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

In the Matter of the Accusation Against: **CLINTON RUHL COLLINS, M.D.** **3104 Ponte Morino Dr.** **Cameron Park, CA 95682-8282** **Physician's and Surgeon's Certificate No. G 63520,** Respondent.	Case No. 800-2023-101640 **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 August 1, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number G 63520 to Clinton Ruhl Collins, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2026, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code states:

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

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

6. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to a person with substance use disorder under the physician and surgeon's treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

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

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

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

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

(3) Treatment of persons with substance use disorder as provided for by Section 11217.5 of the Health and Safety Code.

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

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

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

7. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under their treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of person with substance use disorder.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

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(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of their purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

8. 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.

9. 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.

10. 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.

11. Health and Safety Code § 11165 states:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, Schedule IV and Schedule V controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, Schedule IV,

and Schedule V controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, if patient information, including any information that may identify the patient, is not compromised. The University of California shall be provided access to identifiable data for research purposes if the requirements of subdivision (t) of Section 1798.24 of the Civil Code are satisfied. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to a third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) The Department of Justice shall, no later than January 1, 2021, adopt regulations regarding the access and use of the information within CURES. The Department of Justice shall consult with all stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of

the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, Schedule IV, or Schedule V controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, 1308.14 and 1308.15, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice or contracted prescription data processing vendor as soon as reasonably possible, but not more than one working day after the date a controlled substance is released to the patient or patient's representative, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) The International Statistical Classification of Diseases (ICD) Code contained in the most current ICD revision, or any other revision deemed sufficient by the State Board of Pharmacy, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Prescribing date of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. A prescriber and dispenser invitee shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or

committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The Department of Justice may enter into an agreement with an entity operating an interstate data sharing hub, or any agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information.

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the Department of Justice pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the Department of Justice for interstate data sharing of prescription drug monitoring program information.

(3) An agreement entered into by the Department of Justice for purposes of interstate data sharing of prescription drug monitoring program information shall ensure that all access to data obtained from CURES and the handling of data contained within CURES comply with California law, including regulations, and meet the same patient privacy, audit, and data security standards employed and required for direct access to CURES.

(4) For purposes of interstate data sharing of CURES information pursuant to this subdivision, an authorized user of another state's prescription drug monitoring program shall not be required to register with CURES, if the authorized user is registered and in good standing with that state's prescription drug monitoring program.

(5) The Department of Justice shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

(i) Notwithstanding subdivision (d), a veterinarian shall report the information required by that subdivision to the department as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed.

(j) If the dispensing pharmacy, clinic, or other dispenser experiences a temporary technological or electrical failure, it shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within its control. The deadline for transmitting prescription information to the department or contracted prescription data processing vendor pursuant to subdivision (d) shall be extended until the failure is corrected. If the dispensing pharmacy, clinic, or other dispenser experiences technological limitations that are not reasonably within its control, or is impacted by a natural or manmade disaster, the deadline for transmitting prescription information to the department or contracted prescription date processing vendor shall be extended until normal operations have resumed.

12. Health and Safety Code § 11165.1 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances pursuant to Section 11150 shall, upon receipt of a federal Drug Enforcement Administration (DEA) registration, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to the practitioner or their delegate the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, upon licensure, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to the pharmacist the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES PDMP.

(iii) A licensed physician and surgeon who does not hold a DEA registration may submit an application developed by the department to obtain approval to electronically access information regarding the controlled substance history of the patient that is maintained by the department. Upon approval, the department shall release to the physician and surgeon or their delegate the electronic history of controlled substances dispensed to a patient under their care based on data contained in the CURES PDMP.

(iv) The department shall implement its duties described in clauses (i), (ii), and (iii) upon completion of any technological changes to the CURES database necessary to support clauses (i), (ii), and (ii), or by October 1, 2022, whichever is sooner.

(B) The department may deny an application or suspend a subscriber, for reasons that include, but are not limited to, the following:

(i) Materially falsifying an application to access information contained in the CURES database.

(ii) Failing to maintain effective controls for access to the patient activity report.

(iii) Having their federal DEA registration suspended or revoked.

(iv) Violating a law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Accessing information for a reason other than to diagnose or treat his or her patients, or to document compliance with the law.

(C) An authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(D) An approved health care practitioner, pharmacist, or a person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the

criteria required in subparagraph (E) to access the CURES database may submit

automated queries to the CURES database that are triggered by predetermined criteria.

(E) An approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system certifies all of the following:

(i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.

(ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:

(I) The date of the query.

(II) The time of the query.

(III) The first and last name of the patient queried.

(IV) The date of birth of the patient queried.

(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(iv) The entity has entered into a memorandum of understanding with the department that solely addresses the technical specifications of the health information technology system to ensure the security of the data in the CURES database and the secure transfer of data from the CURES database. The technical specifications shall be universal for all health information technology systems that establish a method of system integration to retrieve information from the CURES database. The memorandum of understanding shall not govern, or in any way impact or restrict, the use of data received from the CURES database or impose any additional burdens on covered entities in compliance with regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(F) No later than October 1, 2018, the department shall develop a programming interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity's health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the costs of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (H).

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) A request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, 1308.14, and 1308.15 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, or a person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

(g) For purposes of this sections, the following terms have the following meanings:

(1) "Automated basis" means using predefined criteria to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

(2) "Department" means the Department of Justice.

(3) "Entity" means an organization that operates, or provides or makes available, a health information technology system to health care practitioner or pharmacist.

(4) "Health information technology system" means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decision making, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

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

COST RECOVERY

13. Business and Professions Code section 125.3 states that:

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

14. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long-term chronic pain. It has an extremely high danger of abuse and can lead to addiction, as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

15. Oxycodone – Generic name for Oxycontin. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic

[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

used to treat moderate to severe pain. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

16. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short-acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

17. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder, and akathisia. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Temazepam – Generic name for Restoril. It is a medication of the benzodiazepine class which is generally used to treat severe or debilitating insomnia. It is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Butalbital with caffeine and aspirin – Generic name for Fiorinal. Butalbital is a barbiturate with an immediate duration of action. Often combined with other medications, it is commonly used for the treatment of pain and headache. Fiorinal is a Schedule III controlled

substance pursuant to Code of Federal Regulations Title 21 section 1308.13. Fiorinal is a dangerous drug pursuant to Business and Professions Code section 4022.

21. Buprenorphine – Generic name for Butrans. Buprenorphine is an opioid used to treat opioid addiction, moderate acute pain, and moderate chronic pain. When used in combination with naloxone for treating opioid addiction, it is known by the trade name Suboxone. As a transdermal patch, Butrans is used for chronic pain. Buprenorphine is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 Section 1308.13(e). Buprenorphine is a dangerous drug pursuant to Business and Professions Code section 4022.

22. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short-acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

23. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

24. Hydrocodone with ibuprofen – Sold under the brand name Vicoprofen, hydrocodone with ibuprofen is a fixed-dose combination analgesic medication used in short-term therapy to relieve severe pain. Prior to October 6, 2014, hydrocodone with ibuprofen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[3]

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[2] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

[3] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

Hydrocodone with ibuprofen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

25. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, Carisoprodol was classified as a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

26. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, Tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

27. Bupropion – Generic name for Wellbutrin. Bupropion is an atypical antidepressant that is US FDA-approved to treat major depressive disorder, seasonal affective disorder, and to support smoking cessation. It is a dangerous drug pursuant to Business and Professions Code section 4022.

28. Methylphenidate – Generic name for Ritalin and Concerta, it is an FDA-approved central nervous system (CNS) stimulant to treat ADHD and narcolepsy. Methylphenidate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

29. Amphetamine – Combined with other drugs and sold under the trade name Adderall. Adderall is used in the treatment of ADHD and narcolepsy. Adderall is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

30. Methamphetamine – A potent central nervous system (CNS) stimulant that is mainly used as a recreational or performance-enhancing drug and less commonly as a second-line treatment for ADHD. Methamphetamine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

31. Morphine sulfate – Sold under the trade name MS Contin. It is mainly used for pain. Physical and psychological dependence and tolerance may develop with repeated administration. Morphine sulfate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

32. Fluoxetine – Sold under the brand name Prozac, among others, fluoxetine is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. It is a dangerous drug pursuant to Business and Professions Code section 4022.

33. Pregabalin – Sold under the brand name Lyrica among others, pregabalin is an anticonvulsant, analgesic, and anxiolytic amino acid medication used to treat epilepsy, neuropathic pain, fibromyalgia, restless legs syndrome, opioid withdrawal, and generalized anxiety disorder (GAD). It is a Schedule V controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.15. It is a dangerous drug pursuant to California Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

34. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed grossly negligent acts in his care and treatment of Patient A[4], as more particularly alleged hereinafter:

[4] Patient and provider names have been changed to protect patient confidentiality. Full patient names will be provided upon receipt of a Request for Discovery.

35. Respondent was at the time of the allegations herein a physician and surgeon Board Certified in Family Medicine and Occupational Medicine, who practiced at the El Dorado Community Health Center (EDCHC) in Cameron Park, California and at Folsom Urgent Care, in Folsom, California.

Patient A

36. Patient A is a 60-year-old male long-term patient, who was first seen by Respondent more than 10 years ago. Patient A was a complex patient who received multiple controlled substances from Respondent and other prescribers. Patient A had a history of degenerative joint disease, disc herniation, spinal stenosis, chronic neck and back pain, Crohn's disease, ulcerative colitis, chronic diarrhea, erosive esophagitis, duodenal ulcer, chronic fatigue, alcohol abuse, headache, history of cervical spine fusion (2007), cholecystectomy (1995), PTSD, opioid dependence, anxiety, severe depression, hallucinogen use when in high school and was documented to have gotten opioids "from the street".

37. According to the CURES report for Patient A, during the period of on or about May 3, 2017, through on or about September 7, 2017, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
5/3/2017	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
5/17/2017	MORPHINE SULFATE	15 MG	10
5/30/2017	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
6/14/2017	MORPHINE SULFATE	30 MG	30
6/28/2017	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
7/25/2017	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
8/9/2017	OXYCODONE HYDROCHLORIDE	10 MG	120
9/7/2017	OXYCODONE HYDROCHLORIDE	10 MG	120

38. In January 2017, Respondent saw Patient A for a clinic visit. Patient A's controlled medications utilized were documented as Norco 10 – 325 mg, MS Contin 30 mg, morphine sulfate 30 mg ("not taking"), as well as Prozac 20 mg, Wellbutrin 75 mg ("not taking"), and promethazine ("not taking"). During the visit, Respondent failed to address Patient A's high blood pressure (142/90). Respondent documented no abnormalities in his limited examination of

the neck, heart, and abdomen. Respondent's plan was to refill Norco, increase gabapentin to 800 mg three times a day, and stop Wellbutrin (however the progress note states Patient A was not taking this medicine.)

39. In a follow-up visit in March 2017, Respondent performed a minimal examination including general appearance, neck, lungs, heart, and abdomen. The only abnormality documented was "tender RUQ[5]". Respondent advised Patient A to stop Norco and to start Percocet 10 – 325 mg every eight hours. Laboratory tests were ordered including TSH, CBC, and a comprehensive metabolic panel.

40. Respondent next saw Patient A in April 2017. Patient A requested to go back to Norco as Percocet was making him sick. Respondent documented the urine drug test results in the note which revealed that Patient A was negative for all drugs tested with the exception of THC. Respondent failed to address this aberrant test. Respondent stopped Percocet and prescribed Norco 10 – 325 mg every six hours. Respondent also refilled gabapentin.

41. Respondent next saw Patient A in May 2017. Patient A stated that gabapentin makes him feel "foggy" at the current dosage. Respondent lowered gabapentin to 600 mg, and refilled Norco, 10 doses of morphine sulfate 15 mg to be used as needed. Respondent documented the results of the urine drug test which revealed that Patient A was positive for alcohol and marijuana but negative for the prescribed benzodiazepines. Respondent failed to address the aberrant results of the urine drug test.

42. Respondent next saw Patient A in June 2017 for neck pain and ulcerative colitis with abdominal pain. Respondent did not perform an abdominal examination and only performed a minimal examination of the neck. Respondent performed a neurological examination and stopped morphine. Respondent refilled Norco. The urine drug test revealed that Patient A was positive for THC but negative for opiates and benzodiazepines. Respondent failed to address the aberrant results of the urine drug test.

43. Respondent next saw Patient A in September 2017 for neck pain and jaw pain. Patient A reported that oxycodone helped without bothering his gastrointestinal area. Respondent performed

[5] RUQ = right upper quadrant of abdomen

a limited examination and documented "High risk medication use" under his assessment. The September urine drug test revealed that Patient A was positive for marijuana, alcohol, benzodiazepines, and alprazolam, but negative for prescribed opiates. Respondent failed to address the aberrant urine drug test.

44. According to the CURES report for Patient A, during the period of on or about April 24, 2018, through on or about December 19, 2018, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
4/24/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	5-325 MG	30
6/26/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	30
7/27/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	30
8/23/2018	LORAZEPAM	0.5 MG	5
8/24/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	30
9/6/2018	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	30
9/11/2018	LORAZEPAM	0.5 MG	5
9/21/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60
10/19/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60
12/19/2018	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60

45. In September 2018, Patient A's urine drug test revealed that Patient A was positive for alcohol metabolites but negative for opiates and benzodiazepines. Respondent failed to address Patient A's aberrant urine drug test. Respondent's assessment documented high-risk medication use. Patient A was advised to stop Percocet and gabapentin. Respondent refilled Norco.

46. In November 2018, another provider ordered an MRI on Patient A's shoulder and referred Patient A to physical therapy. Patient A's urine drug test was positive for benzodiazepine.

47. According to the CURES report for Patient A, during the period of on or about January 18, 2019, through on or about December 2, 2019, Patient A filled the following prescriptions for controlled substances:

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Date Filled	Drug Name	Strength	Quantity
1/18/2019	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	60
10/1/2019	HYDROCODONE BITARTRATE ACETAMINOPHEN	5-325 MG	60
11/1/2019	HYDROCODONE BITARTRATE ACETAMINOPHEN	5-325 MG	10
11/15/2019	HYDROCODONE BITARTRATE ACETAMINOPHEN	5-325 MG	60
12/2/2019	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60

48. According to the CURES report for Patient A, during the period of on or about February 4, 2020, through on or about December 23, 2020, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
2/4/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60
3/24/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	60
4/7/2020	PREGABALIN	25 MG	30
4/12/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
5/10/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
5/29/2020	PREGABALIN	25 MG	60
5/29/2020	OXYCODONE HYDROCHLORIDE	5 MG	90
6/27/2020	PREGABALIN	25 MG	60
6/30/2020	OXYCODONE HYDROCHLORIDE	5 MG	90
7/21/2020	PREGABALIN	25 MG	60
7/25/2020	OXYCODONE HYDROCHLORIDE	5 MG	120
8/11/2020	LORAZEPAM	0.5 MG	5
8/23/2020	OXYCODONE HYDROCHLORIDE	10 MG	60
8/28/2020	MORPHINE SULFATE	15 MG	30
9/4/2020	PREGABALIN	25 MG	60
9/11/2020	MORPHINE SULFATE	15 MG	30
9/25/2020	MORPHINE SULFATE	15 MG	30
10/9/2020	MORPHINE SULFATE	15 MG	60
10/14/2020	LORAZEPAM	0.5 MG	5
10/28/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
11/13/2020	PREGABALIN	25 MG	90
11/18/2020	LORAZEPAM	0.5 MG	5
11/27/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
12/14/2020	PREGABALIN	25 MG	90
12/23/2020	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90

49. In February 2020, Respondent saw Patient A for a clinic visit. Patient A's urine drug test was positive for benzodiazepine and THC. Respondent refilled Norco, and stopped prescribing bupropion to Patient A. Respondent documented his assessment as high-risk medication use.

50. According to the CURES report for Patient A, during the period of on or about January 13, 2021, through on or about December 27, 2021, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/13/2021	MORPHINE SULFATE	15 MG	6
1/13/2021	MORPHINE SULFATE	15 MG	54
2/9/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
3/10/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
4/28/2021	OXYCODONE HYDROCHLORIDE	5 MG	90
5/28/2021	OXYCODONE HYDROCHLORIDE	5 MG	120
6/26/2021	OXYCODONE HYDROCHLORIDE	5 MG	120
7/2/2021	OXYCODONE HYDROCHLORIDE	10 MG	120
7/9/2021	LORAZEPAM	0.5 MG	10
7/31/2021	OXYCODONE HYDROCHLORIDE	10 MG	120
8/4/2021	LORAZEPAM	0.5 MG	10
8/6/2021	ALPRAZOLAM	1 MG	10
8/13/2021	ALPRAZOLAM	1 MG	2
8/13/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
8/14/2021	ALPRAZOLAM	1 MG	30
9/11/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
9/14/2021	ALPRAZOLAM	1 MG	30
9/21/2021	OXYCODONE HYDROCHLORIDE	5 MG	81
9/21/2021	OXYCODONE HYDROCHLORIDE	5 MG	9
10/5/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
10/29/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
11/2/2021	ALPRAZOLAM	1 MG	30
11/27/2021	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
12/1/2021	ALPRAZOLAM	1 MG	30
12/7/2021	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	83
12/7/2021	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	7
12/27/2021	ALPRAZOLAM	1 MG	30

51. Patient A continued with regular visits with Respondent and other providers, and on or about April 18, 2021, Respondent had a telephone visit with Patient A. Patient A indicated that he was willing to wean off opioids. Respondent documented pharmacy concerns about early refills. Respondent increased the prescription of Xanax from 10 per month to 30 per month. Respondent did not feel there was substance abuse and approved an early refill for gabapentin.

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52. A pharmacy form dated in or around August 2021, provided that Patient A was planning on weaning opiates in the next 3 months. Patient A was prescribed Norco 10-25 mg tid [6] and Xanax 1 mg daily.

53. According to the CURES report for Patient A, during the period of on or about January 6, 2022, through on or about December 11, 2022, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/6/2022	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	90
2/4/2022	OXYCODONE HYDROCHLORIDE	10 MG	90
2/9/2022	ALPRAZOLAM	1 MG	30
2/16/2022	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	45
3/1/2022	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	90
3/24/2022	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
4/22/2022	ALPRAZOLAM	1 MG	30
4/22/2022	HYDROCODONE BITARTRATE ACETAMINOPHEN	10-325 MG	120
4/28/2022	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	120
5/21/2022	ALPRAZOLAM	1 MG	30
5/31/2022	OXYCONTIN	20 MG	60
6/28/2022	ALPRAZOLAM	1 MG	10
6/30/2022	OXYCONTIN	20 MG	90
7/28/2022	OXYCODONE HYDROCHLORIDE ACETAMINOPHEN	10-325 MG	120
7/28/2022	ALPRAZOLAM	1 MG	10
8/26/2022	OXYCODONE HYDROCHLORIDE	10 MG	120
8/26/2022	ALPRAZOLAM	1 MG	10
9/25/2022	OXYCODONE HYDROCHLORIDE	10 MG	120
9/25/2022	ALPRAZOLAM	1 MG	10
10/14/2022	ALPRAZOLAM	1 MG	10
10/24/2022	OXYCODONE HYDROCHLORIDE	15 MG	120
11/12/2022	ALPRAZOLAM	1 MG	10
11/22/2022	OXYCODONE HYDROCHLORIDE	15 MG	48
11/22/2022	OXYCODONE HYDROCHLORIDE	15 MG	12
12/11/2022	ALPRAZOLAM	1 MG	10

54. In a telephone visit in August 2022, Respondent documented that Patient A had severe depression, a PHQ-9 score 17. Respondent referred Patient A to physical therapy for neck and back pain and ordered cervical and lumbar spine imaging.

[6] Tid – medical abbreviation for "three times a day."

55. In November 2022, Patient A was seen by another provider for a chronic pain consultation. Respondent referred Patient A to STEPS for chronic pain. The chronic pain provider documented that Patient A's pain was 8/10, currently taking oxycodone 15 mg and gabapentin 800 mg. He documented that Patient A had a history of anxiety and panic attacks, PTSD, ulcerative colitis, and headaches. Patient A reported taking cannabis for PTSD since age 12. The chronic pain provider also documented that Patient A took opioids for abdominal pain either prescribed or from the street; including the use of hallucinogens when in high school. The chronic pain provider performed a very thorough evaluation and examination and diagnosed Patient A with opioid dependence and anxiety. The urine drug test tested positive for benzodiazepine but negative for opioids and other drugs tested. Patient A admitted that "in the past used opioids to get high." Patient A had "tolerance, dependence and withdrawal symptoms."

56. According to the CURES report for Patient A, during the period of on or about January 10, 2023, through on or about March 12, 2023, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/10/2023	ALPRAZOLAM	1 MG	10
2/9/2023	ALPRAZOLAM	1 MG	10
3/12/2023	ALPRAZOLAM	1 MG	10

57. Respondent next saw Patient A in February and July 2023. Respondent failed to address Patient A's aberrant urine drug screen.

58. Patient A had aberrant urine drug test results on April 7, May 17, June 14, June 28, September 6, September 7, December 14, 2017; June 26, September 21, November 21, 2018; February 4, 2022, February 16, March 14, 23, June 25, 28, 2023; and April 8, 2024.

59. During his interview with the Board investigator on or about August 27, 2024, Respondent stated that he only started using CURES[7] five or six years ago. When asked if other modalities of treatment were attempted to manage Patient A's pain. Respondent stated he had not

[7] Controlled Substance Utilization Review and Evaluation System (CURES). Section 11165.4 of the Health and Safety Code sets forth the requirements for mandatory consultation of CURES.

used other modalities. Respondent stated that Patient A was never very active and was caring for his daughter and mother. Respondent stated that he was not aware that prior to 2017, Patient A was diagnosed with opiate use disorder, and was prescribed Suboxone. Respondent could not explain why between 2017 and 2022, Patient A was generally getting two different short-acting opiates at the same time, including a combination of oxycodone, hydrocodone, and short-acting morphine. The prescriptions overlapped on the CURES report. When asked about the gaps in opiate prescribing including December 2017 through April 2018, and January 2019 to October 2019, Respondent stated that Patient A likely decided to "put up with the pain", and took Tylenol, Advil, and gabapentin. Between April 2021 and July 2021, the MME[8] dosing more than doubled. In October 2021, Patient A had been on oxycodone for years but then told Respondent he was allergic to oxycodone and threw his medication away. By May 2022, Patient A was started on OxyContin. Patient A's MME totaled 60 mg per day and one month later it was increased to 90 mg per day. Respondent could not recall why this occurred. When Patient A saw another provider in November 2022, Patient A acknowledged that he was "getting high on opiates, developed a tolerance, and having withdrawal symptoms". Respondent stated he could not recall knowing this.

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

a. Respondent prescribed and refilled dangerous combinations of controlled substances.

b. Respondent failed to check CURES for Patient A.

c. Respondent failed to address Patient A's history of substance abuse and other red flags for diversion or abuse.

d. Respondent failed to address the aberrant urine drug tests.

e. Respondent failed to perform an adequate periodic review of the controlled substances prescribed to Patient A.

f. Respondent failed to address Patient A's high blood pressure.

[8] Morphine milligram equivalent are values that represent the potency of an opioid dose relative to morphine.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

61. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients B, C, D, E, 1, 2, 3, 4, 5, 6, and 7 as more particularly alleged hereinafter: Paragraphs 34 through 60, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient B

62. Patient B is a 65-year-old female patient who had a history of anxiety, anemia, central sleep apnea, chronic nonspecific lung disease, chronic pain, cirrhosis, depression, diastolic heart failure, history of scleroderma, hyperlipidemia, history of Roux-en-Y gastric bypass, hypertension, hypoglycemia, migraine headaches, narcolepsy, peptic ulcer disease, supraventricular tachycardia, history of cholecystectomy, history of left shoulder surgery, history of cigarette smoking (one pack per day times 20 years, quit in 1998), alcohol use (wine occasionally), history of cervical and lumbar fusions, seizures, intractable vomiting, cervical radiculopathy, abdominal pain, chronic diarrhea, and chronic pancreatitis.

63. In February 2017, Respondent saw Patient B for obstructive sleep apnea. Patient B was using Ritalin and BiPAP[9]. Patient B had a medication list of more than 25 medications.

64. According to the CURES report for Patient B, during the period of on or about April 10, 2017, through on or about December 19, 2017, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
4/10/2017	DIAZEPAM	10 MG	90
4/12/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
4/18/2017	TEMAZEPAM	30 MG	30
5/15/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/15/2017	DIAZEPAM	10 MG	90
5/16/2017	TEMAZEPAM	30 MG	30
6/15/2017	DIAZEPAM	10 MG	90

[9] BiPap is a noninvasive ventilator that helps people breathe when they have medical conditions that make breathing difficult.

Date Filled	Drug Name	Strength	Quantity
6/16/2017	TEMAZEPAM	30 MG	30
6/16/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
6/16/2017	TRAMADOL HYDROCHLORIDE	50 MG	120
7/14/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/15/2017	DIAZEPAM	10 MG	90
7/20/2017	TRAMADOL HYDROCHLORIDE	50 MG	120
8/8/2017	TEMAZEPAM	30 MG	30
8/11/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
8/12/2017	DIAZEPAM	10 MG	90
8/22/2017	TRAMADOL HYDROCHLORIDE	50 MG	120
9/11/2017	TEMAZEPAM	30 MG	30
9/12/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
9/12/2017	DIAZEPAM	10 MG	90
10/12/2017	DIAZEPAM	10 MG	90
10/12/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/13/2017	TEMAZEPAM	30 MG	30
11/9/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
11/9/2017	DIAZEPAM	10 MG	90
11/10/2017	TEMAZEPAM	30 MG	30
12/11/2017	TEMAZEPAM	30 MG	30
12/11/2017	DIAZEPAM	10 MG	90
12/19/2017	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120

65. According to the CURES report for Patient B, during the period of on or about January 11, 2018, through on or about December 21, 2018, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/11/2018	DIAZEPAM	10 MG	90
1/11/2018	TEMAZEPAM	30 MG	30
1/23/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
2/15/2018	DIAZEPAM	10 MG	90
2/15/2018	TEMAZEPAM	30 MG	30
2/20/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/17/2018	TEMAZEPAM	30 MG	30
3/17/2018	DIAZEPAM	10 MG	90
4/17/2018	DIAZEPAM	10 MG	90
4/17/2018	TEMAZEPAM	30 MG	30
4/27/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/15/2018	DIAZEPAM	10 MG	90
5/15/2018	TEMAZEPAM	30 MG	30
6/2/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120

Date Filled	Drug Name	Strength	Quantity
6/13/2018	DIAZEPAM	10 MG	90
6/13/2018	TEMAZEPAM	30 MG	30
7/3/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/13/2018	DIAZEPAM	10 MG	90
7/23/2018	TEMAZEPAM	30 MG	30
8/15/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
8/16/2018	DIAZEPAM	10 MG	90
8/22/2018	TEMAZEPAM	30 MG	30
9/12/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
9/13/2018	DIAZEPAM	10 MG	90
9/19/2018	TEMAZEPAM	30 MG	30
10/18/2018	TEMAZEPAM	30 MG	30
10/18/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/18/2018	DIAZEPAM	10 MG	90
11/15/2018	TEMAZEPAM	30 MG	30
11/15/2018	DIAZEPAM	10 MG	90
11/24/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
12/13/2018	DIAZEPAM	10 MG	90
12/13/2018	TEMAZEPAM	30 MG	30
12/21/2018	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120

66. According to the CURES report for Patient B, during the period of on or about January 11, 2019, through on or about December 19, 2019, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/11/2019	TEMAZEPAM	30 MG	30
1/11/2019	DIAZEPAM	10 MG	90
1/18/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
2/14/2019	TEMAZEPAM	30 MG	30
2/14/2019	DIAZEPAM	10 MG	60
2/15/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/14/2019	DIAZEPAM	10 MG	60
3/14/2019	TEMAZEPAM	30 MG	30
3/15/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
4/11/2019	TEMAZEPAM	30 MG	30
4/11/2019	DIAZEPAM	10 MG	60
4/18/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/9/2019	DIAZEPAM	5 MG	90
5/9/2019	TEMAZEPAM	30 MG	30
5/16/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
6/6/2019	DIAZEPAM	5 MG	90

Date Filled	Drug Name	Strength	Quantity
6/6/2019	TEMAZEPAM	30 MG	30
7/2/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/3/2019	TEMAZEPAM	30 MG	30
7/3/2019	DIAZEPAM	5 MG	90
7/31/2019	DIAZEPAM	5 MG	90
7/31/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/31/2019	TEMAZEPAM	30 MG	30
8/28/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
8/28/2019	DIAZEPAM	5 MG	90
8/28/2019	TEMAZEPAM	30 MG	30
9/25/2019	TEMAZEPAM	30 MG	30
9/25/2019	DIAZEPAM	5 MG	80
9/27/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/23/2019	DIAZEPAM	5 MG	80
10/23/2019	TEMAZEPAM	30 MG	30
11/20/2019	DIAZEPAM	5 MG	80
11/20/2019	TEMAZEPAM	30 MG	30
12/12/2019	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
12/19/2019	TEMAZEPAM	30 MG	30
12/19/2019	DIAZEPAM	5 MG	90

67. In April 2019, Patient B went to the emergency department for abdominal pain, ongoing after gastric bypass. Patient B left without being seen and declined to talk to the medical staff.

68. In October 2019, during an emergency room visit, Patient B tested positive for benzodiazepine and opiates screen, but negative for other drugs tested. Patient B was admitted for abdominal pain, nausea, vomiting, chronic diarrhea, chronic pancreatitis, and chronic back pain.

69. In December 2019, during an emergency room visit, Patient B tested positive for methadone and benzodiazepines, but negative for amphetamines, and barbiturates.

70. According to the CURES report for Patient B, during the period of on or about January 14, 2020, through on or about December 16, 2020, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/14/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
1/16/2020	DIAZEPAM	5 MG	90
1/22/2020	TEMAZEPAM	30 MG	30
2/11/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120

Date Filled	Drug Name	Strength	Quantity
2/13/2020	DIAZEPAM	5 MG	90
2/24/2020	TEMAZEPAM	30 MG	30
3/23/2020	TEMAZEPAM	30 MG	30
4/7/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
4/20/2020	TEMAZEPAM	30 MG	30
5/12/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	90
5/18/2020	TEMAZEPAM	30 MG	30
6/17/2020	TEMAZEPAM	30 MG	30
6/17/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/17/2020	TEMAZEPAM	30 MG	30
7/17/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
8/17/2020	TEMAZEPAM	30 MG	30
8/17/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
9/15/2020	TEMAZEPAM	30 MG	30
9/15/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/16/2020	TEMAZEPAM	30 MG	30
10/21/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
11/18/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
11/18/2020	TEMAZEPAM	30 MG	30
12/16/2020	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
12/16/2020	TEMAZEPAM	30 MG	30

71. In July 2021, Patient B was seen for acute metabolic encephalopathy, possibly substance-induced. Patient B was suspected to have fallen asleep before the accident as a result of her history of narcolepsy, opiate, and benzodiazepine use. The diagnosis included bilateral low back pain without sciatica.

72. According to the CURES report for Patient B, during the period of on or about January 13, 2021, through on or about December 16, 2021, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/13/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
1/13/2021	TEMAZEPAM	30 MG	30
2/6/2021	METHADONE HYDROCHLORIDE	10 MG	60
2/6/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	60
2/10/2021	TEMAZEPAM	30 MG	30
2/10/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/10/2021	TEMAZEPAM	30 MG	30
3/10/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/10/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	60

3/30/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
4/6/2021	LORAZEPAM	1 MG	30
4/21/2021	LORAZEPAM	1 MG	60
4/21/2021	METHADONE HYDROCHLORIDE	10 MG	60
4/29/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
5/5/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/5/2021	TEMAZEPAM	30 MG	30
5/19/2021	LORAZEPAM	1 MG	60
5/20/2021	METHADONE HYDROCHLORIDE	10 MG	60
5/27/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
6/2/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
6/2/2021	TEMAZEPAM	30 MG	30
6/25/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
6/30/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
6/30/2021	TEMAZEPAM	30 MG	30
7/17/2021	METHADONE HYDROCHLORIDE	10 MG	60
7/20/2021	LORAZEPAM	1 MG	60
7/23/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
7/28/2021	TEMAZEPAM	15 MG	30
8/19/2021	LORAZEPAM	1 MG	60
8/20/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
8/20/2021	TEMAZEPAM	15 MG	30
9/13/2021	METHADONE HYDROCHLORIDE	10 MG	60
9/13/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
9/18/2021	TEMAZEPAM	7.5 MG	30
10/12/2021	METHADONE HYDROCHLORIDE	10 MG	60
10/16/2021	TEMAZEPAM	7.5 MG	15
10/19/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
10/19/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/19/2021	LORAZEPAM	1 MG	60
11/11/2021	METHADONE HYDROCHLORIDE	10 MG	60
11/13/2021	TEMAZEPAM	7.5 MG	15
11/16/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
11/16/2021	LORAZEPAM	1 MG	60
11/18/2021	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
12/9/2021	METHADONE HYDROCHLORIDE	10 MG	60
12/11/2021	TEMAZEPAM	7.5 MG	10
12/14/2021	LORAZEPAM	1 MG	60
12/16/2021	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120

73. According to the CURES report for Patient B, during the period of on or about January 10, 2022, through on or about December 12, 2022, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/10/2022	METHADONE HYDROCHLORIDE	10 MG	60
1/11/2022	TEMAZEPAM	7.5 MG	10
1/11/2022	LORAZEPAM	1 MG	60
1/13/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
1/13/2022	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
2/8/2022	TEMAZEPAM	7.5 MG	10
2/8/2022	LORAZEPAM	1 MG	60
2/10/2022	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
2/11/2022	METHADONE HYDROCHLORIDE	10 MG	60
2/11/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/8/2022	LORAZEPAM	1 MG	60
3/10/2022	HYDROMORPHONE HYDROCHLORIDE	2 MG	90
3/11/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
3/11/2022	METHADONE HYDROCHLORIDE	10 MG	60
4/5/2022	TEMAZEPAM	7.5 MG	10
4/5/2022	LORAZEPAM	1 MG	60
4/15/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/3/2022	TEMAZEPAM	7.5 MG	10
5/3/2022	LORAZEPAM	1 MG	60
5/14/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
5/31/2022	TEMAZEPAM	7.5 MG	10
5/31/2022	LORAZEPAM	1 MG	60
6/12/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	48
6/21/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
6/28/2022	TEMAZEPAM	7.5 MG	10
6/28/2022	LORAZEPAM	1 MG	60
7/19/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
7/26/2022	TEMAZEPAM	7.5 MG	10
7/26/2022	LORAZEPAM	1 MG	60
8/16/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
8/23/2022	LORAZEPAM	1 MG	60
9/13/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
9/16/2022	TEMAZEPAM	7.5 MG	10
9/20/2022	LORAZEPAM	1 MG	60
10/14/2022	TEMAZEPAM	7.5 MG	10
10/15/2022	METHYLPHENIDATE HYDROCHLORIDE	20 MG	120
10/18/2022	LORAZEPAM	1 MG	60
11/12/2022	TEMAZEPAM	7.5 MG	10
11/15/2022	LORAZEPAM	1 MG	60
12/2/2022	TEMAZEPAM	7.5 MG	10
12/12/2022	TEMAZEPAM	7.5 MG	10

74. In April 2022, during a pain management visit, Patient B tested positive for opiates, methadone, benzodiazepines, and tricyclic antidepressants but negative for other drugs.

75. In June 2022, Patient B was brought in by EMS[10] for altered mental status starting the night prior. Patient B initially refused CT scan and blood work. Patient B ultimately agreed. CT scan of the head was negative, chest x-ray negative, EKG unremarkable, potassium 5.6 – mild elevation, AST[11] and ALT[12] mildly elevated. Symptoms felt to be secondary to narcolepsy, with mild acute kidney injury and dehydration as well as COVID-19.

76. According to the CURES report for Patient B, during the period of on or about January 5, 2023, through on or about January 24, 2023, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/5/2023	TEMAZEPAM	7.5 MG	10
1/24/2023	TEMAZEPAM	7.5 MG	10

77. Respondent committed repeated negligent acts in the care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent prescribed multiple controlled substances concurrently. Respondent prescribed Patient B a stimulant and multiple benzodiazepines, which were used concurrently with opioids at times.

b. Respondent failed to address multiple "red flags" for possible controlled substance abuse in the treatment of Patient B.

c. Respondent failed to appropriately consider Patient B's history of substance abuse disorder.

d. Respondent escalated controlled substances over time.

e. Respondent failed to document adequate informed consent relating to the prescription of controlled medication.

f. Respondent failed to adequately perform urine drug tests.

[10] Emergency Medical Services

[11] Aspartate Aminotransferase, a liver enzyme that's also known as serum glutamic-oxaloacetic transaminase (SGOT). An AST blood test measures the amount of AST in your blood, which can help diagnose or monitor liver problems.

[12] Alanine Aminotransferase, an enzyme that helps the liver convert food into energy.

g. Respondent failed to consider Patient B's chronic diseases which increases the risk of use of controlled substances.

h. Respondent prescribed benzodiazepines while Patient B was taking opioids.

i. Respondent failed to perform periodic review of Patient B's treatment.

Patient C

78. Patient C is a 37-year-old female who had a history of ADHD (presumed[13]), anxiety, and partner abuse.

79. In April 2017, Patient C tested negative for all drugs tested.

80. Despite failing to document a diagnosis of ADHD, according to the CURES report for Patient C, during the period of on or about April 13, 2017, through on or about December 29, 2017, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
4/13/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
5/12/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
6/13/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
7/12/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
8/9/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
9/7/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
10/6/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
11/3/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
12/29/2017	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60

81. According to the CURES report for Patient C, during the period of on or about January 26, 2018, through on or about December 13, 2018, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/26/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
2/27/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
3/28/2018	AMPHETAMINE SALT COMBO	20 MG	60
4/27/2018	AMPHETAMINE SALT COMBO	20 MG	60
5/17/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
6/22/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
7/24/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60

[13] Respondent treated Patient B for ADHD without verifying or performing tests to confirm the ADHD diagnosis.

Date Filled	Drug Name	Strength	Quantity
8/25/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
9/11/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
10/10/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
11/6/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
12/5/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
12/13/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	35
12/13/2018	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	25

82. According to the CURES report for Patient C, during the period of on or about January 11, 2019, through on or about October 16, 2019, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/11/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
2/8/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
3/5/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
4/2/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
4/27/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
5/7/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
6/6/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
9/20/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
10/16/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
10/16/2019	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60

83. On or about June 16, 2020, Respondent saw Patient C for a telephone visit. Patient C wanted to restart amphetamine – dextroamphetamine. Patient C was taking this prior to her pregnancy and wanted to restart.

84. On or about July 16, 2020, Respondent saw Patient C for a telephone visit. Patient C lost her medications on a trip to Idaho. Patient C was advised that there would be no replacement of lost medications, but the CURES reports reveal that Patient C was prescribed thirty days of amphetamine 20 mg #60 (usual dosing) on July 16, 2020, and another thirty days on August 5, 2020.

85. On or about September 9, 2020, Respondent saw Patient C for a telephone visit. Patient C complained the Adderall was wearing off too quickly. Patient C requested and, according to CURES, received 180 tablets of Adderall 20 mg in the month of September 2020, and 60 tablets each in the months of October, November, and December 2020.

86. According to the CURES report for Patient C, during the period of on or about June 16, 2020, through on or about December 10, 2020, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
6/16/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
6/30/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
7/16/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
8/5/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
9/3/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
9/12/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	54
9/12/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	6
9/29/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
10/27/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	54
10/27/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	6
11/11/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
12/10/2020	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60

87. On or about March 6, 2021, Respondent saw Patient C for a telephone visit. Patient C requested a higher dose of Adderall. Respondent increased Adderall to 30 mg twice daily.

88. On or about August 6, 2021, Respondent saw Patient C for an office visit. Respondent documented a minimal examination and noted that Patient C appeared anxious and at high risk for medication use and ADHD. Patient C's urine drug test results were not documented. Patient C was living in a motel under county protection.

89. On or about August 31, 2021, Respondent saw Patient C for a telephone visit. Respondent documented that Patient C was planning on driving to Idaho to stay with her sister. Patient C requested a refill of her Adderall. The refill was approved; however, the medication was again refilled at the regular time interval – September 30, 2021, October 24, 2021, and November 21, 2021.

90. In August of 2021, Patient C saw another provider for a telephone visit. The provider documented a drug or alcohol risk assessment.

91. On or about November 18, 2021, Respondent saw Patient C for an office visit. Respondent documented that Patient C needed a urine drug test and a letter proving that she is taking Adderall. The results of the urine drug tests were not documented.

92. According to the CURES report for Patient C, during the period of on or about January 9, 2021, through on or about December 16, 2021, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/9/2021	LORAZEPAM	1 MG	2
1/27/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
2/6/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	20 MG	60
3/6/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
4/2/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
4/30/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
6/23/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
7/6/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	30
7/20/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
8/18/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
8/31/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
9/30/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
10/24/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
11/21/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
12/16/2021	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60

93. On or about February 24, 2022, Respondent saw Patient C for a telephone visit. Patient C would reportedly stop by the next day for a urine drug test. Respondent documented his assessment as ADHD and high-risk medication use.

94. According to the CURES report for Patient C, during the period of on or about January 7, 2022, through on or about December 13, 2022, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/7/2022	ADDERALL	30 MG	60
2/5/2022	ADDERALL	30 MG	40
2/10/2022	ADDERALL	30 MG	20
2/24/2022	ADDERALL	30 MG	60
3/23/2022	ADDERALL	30 MG	60
4/16/2022	ADDERALL	30 MG	60
5/14/2022	ADDERALL	30 MG	60
5/24/2022	ADDERALL XR	30 MG	60
6/11/2022	ADDERALL	30 MG	60
7/9/2022	ADDERALL	30 MG	60
7/28/2022	ADDERALL	30 MG	60

Date Filled	Drug Name	Strength	Quantity
8/24/2022	ADDERALL	30 MG	60
10/19/2022	ADDERALL	30 MG	60
11/17/2022	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
12/13/2022	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60

95. In October 2023, Patient C was seen by another provider. Patient C was referred by her primary for a new consult. Patient C stated that she started stimulant medication at age 15 or 16. Patient C reported that her father and brother both had ADHD. The patient reported improvement on the medication. The provider performed a chart review and found several early refill requests "too numerous to count." Examples of early refills included May 14, 2018, February 6, 2019, February 27, 2019, May 5, 2019 and June 29, 2019. The provider noted that Patient C initially received Adderall 20 mg twice daily and increased to 30 mg twice daily. The provider noted that there was no formal ADHD assessment/diagnosis documented in the records. He also noted that Patient C's heart rate was elevated at the majority of the visits.

96. On or about November 14, 2023, Patient C was seen by another provider. Patient C tested positive for amphetamine and methamphetamines. Patient C denied use of methamphetamines, but did vape and thought she might have had marijuana. A subsequent urine drug test was negative for the presence of methamphetamines. The provider noted that a psychiatry assessment was needed.

97. According to the CURES report for Patient C, during the period of on or about January 11, 2023, through on or about September 6, 2023, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/11/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
2/10/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
3/12/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
4/12/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	40
4/12/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	20
5/12/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
6/14/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
7/12/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
8/9/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60
9/6/2023	AMPHETAMINE ASPARTATE AMPHETAMINE SULFATE D	30 MG	60

98. During his interview with the Board investigator on or about August 27, 2024, Respondent stated that "I think overuse... was an ongoing issue."

99. Respondent committed repeated negligent acts in the treatment of Patient C, specifically:

a. Respondent prescribed and/or provided early refills of controlled medication despite no justification for the medication. Respondent provided early refills because Patient C reported she was moving away, but provided Patient C her extra refills at regular intervals, resulting in excess controlled substances being distributed to Patient C. Respondent documented "no replacement," when Patient C reported lost medication but refilled the medication anyway.

b. Respondent prescribed controlled medication to Patient C without an initial or ongoing evaluation. Respondent failed to confirm Patient C's ADHD via query or ongoing standardized forms or monitoring questions.

c. Respondent increased Patient C's controlled medication prescriptions based on Patient C's request, without an appropriate examination or justification.

d. Respondent failed to maintain appropriate documentation in the care and treatment of Patient C.

Patient D

100. Patient D is a female 42-year-old patient who had a history of menstrual period headaches, migraine/tension/daily headaches, anxiety, and PTSD.

101. On or about October 15, 2020, Patient D was initially seen by another provider. The documentation of the visit noted: "Patient with anxiety, seeing Dr. [K], started on clonazepam, continuing sertraline, feeling better on the medications." The documentation provided that for Patient D's headaches, she used butalbital and used all 20 by the end of the day. Other medications included clonazepam for anxiety which Patient D started in 2014. The documentation noted no refills until urine drug tests were performed. In an interview with Board investigators, Respondent denied seeing this provider's note prior to the interview.

102. Patient D was continued under her current medication regimen by other doctors who saw Patient D for headaches, and anxiety. Respondent first saw Patient D on a telephone appointment on or about December 18, 2020. Patient D had a menstrual migraine that lasted up to 10 days. Respondent noted that Patient D had a good response to the current medication regimen. Respondent refilled Patient D's prescription for butalbital.

103. According to the CURES report for Patient D, during the period of on or about June 26, 2020, through on or about December 18, 2020, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
6/26/2020	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	20
6/29/2020	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	20
7/29/2020	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	20
12/18/2020	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	30

104. On or about March 18, 2021, Patient D requested an early refill since she was going out of town. Respondent refilled the butalbital.

105. In April 2021, Respondent saw Patient D for a telephone visit. Respondent noted that Patient D was referred to behavioral health for an assessment. Patient D was diagnosed with anxiety, and migraine headaches. Patient D was started on 60 tablets of butalbital with codeine.

106. On or about April 27, 2021, Safeway pharmacy called and wanted clarification since Patient D had been prescribed butalbital with no codeine in the past, and now was attempting to pick up butalbital with codeine. Respondent clarified that it was okay for early release of the medication and that Patient D had been changed to the combination of butalbital with codeine.

107. On or about May 13, 2021, the pharmacy left a message documenting that Patient D picked up prescriptions for butalbital on April 19, 2021, and butalbital with codeine on April 28, 2021. The pharmacy wanted to clarify which medicine Patient D was to be taking. Patient D was requesting refills on both drugs, 16 days and 14 days respectively. In response, Respondent approved refills on both medications.

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108. On or about May 19, 2021, Patient D was seen by another provider. Patient D presented with some depression symptoms and met the criteria for PTSD. The provider noted that she wanted to notify Respondent.

109. On or about July 7, 2021, Respondent saw Patient D for a video visit. Respondent documented "Difficult interactions with neighbors recent trip to Vegas – bad time – two kids got carsick and there was a heat wave. Anxiety now working with a long-term counselor – helping. Still struggles with anxiety and a few panic attacks. Headaches now daily, persistent, responding well to medications." Respondent refilled clonazepam and butalbital with codeine.

110. On or about November 23, 2021, Respondent saw Patient D for a telephone visit. Respondent documented that the visit was to discuss medications. Respondent documented that Patient D had frequent headaches, and was bothered by her neighbors. Patient D also had difficulty getting butalbital monthly from the pharmacy as a result of stocking issues. Patient D's anxiety continued due to problems with the neighbors. Respondent prescribed an early refill of butalbital with codeine and increased the quantity to 90 pills. Respondent prescribed clonazepam and noted that Patient D was visiting a relative in Las Vegas.

111. According to the CURES report for Patient D, during the period of on or about March 19, 2021, through on or about November 29, 2021, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
3/19/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	30
4/19/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE	50-325-40 MG	30
4/28/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	60
5/18/2021	CLONAZEPAM	0.25 MG	60
5/26/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	18
5/26/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	42
6/11/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	24
6/11/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	46
6/30/2021	CLONAZEPAM	0.25 MG	60
7/7/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	70
8/5/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	70
9/4/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	70
10/4/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	70
11/2/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	60

Date Filled	Drug Name	Strength	Quantity
11/2/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	10
11/23/2021	CLONAZEPAM	0.25 MG	60
11/24/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	36
11/29/2021	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	234

112. On or about February 22, 2022, Respondent conducted a telephone visit with Patient D. Respondent documented that Patient D continued to experience anxiety as a result of difficulty with neighbors. Patient D was seeing a psychiatrist. The psychiatrist advised Patient D to take clonazepam regularly, as needed. Patient D reported chronic headaches – frequent, fairly well controlled with sumatriptan and butalbital.

113. On or about June 30, 2022, Respondent saw Patient D for an office visit. Respondent documented Patient D continued to have anxiety as a result of issues with neighbors. Patient D complained of 20-pound weight loss due to stress. Patient D was started on Adderall. Respondent performed a limited general examination which was normal except the patient being anxious and tearful. The assessment included high-risk medication use and anxiety disorder. Respondent ordered a urine drug test.

114. According to the CURES report for Patient D, during the period of on or about February 19, 2022, through on or about September 2, 2022, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
2/19/2022	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	234
5/13/2022	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	234
7/12/2022	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	127
7/27/2022	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	234
9/2/2022	BUTALBITAL ACETAMINOPHEN CAFFEINE CODEINE	UNKNOWN	234

115. In July 2022, Patient D received an early refill of 127 pills. Patient D had received 234 pills just over two months prior. In his interview with the Board, Respondent felt this might have been the time that Patient D was gone quite a bit. Two weeks later, Patient D received another 234 pills. Patient D received another 234 pills in September 2022. In his interview with the Board, Respondent stated that Patient D was having increased stress. Respondent was asked whether Patient D was seen by a neurologist to assist in managing Patient D's headaches.

Respondent stated she had not. Respondent stated he did not believe Patient D had analgesic rebound headaches when queried.

116. Respondent committed repeated negligent acts in the care and treatment of Patient D in that:

a. Respondent failed to address Patient D's early refills and potential overuse when Patient D used up all 20 tablets in her initial visit with another provider.

b. Respondent prescribed increasing dosages of controlled substances which may have contributed to Patient D's exacerbation of her headaches.

c. Respondent prescribed dangerous combinations of controlled medication.

d. Respondent failed to provide accurate, complete documentation required when prescribing controlled substances and managing potentially serious medical problems.

Patient E

117. Patient E is a 71-year-old male patient who has a history of arthritis, chronic pain, hiatal hernia, hypertension, osteoporosis, steatohepatitis, history of splenectomy, history of appendectomy, history of umbilical hernia repair, history of vasectomy, history of excessive alcohol use, history of drug use prior to 1976, peripheral polyneuropathy, multiple pulmonary emboli (2023), upper gastrointestinal bleed (2023), and a history of alcoholism.

118. In 2018, Patient E was seen by an endocrinology specialist. The specialist documented diagnoses including osteoporosis, lumbar spondylosis with radiculopathy, and a history of alcoholism resolved. Patient E denied current use of alcohol.

119. In December 2018, Respondent saw Patient E for an office visit. Respondent documented diagnoses including lumbago with sciatica – resolved, neck pain, facet arthritis lumbar region. Respondent started Patient D on fentanyl patch 25 mcg/hr every three days.

120. According to the CURES report for Patient E, on or about December 31, 2018, Patient E filled the following prescription for controlled substances:

Date Filled	Drug Name	Strength	Quantity
12/31/2018	FENTANYL	25 MCG	10

121. In January 2019, Respondent saw Patient E for an office visit. Patient E stated that pain control was not sufficient. Respondent referred Patient E for physical therapy and increased fentanyl patch to 50 mcg/hr.

122. In May 2019, Respondent saw Patient E for an office visit. Respondent documented Patient E's history of alcohol use and noted that Patient E drinks two glasses of wine with dinner, which Respondent advised against, and suggested use of only one glass of wine with dinner. Respondent documented Patient E may need to get along without the opiate however it is helping a lot.

123. In June 2019, Respondent saw Patient E for an office visit. Respondent documented that Patient E wanted to get off of fentanyl.

124. In October 2019, Respondent saw Patient E for an office visit. The urine drug test referenced "Lab: Pain MGMT, alcohol metab w. conf." Respondent failed to address this aberrant urine drug test.

125. According to the CURES report for Patient E, during the period of on or about February 4, 2019, through on or about December 31, 2019, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
2/4/2019	FENTANYL	50 MCG	10
3/8/2019	FENTANYL	50 MCG	10
5/8/2019	FENTANYL	50 MCG	5
5/23/2019	FENTANYL	50 MCG	10
10/23/2019	FENTANYL	50 MCG	5
11/6/2019	FENTANYL	50 MCG	5
11/20/2019	FENTANYL	50 MCG	5
12/4/2019	FENTANYL	50 MCG	5
12/18/2019	FENTANYL	50 MCG	5
12/31/2019	FENTANYL	50 MCG	5

126. According to the CURES report for Patient E, during the period of on or about January 14, 2020, through on or about December 22, 2020, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/14/2020	FENTANYL	50 MCG	5
1/28/2020	FENTANYL	50 MCG	5
2/11/2020	FENTANYL	50 MCG	10
3/21/2020	FENTANYL	50 MCG	5
4/4/2020	FENTANYL	50 MCG	5
4/18/2020	FENTANYL	50 MCG	5
5/2/2020	FENTANYL	50 MCG	5
5/16/2020	FENTANYL	50 MCG	5
5/30/2020	FENTANYL	50 MCG	5
6/13/2020	FENTANYL	50 MCG	5
6/27/2020	FENTANYL	50 MCG	5
7/11/2020	FENTANYL	50 MCG	5
7/24/2020	FENTANYL	50 MCG	5
8/7/2020	FENTANYL	50 MCG	5
8/19/2020	FENTANYL	50 MCG	5
9/1/2020	FENTANYL	50 MCG	5
9/15/2020	FENTANYL	50 MCG	5
9/29/2020	FENTANYL	50 MCG	5
10/13/2020	FENTANYL	50 MCG	5
10/27/2020	FENTANYL	50 MCG	5
11/10/2020	FENTANYL	50 MCG	5
11/24/2020	FENTANYL	50 MCG	5
12/8/2020	FENTANYL	50 MCG	5
12/22/2020	FENTANYL	50 MCG	5

127. In April 2020, Respondent saw Patient E for a telephone visit. Respondent continued to refill fentanyl at 50 mcg/hr. despite failing to address Patient E's alcohol use.

128. Respondent saw Patient E for telephone visits in June 2020, September 2020, November 2020, December 2020, and April 2021.

129. According to the CURES report for Patient E, during the period of on or about January 5, 2021, through on or about December 15, 2021, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/5/2021	FENTANYL	50 MCG	5
1/19/2021	FENTANYL	50 MCG	5
2/2/2021	FENTANYL	50 MCG	5
2/16/2021	FENTANYL	50 MCG	5
3/2/2021	FENTANYL	50 MCG	5
3/16/2021	FENTANYL	50 MCG	5

Date Filled	Drug Name	Strength	Quantity
3/30/2021	FENTANYL	50 MCG	5
4/13/2021	FENTANYL	50 MCG	5
4/27/2021	FENTANYL	50 MCG	5
5/11/2021	FENTANYL	50 MCG	5
5/24/2021	FENTANYL	50 MCG	5
6/7/2021	FENTANYL	50 MCG	5
6/21/2021	FENTANYL	50 MCG	5
7/5/2021	FENTANYL	50 MCG	5
7/19/2021	FENTANYL	50 MCG	5
8/2/2021	FENTANYL	50 MCG	5
8/16/2021	FENTANYL	50 MCG	5
8/30/2021	FENTANYL	50 MCG	5
9/17/2021	BUPRENORPHINE	20 MCG	2
9/21/2021	FENTANYL	50 MCG	5
10/5/2021	FENTANYL	50 MCG	5
10/19/2021	FENTANYL	50 MCG	5
11/1/2021	FENTANYL	50 MCG	5
11/15/2021	FENTANYL	50 MCG	5
12/1/2021	FENTANYL	50 MCG	5
12/15/2021	FENTANYL	25 MCG	5

130. In May 2021, Respondent saw Patient E for an office visit. Patient E tested positive for alcohol metabolites and was negative for prescribed opiates. Respondent failed to address Patient E's aberrant urine drug test. Respondent documented that Patient E was no longer taking medications for "G.I." Patient E's neck pain was feeling better, and Patient E was using fentanyl patches 12 hours per day. Respondent documented mild tenderness and limited range of motion. Respondent completed a controlled substance agreement.

131. In September 2021, Respondent saw Patient E for an office visit. Respondent documented that Patient E wanted to wean off opiates, and Patient E stated that wine was medicinal. Patient E tested positive for alcohol metabolites. Respondent failed to address Patient E's aberrant urine drug test. In a subsequent visit, Patient E requested switching his fentanyl patch medication to buprenorphine, stating it would be safer and likely would manage his chronic neck pain. After switching to buprenorphine, Patient E's neck pain felt worse and he went back to fentanyl.

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132. In December 2021, Respondent saw Patient E for an office visit. Respondent decreased Patient E's fentanyl patches to 37.5 mcg/hr., down from 50 mcg/hr. Patient E tested positive for alcohol metabolites. Respondent failed to address Patient E's aberrant urine drug test.

133. According to the CURES report for Patient E, during the period of on or about January 11 through on or about December 27, 2022, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/11/2022	FENTANYL	25 MCG	5
1/25/2022	FENTANYL	25 MCG	5
4/15/2022	FENTANYL	12 MCG	5
9/1/2022	MORPHINE SULFATE	15 MG	30
9/13/2022	FENTANYL	25 MCG	5
10/4/2022	FENTANYL	50 MCG	5
10/18/2022	FENTANYL	50 MCG	5
11/1/2022	FENTANYL	50 MCG	5
11/15/2022	FENTANYL	50 MCG	5
11/29/2022	FENTANYL	50 MCG	5
12/13/2022	FENTANYL	50 MCG	5
12/27/2022	FENTANYL	50 MCG	5

134. In March 2023, Patient E tested positive for fentanyl and alcohol metabolites.

135. In September 2023, Patient E tested positive for alcohol metabolites.

136. In November 2023, Patient E tested positive for alcohol metabolites.

137. According to the CURES report for Patient E, during the period of on or about January 10, 2023, through on or about September 28, 2023, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Strength	Quantity
1/10/2023	FENTANYL	50 MCG	5
1/24/2023	FENTANYL	50 MCG	5
2/7/2023	FENTANYL	50 MCG	5
2/21/2023	FENTANYL	50 MCG	5
3/11/2023	FENTANYL	50 MCG	5
3/25/2023	FENTANYL	50 MCG	5
4/12/2023	FENTANYL	37.5 MCG	10

Date Filled	Drug Name	Strength	Quantity
5/11/2023	FENTANYL	37.5 MCG	10
6/8/2023	FENTANYL	37.5 MCG	10
7/6/2023	FENTANYL	37.5 MCG	10
8/3/2023	FENTANYL	37.5 MCG	10
8/31/2023	FENTANYL	37.5 MCG	5
9/14/2023	FENTANYL	37.5 MCG	5
9/28/2023	FENTANYL	37.5 MCG	5

138. In February 2024, Patient E tested positive for alcohol metabolites.

139. Respondent committed repeated negligent acts in the care and treatment of Patient E which include, but are not limited to, the following:

a. Respondent failed to appropriately address multiple aberrant urine drug tests and red flags for controlled substance abuse or diversion.

b. Respondent failed to document his plan regarding Patient E's aberrant drug tests.

c. Respondent failed to document his justification for prescribing controlled medication to a patient over 65 years old.

d. Respondent prescribed dangerous combinations of controlled substances long term.

e. Respondent failed to provide appropriate and adequate documentation required for prescribing controlled substances.

Patient 1

140. Patient 1 is a 50-year-old male patient who was homeless at times, had peripheral neuropathy, and had failed carpal tunnel surgery on both hands. Patient 1 had a history of recurrent MRSA face lesions, history of anxiety, carpal tunnel syndrome, chronic pain disorder, Molnar neuropathy – right upper extremity, chronic right groin pain, chronic low back pain, history of panic disorder, history of medical marijuana use, history of bilateral carpal tunnel release, history of inguinal hernia repair, opioid use disorder, opioid withdrawal (September 2023), and periodic homelessness. Patient 1 presented with psychological trauma due to previously finding the mother of his girlfriend deceased. Patient 1 was prescribed both opiates and benzodiazepines.

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141. Patient 1 was treated by Respondent with Vicoprofen and Xanax. In 2017, Patient 1 was sent a letter from El Dorado Community Health Center (EDCHC) stating that in the future, opiates and benzodiazepines would not be prescribed together. In his interview with the Board, Respondent could not recall the letter.

142. In 2018, Patient 1 was discharged from pain management. He was felt to be at high risk for substance abuse disorder. In his interview with the Board, Respondent denied being aware of this.

143. In 2019, a "global alert" was issued by another doctor working at EDCHC, stating that Patient 1 "has a volatile behavior, medication seeking, and threats of violence toward staff." In his interview with the Board, Respondent stated that Patient 1 never acted that way to him.

144. In December 2021, Respondent saw Patient 1 for an office visit. Patient 1 was seen for a rash, and an abscess on his face. Respondent documented that Patient 1 had been to the emergency room four times and given three different antibiotics. Respondent's assessment was severe anxiety with panic, high-risk medication use, cellulitis of the face, chronic pain syndrome, cervical radiculopathy, and neuropathy. Respondent documented but did not address Patient 1's elevated heart rate of 134 bpm. Patient 1 requested Vicoprofen, not morphine or oxycodone. Respondent prescribed hydrocodone/ibuprofen every six hours, and alprazolam .5 mg twice daily. Respondent requested a referral to pain management.

145. In December 2021, the only urine drug test found in Patient 1's records revealed that Patient 1 was completely negative for all drugs prescribed. In his interview with the Board, Respondent stated that he usually ordered urine drug tests every three months. Respondent added that near the end of his care of Patient 1, the patient tested positive for fentanyl and methamphetamine and was sent to the STEPS Recovery Program[14].

146. In January 2022, Respondent saw Patient 1 for a telephone visit. Respondent documented Patient 1 had "rash/cellulitis on face improve, sans dermatology, antibiotic change to

[14] STEPS Recovery Program is a comprehensive treatment program for substance use disorders including Medically Assisted Treatment (MAT) for Opioid Use Disorder (OUD) administered by El Dorado County Community Health Center (EDCHC).

doxycycline." Patient 1 was also referred to Roseville Pain Clinic for chronic pain syndrome and anxiety, but the clinic had a four-month wait at the time. Respondent refilled hydrocodone/ibuprofen 200 mg to be used five times a day, and alprazolam .5 mg to be used twice daily. Respondent documented that Patient 1 used inhaled cannabis.

147. In February 2022, Respondent saw Patient 1 for a telephone visit. Patient 1 requested an increase of hydrocodone/ibuprofen to six per day. Respondent's documented diagnoses were: severe anxiety with panic, cellulitis of the face, and chronic pain syndrome. Respondent increased hydrocodone/ibuprofen up to two tablets three times a day #180.

148. In March 2022, Respondent saw Patient 1 for a telephone visit. Respondent documented that Patient 1's face abscess may need to be lanced again. Patient 1 was on doxycycline[15], and was to return to dermatology. Patient 1 was still waiting to be seen by pain management and still had anxiety. Respondent refilled hydrocodone/ibuprofen and alprazolam.

149. Respondent continued to refill hydrocodone/ibuprofen and alprazolam in May and June 2022 after telephone visits.

150. In August 2023, Respondent saw Patient 1 for an office visit. Respondent documented that Patient 1 thought he was in withdrawal, and was out of pain medications for two days. Patient 1 also had a recent visit to the emergency room and was positive for fentanyl and methamphetamine. Patient 1 was referred to the STEPS program with an appointment scheduled for the following week in the homeless camp via a mobile unit. Patient 1 had transportation issues and was instead referred to the Marshall CARES program[16] for buprenorphine.

151. Patient 1's medical records reveal that Respondent prescribed alprazolam and hydrocodone in 2021, 2022, and 2023.

152. Respondent committed repeated negligent acts in the care and treatment of Patient 1, which include, but are not limited to, the following:

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[15] Doxycycline is a tetracycline antibiotic used for bacterial infections.
[16] Community Assisted Recovery and Education Services (CARES).

a. Respondent prescribed multiple controlled substances concurrently.

b. Respondent prescribed controlled substances despite multiple red flags of abuse and a history of abuse or diversion.

c. Respondent prescribed controlled substances despite failing to perform periodic reviews or ongoing evaluations.

d. Respondent failed to adequately address the potential overuse of controlled substances.

e. Respondent failed to check CURES before prescribing controlled substances and failed to review Patient 1's CURES at least every six months while treating Patient 1 with controlled substances.

f. Respondent failed to document informed consent related to the prescribing of controlled substances.

g. Respondent failed to perform regular testing for controlled substances.

h. Respondent failed to address aberrant urine drug test results.

i. Respondent increased controlled substances prescriptions without an appropriate in-person examination. In February 2022, Respondent increased opioid dosing without an in-person appointment for nearly six months.

j. Respondent failed to address significant chronic and cardiac-related diseases.

k. Respondent prescribed a combination of opioids and benzodiazepines.

l. Respondent failed to maintain adequate and appropriate documentation.

Patient 2

153. Patient 2 is a 30-year-old male patient who had a history of benign prostatic hyperplasia, mixed hyperlipidemia, hypogonadism, hypopituitarism, Addison's disease, medulloblastoma other temporal lobe – in remission, severe benzodiazepine use disorder, opioid dependency, right temporal encephalomyelitis, history of whole brain radiation, history of multiple drug chemotherapy, mixed age right hemispheric subdural hematoma, seizure disorder, high anxiety levels, epilepsy, cervicalgia, mid back pain, lumbar back pain, cigarette smoking, and left shoulder pain.

154. In January 2022, Respondent saw Patient 2 for a telephone visit. Respondent

discontinued venlafaxine[17], and started Patient 2 on alprazolam 1 mg, 3 times a day for anxiety (cancer induced).

155. On or about February 17, 2022, Respondent saw Patient 2 for an office visit. Patient 2 requested a letter for CBD/marijuana use. Patient 2 requested more Norco and Xanax. Respondent discouraged and advised against the combination and documented that "we should be tapering meds and not increasing," then refilled Patient 2's prescription for alprazolam.

156. On or about March 1, 2022, Patient 2 requested refills over the phone. Respondent refilled prescriptions of Xanax and Norco.

157. On or about March 16, 2022, Respondent documented that Patient 2 was taking seven psychoactive medications including Norco and Xanax. Patient 2 also wanted to add Effexor.

158. On or about March 29, 2022, Patient 2 complained of anxiety, and wanted to restart Effexor. Respondent ordered venlafaxine and advised Patient 2 to stop amitriptyline.

159. In April 2022, Patient 2's urine drug test was positive for opioids, benzodiazepines, nicotine, and marijuana.

160. On or about April 14, 2022, Respondent saw Patient 2 for an office visit. Respondent documented that Patient 2 was less anxious after starting Effexor, but still having problems sleeping. Patient 2 wanted to restart temazepam but not stop the Xanax. Respondent recommended melatonin and refilled hydrocodone/acetaminophen 10-325 mg, one-half tablet five times a day.

161. On or about April 19, 2022, Patient 2 requested more Norco for low back pain, however, Respondent recommended Patient 2 see a chiropractor.

162. In his interview with the Board, Respondent stated that "lots of things that didn't get ... Captured because of [Patient 2's] psychological balance or lack of balance".

163. Respondent prescribed hydrocodone and alprazolam in 2022 to 2023.

164. Respondent committed repeated negligent acts in the care and treatment of Patient 2, which include, but are not limited to, the following:

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[17] Venlafaxine is an antidepressant medication of the serotonin–norepinephrine reuptake inhibitor (SNRI) class

a. Respondent prescribed dangerous combinations of controlled substances without adequate periodic assessments.

b. Respondent prescribed controlled substances despite multiple red flags of abuse and a history of abuse or diversion.

c. Respondent failed to maintain adequate documentation.

Patient 3

165. Patient 3 is a 66-year-old female with a history of back pain, headache, planter fasciitis, gastroesophageal reflux disease, psoriasis, intermittent asthma, chronic depression, insomnia, transient ischemic attack, history of gallbladder surgery, history of shoulder surgery, former smoker, frequent falls, ataxia, lumbar degenerative disc disease, and obstructive sleep apnea syndrome.

166. In February 2022, Respondent saw Patient 3 for an office visit. Respondent documented Patient 3's pain in the back and legs, and that she lost her pain pills while flying to Oregon. Respondent documented an assessment of high-risk medication use and back strain. Respondent failed to document a back examination. Respondent documented hydrocodone 40 tablets for 10 days and refilled Percocet for 30 days.

167. In August 2022, Respondent saw Patient 3 for an office visit. Respondent documented that Patient 3 continued to have low back pain. Respondent failed to document a back examination. Patient 3's heart rate was 108. Respondent refilled Percocet.

168. Respondent saw Patient 3 in November 2022, March 2023 (telephone visit), and April 2023. Respondent continued to refill Percocet. Respondent failed to perform a back examination.

169. In August 2023, Patient 3 tested positive for opiates, Tramadol, and oxycodone. Respondent did not prescribe Patient 3 Tramadol and hydrocodone. Respondent failed to address the aberrant urine drug test. Respondent failed to document a back examination and refilled Percocet.

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170. In September 2023, Respondent saw Patient 3 for an office visit. Respondent documented that Patient 3 was going to UC Davis for spine surgery soon. Respondent failed to document a back examination. Respondent repeated the urine drug test.

171. Respondent prescribed hydrocodone/acetaminophen to Patient 3 in 2022 and 2023. Respondent prescribed oxycodone/acetaminophen to Patient 3 from 2021 through 2023.

172. Respondent committed repeated negligent acts in the care and treatment of Patient 3 which include, but are not limited to, the following:

a. Respondent failed to document adequate informed consent in the medical records relating to the prescribing of controlled substances.

b. Respondent failed to appropriately address multiple aberrant urine drug tests and red flags for controlled substance abuse or diversion.

c. Respondent failed to perform an appropriate initial and periodic examination to justify ongoing opioid prescriptions.

d. Respondent prescribed dangerous combinations of controlled substances medications.

Patient 4

173. Patient 4 is a 40-year-old female patient who was related to Patient 3. Patient 4 had a history of dense breast tissue, polycystic ovary disease, chronic fatigue syndrome, fibromyalgia, obstructive sleep apnea syndrome, chronic pain syndrome, pelvic and peroneal pain, fatty liver, bipolar disease, depression, ADHD, and migraine headaches (saw neurology in 2010 - many treatments attempted.) Patient 4 was referred to the STEPS program in October 2023, but Patient 4 refused to attend the program.

174. In March 2022, Respondent saw Patient 4 for a telephone visit. Respondent documented that Patient 4's pain was stable and that there was numbness in the first and second toes. Respondent documented fibromyalgia and refilled Patient 4's hydrocodone and carisoprodol.

175. In July 2022, Respondent documented Patient 4 was feeling ill, and achy, with a cough, and headaches. Respondent documented polycystic ovaries and refilled hydrocodone. Respondent also ordered lab tests for fatty liver.

176. In September 2022, Respondent saw Patient 4 for a telephone appointment. Respondent documented yeast vaginitis. Respondent failed to inquire or look into Patient 4's chronic pain. Respondent refilled hydrocodone, zolpidem, and carisoprodol.

177. In December 2022, Respondent saw Patient 4 for an office visit. Respondent documented sore throat, body aches, and chills. Respondent ordered follow-up urine drug tests. Respondent documented that Patient 4 continued to have low back pain, and that the medications including carisoprodol helped a lot. Respondent failed to examine Patient 4's pharynx. Respondent refilled hydrocodone, zolpidem, and carisoprodol.

178. In April 2023, Respondent saw Patient 4 for an office visit. Respondent documented that Patient 4 continued to have back pain. Patient 4's heart rate was 106 bpm. Respondent failed to document a back examination. Respondent refilled hydrocodone.

179. In August 2023, Respondent saw Patient 4 for an office visit. Respondent documented that Patient 4 continued to have back and neck pain and was stable on hydrocodone and carisoprodol. Respondent failed to examine CURES which revealed that Patient 4 obtained Tramadol from veterinarians. The Tramadol was given to Patient 4's mother.

180. Respondent prescribed hydrocodone, zolpidem, and carisoprodol to Patient 4 from 2021 through 2023.

181. Respondent committed repeated negligent acts in the care and treatment of Patient 4 which includes, but is not limited to, the following:

a. Respondent failed to document adequate informed consent from Patient 4 related to the prescribing of controlled substances.

b. Respondent failed to check Patient 4's CURES and failed to identify two Tramadol prescriptions from veterinarians which were included on the CURES.

c. Respondent prescribed dangerous combinations of controlled substances.

d. Respondent failed to perform an adequate periodic review of Patient 4's treatment. He failed to examine and/or adequately document a history regarding the area of symptoms.

e. Respondent failed to maintain adequate documentation.

Patient 5

182. Patient 5 is a 50-year-old male patient who was seen by multiple providers other than Respondent. Patient 5 had a history of hypertension, colitis, and opioid dependence with opioid-induced disorder. Respondent saw Patient 5 two times in 2023. Respondent saw Patient 5 on or about July 12, 2023, and December 29, 2023. During the July 12, 2023, visit, Patient 5 had an elbow injury. In his interview with the Board, Respondent stated that had been seen in the emergency room, and Respondent thought there was a strong suspicion of a possible occult fracture. Respondent stated that he gave Patient 5, two weeks of medication, Norco, and instructed Patient 5 to follow up with an orthopedist. Respondent admitted that he did not check CURES prior to prescribing hydrocodone to Patient 5.

183. Respondent committed repeated negligent acts in the care and treatment of Patient 5 in that he failed to check CURES prior to prescribing Norco.

Patient 6

184. Patient 6 is a 30-year-old male patient who had a history of opioid dependence on agonist therapy/opiate abuse, ADHD, anxiety, eating disorder (2013), intermittent insomnia (2013), THC use disorder – moderate, carpal tunnel surgery – right wrist, right surgery ligament repair (2013), adjustment disorder with depressed mood, and history of an eating disorder.

185. In December 2021, Respondent saw Patient 6 for an office visit. Respondent documented his assessment as high-risk medication use. Respondent ordered urine drug tests. Respondent documented Patient 6's past medical history to include opioid abuse, THC use disorder– moderate–dependence, anxiety, adjustment disorder with depressed mood, history of eating disorder, and intermittent insomnia with prior surgeries of carpal tunnel syndrome – right wrist and right shoulder ligament repair.

186. In May 2022, Patient 6's urine drug test was negative for alcohol and negative for prescribed amphetamines and opiates. Respondent failed to appropriately address the aberrant results.

187. In August 2022, Patient 6's urine drug test was negative for prescribed amphetamine and positive for THC. Respondent failed to appropriately address the aberrant results.

188. In October 2022, Patient 6's urine drug test was positive for buprenorphine, negative for amphetamine, and positive for THC. Respondent failed to appropriately address the aberrant results.

189. In December 2022, Patient 6's urine drug test was negative for alcohol, and negative for prescribed amphetamines and opiates. Respondent failed to appropriately address the aberrant results.

190. In February 2023, Respondent saw Patient 6 for a follow-up visit. Patient 6's urine drug test was positive for amphetamine and buprenorphine and positive for THC. Respondent failed to appropriately address the aberrant results.

191. In May 2023, Respondent saw Patient 6 for an office visit. Respondent documented that the visit was a three-month recheck. Diagnoses include ADHD, opioid dependence on agonist therapy, and high-risk medication use. Patient 6's urine drug test was positive for amphetamine, positive for codeine, negative for alcohol metabolites, positive for morphine, and positive for opiates. Respondent failed to appropriately address the aberrant results. Respondent changed Adderall 20 mg to Adderall ER 25 mg.

192. In July 2023, Respondent saw Patient 6 for an office visit. Patient 6's urine drug test was positive for alcohol metabolites and positive for amphetamines. Respondent failed to appropriately address the aberrant results. The prior urine drug test was positive for codeine and morphine without explanation. Patient 6 stated he was diagnosed with ADHD when in school and was in special ed classes. Respondent ordered Adderall during the office visit.

193. Respondent prescribed buprenorphine and amphetamine to Patient 6 from 2021 through 2024.

194. Respondent committed repeated negligent acts in the care and treatment of Patient 6 which include, but are not limited to, the following:

a. Respondent failed to appropriately address multiple aberrant urine drug tests and red flags for controlled substance abuse or diversion.

b. Respondent failed to appropriately document informed consent related to the prescription of controlled substances.

c. Respondent prescribed dangerous combinations of controlled substances.

Patient 7

195. Patient 7 is a 50-year-old female who had a history of gastritis, benign hyperplastic gastric polyps, morbid obesity, status post-sleeve gastrectomy, nonalcoholic fatty liver disease, dyslipidemia, type II diabetes, hypertension, possible PCOS (polycystic ovary syndrome), androgen excess, suicide attempt (June 2023), moderate depression, and Cushing syndrome (possible).

196. In February 2023, Respondent saw Patient 7 for an office visit. Respondent documented "New to PCP," "very bad" pain in pelvic area, past diagnostic testing "found nothing." Respondent prescribed hydrocodone and physical therapy.

197. On or about June 1, 2023, Respondent saw Patient 7 for an office visit. Respondent documented that Patient 7 had moderate depression. The focus of the visit was Patient 7's pelvic pain. Respondent refilled hydrocodone and ordered urine drug tests. Patient 7's urine drug test was positive for alcohol metabolites. Respondent failed to address the aberrant urine drug test.

198. On or about July 10, 2023, Patient 7 took an intentional overdose of Norco, morphine and Ativan, and fluoxetine when she had a breakup. Patient 7 spent a week in the hospital and 57 days in a mental health rehab facility.

199. Respondent prescribed controlled substances to Patient 7 in 2022 through June 2023.

200. Respondent committed repeated negligent acts in the care and treatment of Patient 7 in that he failed to address the aberrant urine drug test and continued to prescribe hydrocodone.

THIRD CAUSE FOR DISCIPLINE
(Prescribing Dangerous Drugs without Appropriate Examination or Medical Indication)

201. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed controlled substances and dangerous drugs to Patients A, B, C, D, E, 1, 2, 3, 4, 5, 6, and 7, without an appropriate medical examination or medical indication, as more particularly alleged hereinafter: Paragraphs 34 through 200, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Prescribing Dangerous Drugs to a Substance Abuser)

202. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by sections 2241 and 2241.5, of the Code, in that he prescribed controlled substances and dangerous drugs to Patients A, B, C, D, E, 1, 2, 3, 4, 5, 6, and 7, which Respondent reasonably should have known was for a non-medical purpose, as more particularly alleged hereinafter: Paragraphs 34 through 200, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Check CURES)

203. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by sections 11165 and 11165.1 of the Health and Safety Code, in that he prescribed controlled substances and dangerous drugs to Patients A, B, C, D, E, 1, 2, 3, 4, 5, 6, and 7, without appropriately checking CURES, as more particularly alleged hereinafter: Paragraphs 34 through 200, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate Records)

204. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate records, as more particularly alleged hereinafter: Paragraphs 34 through 200, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE
(Patient Harm)

205. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2228.1, of the Code, in that he caused patient harm to Patient A. Paragraphs 34 through 200, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate License No. G 63520, issued to Respondent Clinton Ruhl Collins, M.D.;

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

3. Ordering Respondent Clinton Ruhl Collins, 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 Clinton Ruhl Collins, 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: FEB 2 5 2025

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

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