respondent failed to address abnormal findings on multiple visits, including Patient 1's elevated blood pressure, depression, decreased breath sounds, and edema. Respondent documentation set forth conflicting findings – for example on April 15, 2019, Patient 1 denied shortness of breath and Respondent documented dyspnea (shortness of breath) without explanation. Respondent failed to accurately document Patient 1's medications on multiple visits, including the frequency of prescribing oxycodone as well as failing to list Lisinopril in Patient 1's medication list despite documenting that Patient 1 is taking

[5] Medication reconciliation, defined by Centers for Medicare & Medicaid Services (CMS) is "the process of identifying the most accurate list of all the mediations that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider."

Lisinopril for hypertension. This is an extreme departure from the standard of care.

Continuation, Titration, and Monitoring of Chronic Opiate Pain Management.

29. When prescribing opiate pain medications, the standard of care requires that the physician prescribe the lowest potency for a defined period, while monitoring the patient's progress for both benefit and harm, including pain level, quality of life, functional status and adverse effects. The patient's risk of drug addiction and aberrancy should also be assessed prior to initiation of long term opiate therapy. Patients with above-average risk of addiction should be referred to psychiatrists who are adept in addiction treatment. When prescribing opiates, regular urine drugs screens should be performed and CURES should be reviewed. When a patient transfers care for pain management to another physician, the standard of care requires that the physician obtain the medical records from the previous physician and re-evaluate the patient for continuous and titration of therapy. To continue a patient on opiate therapy, there should be fulfillment of functional goals. Pain relief should not be used as the primary indicator to assess the success of treatment. When prescribing opiate therapy on a chronic basis, the MME of the patients' daily opiate therapy should generally not exceed 90 milligrams per day, as the risks of drug overdose, death and adverse effects increase significantly beyond this dosage. The prescribing physician must provide patient and caregiver education regarding the adverse side effects of opiate therapy and naloxone antidote therapy. Once a patient's pain is adequately controlled on a safe dosage of opiate therapy, periodic assessments must be performed, with regular monitoring every one to three months to determine if the opiate therapy is meeting the patient's goals of improved pain control and functional status. Tapering or discontinuation of therapy should be timely performed should the harms of opiate therapy outweigh the benefits, or if there are concerns for diversion or exposure to other illicit drugs.

30. Patient 1 was consistently prescribed 660 MME a day for lumbar disc degeneration. Respondent failed to document the reasons for the high dose of opioids for lumbar disc degeneration and whether the high doses of opioids could be masking another condition that warranted workup and treatment. Respondent failed to document any discussions with Patient 1 of the risks of drug overdose, death, and adverse effects despite seeing Patient 1 at a frequency of

approximately every one to three months between June 2017, and March 2020. Patient 1, with known COPD, had a high risk of respiratory compromise. Respondent failed to document the reasons for escalating Patient 1's opioid dosage at the end of 2017, and merely documented "continue med" under his plan for lumbar disc degeneration on November 13, 2017. Respondent failed to document offering naloxone antidote therapy during any of the multiple visits between 2017, and 2020. Respondent failed to perform urine drug screens to evaluate for diversion and/or determine if Patient 1 was taking other prescribed or illicit drugs. This is an extreme departure from the standard of care.

Informed Consent and Pain Care Agreement.

31. When prescribing opiates, the standard of care requires that the prescribing physician obtain the patient's informed consent for the planned therapy. The prescribing physician must discuss the risks and benefits of the treatment plan with the patient or the patient's surrogate decision maker. The risks and side effects associated with opiates, including constipation, sexual dysfunction, addiction/dependency, osteoporosis, cognitive impairment, over-sedation, drug interactions, respiratory depression, and impaired driving, should be addressed as well as medical evidence on the efficacy of long term opiate therapy. Patient informed consent for the use of opiates can be included in the patient's pain management agreement. When prescribing opiates, the standard of care requires that the prescribing physician enter into a pain management agreement with the patient. The pain management agreement outlines the joint responsibilities of the physician and the patient, including replacement and early refills of lost medications. The pain management agreement should also set forth that it is the patient's responsibility to obtain the prescribed opiates from only one physician or practice and that periodic drug screening will be conducted and the patient's CURES report will be reviewed.

32. Respondent failed to document any informed consent discussions with Patient 1 regarding the risks associated with the opiates being prescribed. Respondent failed to enter into a pain management agreement with Patient 1 and failed to document discussing the elements of a pain management agreement with Patient 1. This is an extreme departure from the standard of care.

Patient 2:

33. Patient 2 was documented to have been seen by Respondent from June 9, 2017, until August 2, 2022, for a variety of conditions, including lupus, back pain, edema, hypertension, anxiety, insomnia, anemia, vertigo, coughs and shortness of breath. Respondent documented seeing Patient 2 on a near monthly basis until September 28, 2021, and thereafter, he documented seeing her on three occasions: February 17, 2022, May 24, 2022, and August 2, 2022.

34. The first available chart entry reflects that on or about June 7, 2017, Patient 2, a then 58-year-old female, was being seen by Respondent for follow up of back pain, lupus, and a liver abscess. Patient 2's review of systems was documented to be positive for fatigue, arthralgia, back pain, and joint pain. Respondent's assessment was low back pain, systemic lupus erythematosus, and abscess of the liver. Patient 2's medication list reflected that she was taking Cymbalta (60 mg) once a day, gabapentin (12,000 mg) three times a day and Norco (10/325 mg) ever 12 to 24 hours, as needed. Respondent's assessment was back pain and diabetes."

35. Patient 2's pharmacy records reflect that she filled prescriptions for Cymbalta, gabapentin, Norco, and Diazepam, prescribed by Respondent following her June 2017 visit.

36. Respondent prescribed 90 tablets of Diazepam (5 mg) on an approximate monthly basis since June 2017, but did not include Diazepam on Patient 2's medication list until May 9, 2018. Only on or about July 31, 2018, Respondent noted that Diazepam was prescribed for anxiety.

37. Respondent prescribed 30 tablets of Ambien (5 mg) on an approximate monthly basis to Patient 2 since approximately March 22, 2019. On or about May 24, 2019, June 24, 2019, and July 29, 2019, Respondent noted that Ambien was prescribed to Patient 2 for Anxiety. On or about January 16, 2020, February 18, 2020, June 19, 2020, October 16, 2020, November 18, 2020, January 20, 2021, Marcy 9, 2021, and February 17, 2022, Respondent noted that Ambien was prescribed to Patient 2 for insomnia.

38. On or about July 19, 2017, January 4, 2018, March 28, 2018, May 9, 2018, June 7, 2018, and July 31, 2018, Respondent prescribed temazepan (15 mg) to Patient 2. On or about March 28, 2019, Respondent documented that temazepam was prescribed for sleep problems. On

or about July 31, 2018, Respondent documented that the temazpam was prescribed for insomnia.

39. Respondent prescribed 180 tablets of Norco (325/10 mg) to Patient 2 on a monthly basis from approximately June 2017, through July 2021. Respondent's documentation in Patient 2's medical records reflects that he prescribed one tablet of Norco (325/10 mg) to be taken every 12 to 24 hours as needed for pain. Respondent's documentation of the Norco that he prescribed to Patient 2 does not reflect the actual quantities (180 tablets per month) prescribed by Respondent and filled by Patient 2.

40. On or about October 25, 2017, November 22, 2017, February 8, 2018, May 9, 2018, June 7, 2018, October 24, 2018, and January 4, 2019, Respondent prescribed tuzistra to Patient 2. Respondent did not include tuzistra on Patient 2's medication list until approximately May 9, 2018. Respondent did not document the reason for prescribing tuzistra. Other than on or about January 4, 2019, when Respondent noted "Effort – decreased BS" as to the respiratory examination, Patient 2's review of systems was negative for cough and dyspnea and the examination of Patient 2's respiratory system was normal on each of the visits he prescribed tuzistra.

41. Patient 2's pharmacy records and CURES report reflects that she was intermittently filling opioid prescriptions from other physicians while also receiving opioids from Respondent. It is unclear whether Respondent was aware of that Patient 2 was filling opioid prescriptions prescribed by other providers, as he did not document it in Patient 2's medical records.

42. Respondent did not document any discussions with Patient 2 regarding the risks of concurrent use of benzodiazepines and opiates, including the risks of drug overdose, death, and adverse effects. There was no documentation of the reasons for the concurrent use of benzodiazepines and opiates. There was no documentation of naloxone antidote therapy being offered. Respondent did not maintain a pain agreement with Patient 2 nor did Respondent document discussing the elements of a pain agreement with Patient 2. Respondent did order any drug screening tests for Patient 2.

43. On or about June 7, 2018, July 31, 2018, September 17, 2018, and May 24, 2019, Respondent documented that Patient 2 was following up for insomnia but also noted that the

review of systems was negative for insomnia.

44. On or about August 11, 2021, and September 28, 2021, Respondent noted that Patient 2 had edema.

45. On or about October 1, 2018, June 19, 2020, July 17, 2020, and August 11, 2021, Respondent noted that Patient 2 complained of shortness of breath.

46. On or about June 7, 2017, February 8, 2018, August 26, 2019, October 1, 2019, November 7, 2019, July 17, 2020, January 25, 2021, May 24, 2022, Respondent noted that Patient 2 complained of fatigue.

47. Though Respondent documented that Patient 2 had anemia, he did not document any work-up, at any time during his care and treatment of Patient 2, to determine the cause of her anemia.

Medical Record Keeping

48. Respondent failed to document Patient 2's treatment of lupus. Respondent failed to address abnormal findings on multiple occasions, including Patient 2's anemia. Respondent failed to accurate document the medications that Patient 2 was taking. The dose and amount of Norco that Respondent documents in Patient 2's medical records does not reconcile with Patient 2's pharmacy records and CURES reports. On or about June 7, 2018, July 13, 2018, September 17, 2018, and May 24, 2019, Respondent documented that Patient 2 followed up for insomnia and Respondent documented the review of systems was negative for insomnia. Respondent failed to document the indications for prescribing tuzistra. This is an extreme departure from the standard of care.

Continuation, Titration, and Monitoring of Chronic Opiate Pain Management.

49. Patient 2 was prescribed over 2200 MME a day based upon the Norco prescribed by Respondent as well as hydromorphone from outside sources. Respondent failed to document why Patient 2 was being prescribed high doses of Norco when she was also receiving narcotics from outside sources. Respondent failed to document that Patient 2 was receiving narcotics from outside sources. Respondent failed to document any discussions with Patient 2 of the risks of drug overdose, death, and adverse effects despite seeing Patient 2 at a frequency of approximately

once a month between June 2017, and September 2019. Respondent failed to document offering naloxone antidote therapy during any of the multiple visits between 2017, and 2020. Respondent failed to perform urine drug screens to evaluate for diversion and/or determine if Patient 2 was taking other prescribed or illicit drugs. This is an extreme departure from the standard of care.

Informed Consent and Pain Care Agreement.

50. Respondent failed to document any informed consent discussions with Patient 2 regarding the risks associated with the opiates being prescribed. Respondent failed to enter into a pain management agreement with Patient 2 and failed to document discussing the elements of a pain management agreement with Patient 2. This is an extreme departure from the standard of care.

Concurrent Usage of Benzodiazepines, Nonbenzodiazepine Benzodiazepine Receptor Agonists (NBBRAs), and Opiates.

51. The standard of care requires that physicians avoid prescribing both opioids and benzodiazepines at the same time. Benzodiazepines, NBBRAs, and opiates all cause central nervous system depression and can decrease respiratory drive. There is also a risk of dependence with all these medications. Concurrent use of benzodiazepines and opiates has been associated with the risks of overdose death almost four folds compared with opiate prescription alone. When treating a patient who is taking both opioids and benzodiazepines already, the standard of care requires that the physician attempt to taper the patient off one of the medications. Psychiatry consultation for cognitive behavior therapy and alternative therapy should be utilized when necessary. Risks and side effects, including risk of dependence, central nervous system and respiratory depression, should be discussed with the patient. The prescribing physician must provide patient and caregiver education regarding the adverse side effects of the medications and naloxone antidote therapy. High doses of benzodiazepines, NBBRAs, and opiates without side effects or negative urine toxicology should also raise concerns for diversion.

52. Respondent concurrently prescribed Ambien, Diazepam, and Norco to Patient 2. Respondent failed to taper Patient 2 off this combination of medications. Respondent failed to document discussing that Patient 2 may be at higher risk for respiratory compromise given the

documented edema and shortness of breath on several visits. Respondent failed to order any toxicology to screen for diversion. Respondent failed to document offering Patient 2 naloxone antidote therapy. This is an extreme departure from the standard of care.

Evaluation for Anemia.

53. When a patient has a diagnosis of anemia, the standard of care requires that the physician work up its cause. A thorough history and physical examination should be performed to identify features of various diagnoses causing anemia. Many medical conditions and medications that cause anemia. Certain types of anemia may be hereditary, while acquired anemia may be due to dietary deficiencies acquired infections, and bleeding. Symptoms of anemia include fatigue, weakness, shortness of breath, and in extreme cases, death.

54. Despite documenting that Patient 2 had anemia intermittently from 2017, to 2022, and Patient 2's complaints of fatigue on multiple visits, Respondent failed to work-up Patient 2 for anemia. This is an extreme departure from the standard of care.

Patient 3:

55. Patient 3 was documented to have been seen by Respondent on a near monthly basis from June 29, 2017, until December 5, 2022, for a variety of conditions, including neck pain, back pain, seizure disorder, Attention Deficit Disorder (ADD), COPD, insomnia, and anxiety.

56. On or about June 29, 2017, Patient 3, was a then 61-year-old female, when she presented to Respondent with complaints of neck and back pain. Respondent noted that Patient 3 reported that her symptoms were relieved by pain medications. Respondent's examination of Patient 3 reflected decreased range of motion and pain on range of motion of the back, spine, and neck. Respondent's assessment was lumbar and cervical disc degeneration. Respondent ordered that Patient 3 continue the same medications and activities as tolerated. No medications were listed at the time of this visit.

57. Patient 3's CURES Report reflects that following the June 29, 2017 visit, Patient 3 filled the following prescriptions, prescribed by Respondent: 90 tablets of oxycodone (30 mg), 90 tablets of carisoprodol (350 mg), 90 tablets of alprazolam (2 mg), and 45 tablets of Ambien (10 mg).

58. From approximately June 2017, to March 2021, Respondent prescribed 90 tablets of oxycodone (30 mg) to Patient 3 on a monthly basis for her complaints of pain secondary to lumbar and cervical disc degeneration. Beginning in approximately April 2021, Respondent prescribed 120 tablets of oxycodone (30 mg) to Patient 3 without any documentation reflecting the indication for the dosage increase.

59. From approximately June 2017, to August 2019, Respondent prescribed 90 tablets of carisoprodol (350 mg) to Patient 3 on an approximate monthly basis. Respondent did not document the reason for prescribing carisoprodol.

60. From approximately June 2017, to August 2021, Respondent prescribed 90 tablets of alprazolam (2 mg) to Patient 3 on an approximate monthly basis for anxiety.

61. From approximately June 2017, to August 2021, Respondent prescribed 45 tablets of Ambien (10 mg) to Patient 3 on an approximate monthly basis. On or about January 13, 2022, Respondent documented that the Ambien was prescribed for insomnia. Respondent did not document the reason for prescribing Ambien on any other occasions.

62. Respondent did not document any discussions with Patient 3 regarding the risks of opiate and/or benzodiazepine therapy, including the risks of drug overdose, death, and adverse effects. Respondent did not document discussing the high risk of respiratory compromise given Patient 3's diagnosis of COPD. There was no documentation of the reasons for the high opioid and benzodiazepine doses. Respondent did not maintain a pain agreement with Patient 3 nor did Respondent document discussing the elements of a paint agreement with Patient 3. Respondent did order any drug screening tests for Patient 3.

63. On or about January 8, 2021, Patient 3 had a documented oxygen saturation level of 76% via pulse oximetry reading,[6] with no documented explanation of this abnormal finding. On or about February 8, 2021, Patient 3 had a documented oxygen saturation level of 57% via pulse oximetry reading, with no documented explanation of this abnormal finding.

64. Respondent documented a past medical history of depression for Patient 3 at

[6] The normal rage for oxygen saturation level via pulse oximetry reading is between 95% and 100%.

approximately every office visit. On or about May 28, 2020, Respondent noted Patient 3's review of systems was positive for depression and did not address this abnormal finding.

65. On or about September 17, 2019, Respondent noted bilateral upper extremity ecchymosis upon examination of Patient 3. He did not address this abnormal finding.

66. On multiple visits, including on or about April 13, 2018, August 9, 2018, September 6, 2018, October 5, 2018, December 3, 2018, January 2, 2019, April 25, 2019, January 7, 2020, February 6, 2020, April 2, 2020, May 8, 2020, May 28, 2020, July 23, 2020, August 20, 2020, October 15, 2020, November 12, 2020, December 10, 2020, February 8, 2021, May 27, 2021, August 19, 2021, and October 21, 2021, Respondent noted decreased breath sounds upon examination of Patient 3 and did not address that abnormal finding.

67. On or about October 15, 2020, December 10, 2020, October 21, 2021, January 13, 2022, and February 11, 2022, Respondent documented that Patient 3 complained of a rash and also documented that the review of systems of Patient 3 was negative for rash.

68. Respondent included lithium on Patient 3's medication list at almost every visit, but did not document the reason lithium was prescribed.

Medical Record Keeping

69. Respondent failed to document abnormal findings in his assessment and plan for Patient 3, including on those occasions that he noted low pulse oximetry, depression, bilateral upper extremity ecchymosis, and decreased breath sounds. On or about October 15, 2020, December 10, 2020, October 21, 2021, January 13, 2022, and February 11, 2022, Respondent documented that Patient 3 complained of a rash, yet documented that the review of systems was negative for rash. On multiple visits, Respondent failed to accurately document the medications prescribed for Patient 3, including failing to document the dosage frequency. Respondent failed to document the indications for prescribing lithium for Patient 3 on multiple visits. This is an extreme departure from the standard of care.

Continuation, Titration, and Monitoring of Chronic Opiate Pain Management.

70. Patient 3 was prescribed 315 MME per day from approximately June 2017, to April 2019, with an increase to 360 MME after approximately April 2019, for cervical and lumbar disc

degeneration. Respondent failed to document the reasons for the high dose of opioids for cervical lumbar disc degeneration and indication for increased dosage in April 2019. Respondent failed to document any discussions with Patient 3 of the risks of drug overdose, death, and adverse effects despite seeing Patient 3 approximately once a month between 2017, and 2022. Respondent failed to document offering naloxone antidote therapy during any of the multiple visits between 2017, and 2022. Respondent failed to perform urine drug screens to evaluate for diversion and/or determine if Patient 3 was taking other prescribed or illicit drugs. This is an extreme departure from the standard of care.

Informed Consent and Pain Care Agreement.

71. Respondent failed to document any informed consent discussions with Patient 3 regarding the risks associated with the opiates being prescribed. Respondent failed to enter into a pain management agreement with Patient 3 and failed to document discussing the elements of a pain management agreement with Patient 3. This is an extreme departure from the standard of care.

Concurrent Usage of Benzodiazepines, Nonbenzodiazepine Benzodiazepine Receptor Agonists, and Opiates.

72. Respondent concurrently prescribed Ambien, Alprazolam, and Norco to Patient 3. The maximum recommended daily dose for Ambien is 10 mg, yet Respondent prescribed Patient 3 a daily dose of 15 mg of Ambien. Respondent failed to taper Patient 3 off this combination of medications. Respondent failed to document discussing with Patient 3 that she may be at higher risk for respiratory compromise given that she was documented to have COPD. Respondent failed to order any toxicology to screen for diversion. Respondent failed to document offering Patient 3 naloxone antidote therapy. This is an extreme departure from the standard of care.

Patient 4:

73. Patient 4 was documented to have been seen by Respondent, on a near bi-weekly basis, from June 15, 2017, until December 30, 2022, for a variety of conditions, including hypertension, anxiety, depression, neck pain, and back pain.

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74. The first available chart entry reflects that on or about June 15, 2017, Patient 4, a then 68-year-old male, was being seen in follow up for hypertension, lumbar disc disease, and cervical disc disease. Patient 4 was assessed as having hypertension, intervertebral disc degeneration of the lumbar region, and intervertebral disc degeneration of the cervical region. Patient 4 was prescribed Ativan (1 mg) and Endocet (10/325 mg) as well as hypertension medication, Benicar.

75. From approximately June 2017, to December 2022, Respondent prescribed 180 tablets of Endocet (325/10 mg) to Patient 4 on a monthly basis.

76. From approximately June 2017, to December 2022, Respondent prescribed 90 tablets of lorazepam (1 mg) to Patient 4 on an approximate monthly basis.

77. Respondent did not document any discussions with Patient 4 regarding the risks of concurrent use of benzodiazepines and opiates, including the risks of drug overdose, death, and adverse effects. There was no documentation of the reasons for the concurrent use of benzodiazepines and opiates. Respondent did not document any tapering efforts for either Endocet or lorazepam. There was no documentation of naloxone antidote therapy being offered. Respondent did not maintain a pain agreement with Patient 4 nor did Respondent document discussing the elements of a pain agreement with Patient 4. Respondent did order any drug screening tests for Patient 4.

78. On or about August 13, 2018, June 2, 2022, and June 16, 2022, Respondent noted abdominal pain but did not address abdominal pain in his plan of care.

79. Despite noting decreased breath sounds on examination on multiple visits, Respondent did not address the decreased breath sounds in his plan of care.

80. From approximately May 2022, through December 2022, Respondent documented every month that Patient 4 was taking the antibiotic keflex.

81. On or about March 15, 2018, July 30, 2018, February 27, 209, October 14, 2019, December 16, 2019, June 30, 2020, October 30, 2020, November 13, 2020, January 21, 2021, February 12, 2021, August 16, 2021, September 15, 2021, November 15, 2021, December 21, 2021, January 14, 2022, and January 31, 2022, Respondent documented that Patient 4 was an occasional tobacco smoker as well as a heavy tobacco smoker.

82. Under his Assessment and Plan for Patient 4, Respondent frequently listed symptoms, such as pain in right hand, chest pain, abdominal pain, rather than diagnoses.

Medical Record Keeping

83. Respondent failed to document abnormal findings in his assessment and plan for Patient 4, including on those occasions that he noted abdominal pain and decreased breath sounds. Respondent failed to accurately document Patient 4's medications on multiple visits, including repeated documentation that Patient 4 was on Keflex every visit. Respondent documented conflicting information without reconciliation. Respondent documented on several occasions that Patient 4 was an occasional tobacco smoker and on several other occasions documented that Patient 4 was a heavy tobacco smoker. Respondent failed to document Patient 4's diagnoses and instead listed symptoms. This is an extreme departure from the standard of care.

Continuation, Titration, and Monitoring of Chronic Opiate Pain Management.

84. Patient 4 was prescribed 270 MME per day from approximately 2017, to 2022. Respondent failed to document the reasons for the high dose of opioids for lumbar disc degeneration. Respondent failed to document any discussions with Patient 4 of the risks of drug overdose, death, and adverse effects despite seeing Patient 4 approximately twice a month between 2017, and 2022. Respondent failed to document any efforts to taper Patient 4 off opioid therapy. Respondent failed to document offering naloxone antidote therapy during any of the multiple visits between 2017, and 2022. Respondent failed to perform urine drug screens to evaluate for diversion and/or determine if Patient 4 was taking other prescribed or illicit drugs. This is an extreme departure from the standard of care.

Informed Consent and Pain Care Agreement.

85. Respondent failed to document any informed consent discussions with Patient 4 regarding the risks associated with the opiates being prescribed. Respondent failed to enter into a pain management agreement with Patient 4 and failed to document discussing the elements of a pain management agreement with Patient 4. This is an extreme departure from the standard of care.

Concurrent Usage of Benzodiazepines and Opiates.

86. The standard of care requires that physicians avoid prescribing both opioids and benzodiazepines at the same time. Benzodiazepines and opiates cause central nervous system depression and can decrease respiratory drive. There is also a risk of dependence with all these medications. Concurrent use of benzodiazepines and opiates has been associated with the risks of overdose death almost four folds compared with opiate prescription alone. When treating a patient who is taking both opioids and benzodiazepines already, the standard of care requires that the physician attempt to taper the patient off one of the medications. Psychiatry consultation for cognitive behavior therapy and alternative therapy should be utilized when necessary. Risks and side effects, including risk of dependence, central nervous system and respiratory depression, should be discussed with the patient. The prescribing physician must provide patient and caregiver education regarding the adverse side effects of the medications and naloxone antidote therapy. High doses of benzodiazepines and opiates without side effects or negative urine toxicology should also raise concerns for diversion.

87. Respondent concurrently prescribed Endocet and lorazepam to Patient 4. Respondent failed to taper Patient 4 off this combination of medications. Despite seeing Patient 4 twice a month for recurrent complaints of depression, Respondent only documented referring the Patient 4 for a psychiatry consult on June 28, 2019. Respondent failed to evaluate whether lorazepam was the appropriate anxiolytic for Patient 4. Respondent failed to order any toxicology to screen for diversion. Respondent failed to document offering Patient 4 naloxone antidote therapy. This is an extreme departure from the standard of care.

Patient 5:

88. Patient 5 was documented to have been seen by Respondent on an approximately monthly basis from June 7, 2017, for a variety of conditions, including hyperlipidemia, hypertension, atrial fibrillation, anticoagulation, coronary artery disease, knee pain, shoulder pain, back pain, and depression.

89. The first available chart entry reflects that on or about June 7, 2017, Patient 5, a then 77-year-old male, had a history of atrial fibrillation and was on long-term anticoagulation.

Respondent assessed Patient 5 as having atrial fibrillation, long-term use of anticoagulants and hyperlipidemia. Respondent noted that Patient 5 was taking anticoagulation medication warfarin as well as one tablet of Norco (10/325 mg) every 12 to 24 hours, as need and one tablet of oxycodone (30 mg) every six hours, as needed.

90. From approximately June 2017, to December 2022, Respondent prescribed 180 tablets of Norco to Patient 5 on a monthly basis.

91. From approximately June 2017, to September 2020, Respondent prescribed 90 tablets of oxycodone (30 mg) to Patient 5 on a monthly basis. In approximately October 2020, to December 2022, Respondent prescribed 120 tablets of oxycodone (30 mg) to Patient 5 on a monthly basis. Respondent did not document the reason for the quantity increase of oxycodone.

92. From approximately June 2017, to October 2017, Respondent prescribed 60 tablets of lorazepam (2 mg) to Patient 5 on a monthly basis. In approximately November 2017, Respondent increased the quantity of lorazepam (2 mg) to 90 tablets per month. In approximately May 2018, Respondent decreased the quantity of lorazepam (2 mg) to 60 tablets per month. In approximately November 2018, Respondent changed the dose and quantity to 90 tablets of lorazepam (1 mg) per month. In approximately February 2020, Respondent changed the dose and quantity to 30 tablets of lorazepam (2 mg) per month. Respondent did not document discussing with Patient 5 any reason for the change of quantity and doses of the lorazepam.

93. On or about September 15, 2017, Respondent documented that Patient 5 had been injured in a motor vehicle accident. Respondent did not document any discussion with Patient 5 regarding the dangers of driving a vehicle while under the influence of opioids and benzodiazepines. Patient 5 continued to follow up with Respondent for injuries sustained in the motor vehicle accident on or about September 22, 2017, October 19, 2017, November 27, 2017, and December 11, 2017. Respondent did not document any discussion with Patient 5 regarding the relation between the opioids and benzodiazepines he was taking and the motor vehicle accident.

94. On or about November 29, 2019, and July 16, 2020, Respondent documented that Patient 5 had an irregular heart rate and a regular heart rate. On or about October 26, 2020,

November 13, 2020, November 23, 2020, February 15, 2021, April 12, 2021, May 4, 2021, July 22, 2021, December 3, 2021, December 20, 2021, and January 13, 2022, Respondent documented that Patient 5 had atrial fibrillation as well as a regular heart rate and rhythm.

95. On multiple dates, including but not limited to July 5, 2020, September 17, 2021, October 5, 2021, October 19, 2021, November 16, 2021, December 3, 2021, December 20, 2021, and January 13, 2022, Patient 5 had an elevated blood pressure reading that was not addressed by Respondent.

96. On multiple dates, including but not limited to September 17, 2021, October 5, 2021, November 16, 2021, December 3, 2021, December 20, 2021, and January 13, 2022, Patient 5 had an elevated pulse that was not addressed by Respondent.

97. Respondent documented recurrent complaints of depression during Patient 5's care and treatment. On one occasion, September 10, 2019, Patient 5's review of systems was positive for suicidal ideation. Respondent documented that the plan was "consider psychiatry versus psychologist referral" and for Patient 5 to return in one month after seeing the specialist. There is no documentation to reflect whether or not Patient 5 was seen by a specialist.

98. On or about June 16, 2020, Patient 5 complained of gastrointestinal bleeding. Respondent documented that Patient 5 reported suffering an episode of gastrointestinal hemorrhage requiring surgical intervention. Respondent assessed Patient 5 as having rectal bleeding. Respondent did not document any discussion regarding the risk of bleeding while on oral anticoagulation.

99. On or about August 5, 2020, Respondent documented that Patient 5 had "fallen 27 times in the last year" and that the falls resulted in injury. Respondent did not document any discussion with Patient 5 regarding the relation between the opioids and benzodiazepines he was taking and the multiple falls. Respondent did not document any discussions with Patient 5 regarding the risk of bleeding while on oral anticoagulation.

100. Patient 5 followed up with Respondent on an approximate monthly basis for atrial fibrillation while on anticoagulation therapy. Respondent documented a significant fall history, up to 27 times, in 2020.

101. Respondent did not document any discussions with Patient 5 regarding the risks of concurrent use of benzodiazepines and opiates, including the risks of drug overdose, death, and adverse effects. There was no documentation of the reasons for the concurrent use of benzodiazepines and opiates. There was no documentation of naloxone antidote therapy being offered. Respondent did not maintain a pain agreement with Patient 5 nor did Respondent document discussing the elements of a pain agreement with Patient 5. Respondent did order any drug screening tests for Patient 5.

Medical Record Keeping

102. Respondent failed to document abnormal findings in his assessment and plan for Patient 5, including on those occasions that Patient 5 had abnormal vital sign readings. Respondent documented conflicting information without reconciliation. Respondent documented on several occasions that Patient 5 had an irregular heart rate and a regular rate as well as atrial fibrillation and a regular heart rate and rhythm. Respondent failed to accurately document Patient 5's medications on multiple visits when compared with Patient 5's pharmacy records and CURES report. This is an extreme departure from the standard of care.

Continuation, Titration, and Monitoring of Chronic Opiate Pain Management.

103. Patient 5 was prescribed 195 to 250 MME per day from approximately 2017, to 2022. Respondent failed to document the reasons for the high dose of opioids. Respondent failed to document attempts at non-narcotic regimens. Respondent failed to document any discussions with Patient 5 of the risks of drug overdose, death, and adverse effects despite seeing Patient 5 on an approximate monthly basis between 2017, and 2022. Respondent failed to document any efforts to taper Patient 5 off opioid therapy. Respondent failed to document offering naloxone antidote therapy to Patient 5 during any of the multiple visits between 2017, and 2022. Respondent failed to perform urine drug screens to evaluate for diversion and/or determine if Patient 5 was taking other prescribed or illicit drugs. This is an extreme departure from the standard of care.

Informed Consent and Pain Care Agreement.

104. Respondent failed to document any informed consent discussions with Patient 5

regarding the risks associated with the opiates being prescribed. Respondent failed to enter into a pain management agreement with Patient 5 and failed to document discussing the elements of a pain management agreement with Patient 5. This is an extreme departure from the standard of care.

Concurrent Usage of Benzodiazepines and Opiates.

105. Respondent concurrently prescribed oxycodone, hydrocodone, and lorazepam to Patient 5. Respondent failed to refer Patient 5 to a psychiatrist despite Patient 5's recurrent complaints of depression, including suicidal ideation at one time. Respondent failed to taper Patient 5 off this combination of medications. Respondent failed to order any toxicology to screen for diversion. Respondent failed to document offering Patient 5 naloxone antidote therapy. This is an extreme departure from the standard of care.

Anticoagulation Therapy for Atrial Fibrillation.

106. Anticoagulation is used to decrease the risk of ischemic stroke and other embolic events. There is no anticoagulant that reduces thrombotic risk without simultaneous increasing the risk of bleeding. In determining whether a patient should receive long-term oral anticoagulation, the standard of care requires that the physician assess the patient's risks of thromboembolism and bleeding along with patient preferences. In patients over the age of 65, variables that raise the risk of bleeding include hypertension, abnormal renal and hepatic function, stroke, anemia, bleeding tendency/predisposition, and labile international normalized ration (INR) on warfarin.

107. Patient 5 followed up with Respondent on an approximate monthly basis for atrial fibrillation while on anticoagulation therapy. Respondent documented a significant fall history, up to 27 times, in 2020. Patient 5 also reportedly suffered an episode of gastrointestinal hemorrhage requiring surgical intervention at the time of his visit with Respondent on June 16, 2020. Respondent failed to consider that these factors contribute to the risk of bleeding while on oral anticoagulation. Respondent failed to document any discussion of the risk and benefit of continuing anticoagulation with Patient 5. This is an extreme departure from the standard of care.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

108. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated acts of negligence in the care and treatment of Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

109. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

110. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

111. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1, 2, 3, 4, and 5 without an appropriate prior examination and/or medical indication. The circumstances are as follows:

112. The allegations in the First and Second Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

113. During the time Respondent treated Patients 1, 2, 3, 4, and 5, he failed to perform an appropriate corresponding prior examination and determine a medical indication for each dangerous drug that he prescribed to each patient.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

114. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

115. The allegations in the First, Second, and Third Causes for Discipline, above, are incorporated herein by reference as if fully set forth.

116. During the time Respondent treated Patients 1, 2, 3, 4, and 5, he excessively

prescribed dangerous drugs to each patient.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

117. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that his action and/or actions represent unprofessional conduct and patient harm occurred as a result. The circumstances are as follows:

118. The allegations set forth in paragraphs 88 through 107 of the First Cause for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

119. Patient harm occurred from Respondent's unprofessional conduct, including, when he inappropriate prescribed medications to Patient 5.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accnrate Medical Records)

120. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records as to Patients 1, 2, 3, 4, and 5. The circumstances are as follows:

121. The allegations in the First Cause for Discipline, above, are incorporated herein by reference as if fully set forth.

DISCIPLINARY CONSIDERATIONS

122. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that in a matter entitled *In the Matter of the Accusation against Richard Jeffrey Kroop, M.D.*, Medical Board Case No. 17-2010-205601, the Board, issued a decision, effective April 11, 2015, in which Respondent's Physician's and Surgeon's Certificate was revoked for committing gross negligence and repeated negligent acts with respect to the care and treatment of four patients. However, the revocation was stayed and Respondent was placed on three years of probation and other terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 36316, issued to Respondent Richard Jeffrey Kroop, M.D.;

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

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

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

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

DATED: MAR 22 2024

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

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