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

In the Matter of the Accusation Against:	)	
Paul E. Kaplan, M.D.	)	**Case No. 800-2016-026082**
Physician's and Surgeon's Certificate No. G 14089	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on October 29, 2019.

IT IS SO ORDERED October 22, 2019

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer

Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **PAUL E. KAPLAN, M.D.** **Capitol Clinical Neuroscience** **104 Summer Shade Ct.** **Folsom, CA 95630-1565** **Physician's and Surgeon's Certificate No. G 14089** Respondent.	Case No. 800-2016-026082 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

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2. Paul E. Kaplan, M.D. (Respondent) is represented in this proceeding by attorney, Robert H. Zimmerman, Esq., whose address is: 400 University Ave. Sacramento, CA 95825-6502.

3. On or about October 18, 1967, the Board issued Physician's and Surgeon's Certificate No. G 14089 to Paul E. Kaplan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-026082 and will expire on October 31, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-026082 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 12, 2019. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-026082 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-026082. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2016-026082, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 14089, issued to Respondent Paul E. Kaplan, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2016-026082 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2016-026082 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Robert H. Zimmerman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 10/9/19

PAUL E. KAPLAN, M.D.
Respondent

I have read and fully discussed with Respondent Paul E. Kaplan, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 10/9/19

ROBERT H. ZIMMERMAN, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 10/10/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

Cor

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-026082

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 12 2019
BY ANALYST

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

In the Matter of the Accusation Against:	Case No. 800-2016-026082
PAUL E. KAPLAN, M.D. **Capitol Clinical Neuroscience** **104 Summer Shade Ct.** **Folsom, CA 95630-1565** **Physician's and Surgeon's Certificate No. G 14089,** Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 18, 1967, the Medical Board issued Physician's and Surgeon's Certificate No. G 14089 to Paul E. Kaplan, 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 October 31, 2020, 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 provides in pertinent part that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"..."

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6. 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.

"(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 his or her 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."

7. Section 725 of the Code provides:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a

physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist."

". . ."

8. Section 4021 of the Code states:

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

9. Section 4022 of the Code states:

" 'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

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

"...

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

10. Section 2266 of the Code states, in pertinent part:

"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."

PERTINENT DRUG INFORMATION

11. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short-acting benzodiazepine used to treat anxiety, and 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).

12. Amphetamine Salts – Generic name for the drug Adderall, which is a combination drug containing four salts of the two enantiomers of amphetamine, a Central Nervous System (CNS) stimulant of the phenethylamine class. Adderall is used to treat attention deficit hyperactivity disorder and narcolepsy but can be used recreationally as an aphrodisiac and euphoriant. Adderall is habit forming. Amphetamine Salts are a Schedule II controlled substance

pursuant to Code of Federal Regulations Title 21 section 1308.12(d) and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Carisoprodol – Generic name for Soma. Carisoprodol is a centrally acting skeletal muscle relaxant. On January 11, 2012, Carisoprodol was classified 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.

14. 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.

15. 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.

16. Dexmethylphenidate – Generic name for the drug Focalin, is a potent central nervous system (CNS) stimulant of the phenethylamine and piperidine classes, and is used in the treatment of attention deficit hyperactivity disorder (ADHD) and narcolepsy. Dexmethylphenidate is classified as a Schedule II controlled substance according to Federal Register Volume 79, Number 163, Code of Federal Regulations Title 21 section 1308.12. Dexmethylphenidate 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).

17. Eszopiclone – Generic name for Lunesta. Eszopiclone is a nonbenzodiazepine hypnotic agent used in the treatment of insomnia. Eszopiclone is 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.

18. 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).

19. Hydrocodone bitartrate 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). 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 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).

20. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride ("hcl") is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone hcl is a short-acting medication used to treat severe pain. Hydromorphone hcl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone hcl 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).

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

21. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast-acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam 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.

22. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Morphine Sulfate – Generic name for the drugs Kadian, MS Contin, and MorphaBond ER. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. With morphine sulfate (MS), the positive charge on the morphine molecule is neutralized by the negative charge on the sulfate. Because it is ionic, MS dissolves readily in water and body fluids, creating an immediate release. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Oxycodone – Generic name for Oxycontin, Roxicodone, and Oxecta. High risk for addiction and dependence. 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 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).

25. Phentermine – Phentermine, also known as dimethylphenethylamine, is a psychostimulant drug of the substituted amphetamine chemical class, with pharmacology similar to amphetamine. It is used medically as an appetite suppressant for short-term use, as an adjunct to exercise and reducing calorie intake. Phentermine 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.

26. Temazepam – Temazepam is a member of the benzodiazepine family and is used for the short-term treatment of insomnia. Temazepam 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.

27. 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.

28. Triazolam – Generic name for the drug Halcion. Triazolam is a central nervous system (CNS) depressant in the benzodiazepine class. It possesses pharmacological properties similar to those of other benzodiazepines, but it is generally only used as a sedative to treat severe insomnia. Triazolam 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.

29. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate 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.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

30. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence during the care and treatment of Patients A, B, C, D, E, F, and G. The circumstances are as follows:

31. Respondent is a physician and surgeon, board certified in physical medicine and rehabilitation who at all times relevant to the charges brought herein worked under Rehabilitation Management Systems (RMS) in Sacramento, California.

Patient A

32. On or about July 19, 2011, Respondent saw Patient A for an initial visit.[2] Patient A was at the time of the visit, a 35-year-old male who had a history of 5 – 10 motor vehicle accidents. These motor vehicle accidents resulted in pain in his neck, shoulders and back area. Respondent documented that Patient A had extra pain doing activities of daily living related to lifting, carrying, pushing and pulling. Patient A also had some difficulty sitting, standing, walking, gripping, grasping, holding and manipulating objects. Respondent documented that Patient A's pain level averages 8-9 out of 10. A review of medical records revealed that Dr. K found bilateral shoulder pain and discomfort. Despite having Vicodin for pain, Patient A remained symptomatic. Patient A was also treated for hypertension, and type 2 diabetes. Patient A was insulin dependent. Respondent documented his diagnoses as "Cervical and lumbosacral spine strain/sprain disorders." Respondent's plan was to x-ray Patient A's cervical spine and lumbosacral spine; and refer for electro diagnostic lab evaluations. Respondent prescribed Norco 10/325 mg 1 tablet t.i.d. p.r.n. #90, no refills and, Soma 350 mg 1 tablet b.i.d. p.r.n. #60, no refills. Patient A had received refills from his prior provider on September 22, 2010, and April 10, 2011 for hydrocodone, Adderall, Xanax, and other drugs. These medications were not listed in

[2] Patient names and information have been removed to protect patient confidentiality. Conduct alleged to have before April 1, 2012, is for informational purposes only.

Respondent's initial treatment visit. Respondent entered into a Medication Management Agreement with Patient A. The pain agreement listed down the doctor as Dr. MH. Patient A signed the pain agreement, but Respondent did not sign the pain agreement. The pain agreement provided that the primary care physician must take over the writing of opioid prescriptions once the dose stabilized.

33. On or about December 9, 2013, and January 6, 2014, Respondent saw Patient A for a follow up visit. During these visits, Patient A's blood pressure was high with chronograph blood pressure noted to be persistently elevated from September 16, 2013 to January 6, 2014, with resting tachycardia. Respondent failed to take action and/or document the clinician managing Patient A's hypertension. Respondent also listed hydrochlorothiazide[3] as removed from Patient A's medication.

34. During the period of April 13, 2014 to April 6, 2015, Respondent saw Patient A for follow up visits. In a majority of these visits, Respondent documented identical physical examination findings. He also documented identical readings for blood pressure 113/82, pulse 89, respiration 14, and weight 242. Respondent failed to document any requests or referrals to physical therapy. Respondent also failed to document the results of Patient A's MRI, CT scans, and EMG/NCV reports.

35. During the period of June 2014, Respondent documented Patient A's current medication as Zolpidem, Oxycodone, Carisoprodol, Alprazolam, Norco, and Restoril. On the status field, he documented the status of each drug as "Removed."

36. On or about July 23, 2014, Respondent saw Patient A for a follow up visit. Respondent documented diagnosis codes for lumbar sprain, neck sprain, and persistent disorder in initiating or maintaining sleep. Respondent failed to document a physical examination. Under miscellaneous notes, Respondent documented "Reduced range of motion of the cervical and lumbosacral spines and lender, painful bilateral cervical and lumbosacral paraspinal muscular spasms." Respondent added that Patient A "...also had reduced sensation and strength in the distribution of the right C6 and S1 spinal nerve roots, absent right biceps deep tendon reflexes,

[3] Hydrochlorothiazide is a diuretic/water pill used to treat high blood pressure.

augmented touch-floor gap, and reduced bilateral straight-leg raising measurements." Respondent documented "Cervical spine disk syndrome with strain-sprain disorder, radiculopathy, and hypertension. Lumbosacral spine disk syndrome with strain-sprain disorder, radiculopathy." Under Patient A's current medication, Respondent documented Norco, oxycodone, zolpidem tartrate, carisoprodol, Xanax, and Restoril as "Removed."

37. On or about August 20, 2014, September 18, 2014, October 16, 2014, and November 13, 2014, Respondent saw Patient A for follow up visits. Under Patient A's current medication, Respondent documented Norco, oxycodone, zolpidem tartrate, carisoprodol, Xanax, and Restoril as "Removed." Despite documenting that he had removed these drugs from Patient A's medication list, Respondent prescribed these drugs to Patient A. Respondent prescribed zolpidem on June 25, 2014, with 4 refills given, which was filled by Patient A on November 11, 2014. Respondent prescribed hydrocodone that Patient A filled on November 13, 2014. Respondent prescribed oxycodone that Patient A filled on November 7, 2014. Respondent prescribed carisoprodol that Patient A filled on November 17, 2014. Despite Patient A's history of diabetes, Respondent failed to document lab studies indicating Patient A's renal function; and/or document any blood tests, before prescribing carisoprodol and hydrocodone to Patient A.

38. On or about October 19, 2015, November 16, 2015, and December 16, 2015, Respondent saw Patient A for follow up visits. Respondent billed the encounter as CPT code 99215 office visits[4]. However, Respondent's documentation failed to support the 99215-office visit. Respondent copied note entries from previous visits, and there were no substantive differences from encounter to encounter.

39. During the period of November 2014, Respondent prescribed two short acting opioids and three sedative hypnotics concurrently[5]. On or about November 11, 2014, Respondent prescribed zolpidem 10mg #30, 30-day supply refill x5 and diazepam 10mg #90, 30-day supply refill x3. On or about November 13, 2014, Respondent prescribed hydrocodone/APAP 10/325

[4] CPT Code 99215 requires comprehensive level of documentation 18 + exam elements; 4+ history of present illness or a 40 minute face-to-face visit with more than 20 minutes spent on counselling.

[5] Prescribing opioids together with benzodiazepines and muscle relaxants is a highly addictive and dangerous mix also called the "Holy Trinity."

#150, 15-day supply, refill x0. On or about November 17, 2014, Respondent prescribed oxycodone 30gm #150, 30 day supply, refill x0 and carisoprodol 350mg #90, 30 day supply, refill x2.

40. During the period of January 2015 to December 2015, Respondent continued to prescribe oxycodone, hydrocodone, alprazolam, and diazepam to Patient A.

41. On or about December 18, 2015, Respondent ordered urine drug testing for Patient A. The results came out on or about December 22, 2015. The results revealed that Patient A tested positive for the prescribed carisoprodol, and oxycodone but Patient A tested negative for the prescribed hydrocodone and alprazolam. Respondent failed to perform future repeat urine tests. Respondent also failed to act upon this information, and document the possibility of drug diversion.

42. The Medical Board obtained certified pharmacy profiles pertaining to Patient A, from the dates of November 11, 2014, to October 18, 2017. During this period, Respondent prescribed large amounts of a variety of controlled substances to Patient A. Respondent prescribed or re-filled the following controlled substances to Patient A:

Date Filled	Prescription	Quantity	Dosage	Schedule
November 11, 2014	Zolpidem tartrate	30 tablets	10 milligram	II
November 11, 2014	Diazepam	90 tablets	10 milligram	IV
November 13, 2014	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
November 17, 2014	Oxycodone	150 tablets	30 milligrams	II
November 17, 2014	Carisoprodol	90 tablets	350 milligrams	IV
December 4, 2014	Alprazolam	90 tablets	2 milligrams	IV
December 12, 2014	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
December 12, 2014	Diazepam	90 tablets	10 milligram	IV
December 13, 2014	Oxycodone	150 tablets	30 milligrams	II
December 13, 2014	Carisoprodol	90 tablets	350 milligrams	IV
January 9, 2015	Carisoprodol	90 tablets	350 milligrams	IV

January 9, 2015	Diazepam	90 tablets	10 milligram	IV
January 12, 2015	Oxycodone	150 tablets	30 milligrams	II
January 12, 2015	Alprazolam	90 tablets	2 milligrams	IV
January 14, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
February 9, 2015	Carisoprodol	90 tablets	350 milligrams	IV
February 9, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
February 9, 2015	Alprazolam	90 tablets	2 milligrams	IV
February 9, 2015	Oxycodone	150 tablets	30 milligrams	II
February 9, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
March 3, 2015	Alprazolam	90 tablets	2 milligrams	IV
March 9, 2015	Carisoprodol	90 tablets	350 milligrams	IV
March 9, 2015	Temazepam	30 tablets	30 milligrams	IV
March 9, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
March 9, 2015	Oxycodone	150 tablets	30 milligrams	II
March 13, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
March 31, 2015	Alprazolam	90 tablets	2 milligrams	IV
April 6, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
April 6, 2015	Oxycodone	150 tablets	30 milligrams	II
April 10, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
April 11, 2015	Carisoprodol	90 tablets	350 milligrams	IV
April 28, 2015	Alprazolam	90 tablets	2 milligrams	IV
May 4, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
May 4, 2015	Oxycodone	150 tablets	30 milligrams	II
May 4, 2015	Diazepam	90 tablets	10 milligram	IV
May 8, 2015	Carisoprodol	90 tablets	350 milligrams	IV
May 8, 2015	Zolpidem tartrate	30 tablets	10 milligram	II

May 26, 2015	Alprazolam	90 tablets	2 milligrams	IV
June 1, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
June 1, 2015	Diazepam	90 tablets	10 milligram	IV
June 5, 2015	Carisoprodol	90 tablets	350 milligrams	IV
June 5, 2015	Oxycodone	150 tablets	30 milligrams	II
June 5, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
June 23, 2015	Alprazolam	90 tablets	2 milligrams	IV
June 29, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
June 29, 2015	Oxycodone	150 tablets	30 milligrams	II
June 29, 2015	Tramadol	90 tablets	50 milligrams	IV
June 30, 2015	Diazepam	90 tablets	10 milligram	IV
July 22, 2015	Alprazolam	90 tablets	2 milligrams	IV
July 23, 2015	Carisoprodol	90 tablets	350 milligrams	IV
July 27, 2015	Temazepam	30 tablets	30 milligrams	IV
July 27, 2015	Oxycodone	150 tablets	30 milligrams	II
July 27, 2015	Tramadol	90 tablets	50 milligrams	IV
July 28, 2015	Diazepam	90 tablets	10 milligram	IV
August 4, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
August 5, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
August 20, 2015	Alprazolam	90 tablets	2 milligrams	IV
August 24, 2015	Oxycodone	150 tablets	30 milligrams	II
August 24, 2015	Tramadol	90 tablets	50 milligrams	IV
August 26, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
September 7, 2015	Diazepam	90 tablets	10 milligram	IV
September 7, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
September 18, 2015	Alprazolam	90 tablets	2 milligrams	IV

September 21, 2015	Temazepam	30 tablets	30 milligrams	IV
September 21, 2015	Tramadol	90 tablets	50 milligrams	IV
September 22, 2015	Oxycodone	150 tablets	30 milligrams	II
September 23, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
October 9, 2015	Carisoprodol	90 tablets	350 milligrams	IV
October 12, 2015	Diazepam	90 tablets	10 milligram	IV
October 12, 2015	Zolpidem tartrate	30 tablets	10 milligram	II
October 17, 2015	Alprazolam	90 tablets	2 milligrams	IV
October 19, 2015	Tramadol	90 tablets	50 milligrams	IV
October 20, 2015	Fentanyl	10 transdermal patches	25 micrograms per 1 hour	II
October 20, 2015	Oxycodone	150 tablets	30 milligrams	II
October 30, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
November 6, 2015	Carisoprodol	90 tablets	350 milligrams	IV
November 9, 2015	Diazepam	90 tablets	10 milligram	IV
November 17, 2015	Oxycodone	150 tablets	30 milligrams	II
November 23, 2015	Alprazolam	90 tablets	2 milligrams	IV
November 24, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
December 17, 2015	Oxycodone	150 tablets	30 milligrams	II
December 22, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
January 5, 2016	Alprazolam	90 tablets	2 milligrams	IV
January 5, 2016	Diazepam	90 tablets	10 milligram	IV
January 19, 2016	Zolpidem tartrate	30 tablets	10 milligram	II
January 19, 2016	Oxycodone	150 tablets	30 milligrams	II
January 19, 2016	Carisoprodol	90 tablets	350 milligrams	IV
January 21, 2016	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
February 3, 2016	Alprazolam	90 tablets	2 milligrams	IV

February 18, 2016	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
March 1, 2016	Alprazolam	90 tablets	2 milligrams	IV
March 4, 2016	Carisoprodol	90 tablets	350 milligrams	IV
March 30, 2016	Alprazolam	90 tablets	2 milligrams	IV
April 28, 2016	Alprazolam	90 tablets	2 milligrams	IV
May 26, 2016	Alprazolam	90 tablets	2 milligrams	IV
June 23, 2016	Alprazolam	90 tablets	2 milligrams	IV
July 21, 2016	Alprazolam	90 tablets	2 milligrams	IV
October 4, 2016	Alprazolam	90 tablets	2 milligrams	IV
October 4, 2016	Zolpidem	30 tablets	10 milligrams	IV
November 7, 2016	Hydrocodone bitartrate-acetaminophen	60 tablets	325 milligram / 10 milligram	III
December 30, 2016	Oxycodone	60 tablets	10 milligrams	II
January 27, 2017	Hydrocodone bitartrate-acetaminophen	90 tablets	325 milligram / 10 milligram	III
February 24, 2017	Tramadol	120 tablets	325 milligram / 37.5 milligram	
August 4, 2017	Mixed Amphetamine Salt	60 tablets	30 milligrams	
September 1, 2017	Mixed Amphetamine Salt	60 tablets	30 milligrams	
September 24, 2017	Oxycodone HCL-acetaminophen	24 tablets	325 milligram / 5 milligram	
September 30, 2017	Mixed Amphetamine Salt	60 tablets	30 milligrams	
October 16, 2017	Hydrocodone bitartrate-acetaminophen	14 tablets	325 milligram / 10 milligram	

43. On or about November 9, 2018, A Health Quality Investigations Unit Investigator interviewed Respondent. During the interview, Respondent stated the following regarding Patient A's medical information:

"I had a chart at home that I kept track of and regularly completed and -- um -- at the beginning of the year, which was January, when he established with a new physician -

- um -- I didn't want to keep the notes at home, he'd already established, I took it to the office and for whatever reason I just -- um -- I just sent it to shred, so I didn't keep the records."

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter. Respondent failed to document an accurate medication profile.

b. Respondent billed for services not actually rendered and/or documented. Respondent failed to document appropriate level of service, and overbilled.

c. Respondent failed to perform periodic urine drug screens during chronic opioid therapy. Respondent failed to discuss and document the possibility of drug diversion after the initial urine drug screen was positive or abnormal.

d. Respondent failed to perform and/or document an appropriate physical examination on an ongoing basis. Respondent failed to document imaging and/or diagnostic testing sufficient to warrant the use of chronic opioid therapy.

e. Respondent failed to order appropriate labs or obtain lab results in setting of diabetic patient prescribed medication excreted by kidneys.

f. Respondent failed to document consideration of diabetic neuropathy as source of patient's pain.

Patient B

45. On or about April 2, 2014, Patient B presented to RMS for an initial visit.[6] Patient B was at the time of the visit, a 35-year-old female who had a history of lower back pain. Respondent failed to document past medical history, or past surgical history. Patient B filled out a "Comprehensive Pain Questionnaire" stating her purpose for the visit was "to help with pain management lower back." She wrote that her pain is located in the lower back, upper back

[6] Patient names and information have been removed to protect patient confidentiality. Conduct alleged to have before April 1, 2012, is for informational purposes only.

shoulders, and neck. She wrote that her pain was worse with bending, lifting, sitting too long. She rated her pain as 8 out of 10. She wrote that she had x-rays on March 2013. Patient B listed her medications as Seroquel, Paxil, Docusate, Levoxyl, Norco, Oxycodone, and Valium.

46. On or about November 13, 2014, Respondent prescribed opioids together with benzodiazepines and a muscle relaxant (Holy Trinity) to Patient B. Respondent prescribed Soma, oxycodone, Norco and Restoril.

47. On or about June 25, 2014, Respondent saw Patient B for a follow up visit. Respondent documented that "Patient has reduced ROM at cervical and lumbosacral spine in all planes. Patient has full ROM of both shoulders, but patient also has some weakening bilaterally in the muscles supplied by the bilateral suprascapular nerves." He also documented that "Cervical spine disk syndrome with strain-sprain disorder and radiculopathy. Lumbosacral spine disk syndrome with strain-sprain disorder and radiculopathy. Bilateral shoulder strain-sprain disorder with bilateral suprascapular neuropathy". Respondent copied these assessments on virtually all subsequent encounter dates verbatim. In the current and subsequent visits, Respondent failed to document and/or discuss with Patient B why she required ongoing treatment with chronic opioids and sedative hypnotic medications. Respondent failed to document any imaging or diagnostic testing. Respondent failed to document the results or reports of Patient B's bone scan, EMG/NVC, and MRI. Respondent failed to document whether Respondent continued or discontinued the medications Patient B was taking which she indicated on her "Comprehensive Pain Questionnaire".

48. On or about June 25, 2014, July 23, 2014, September 18, 2014, August 20, 2014, October 16, 2014, November 13, 2014, and on subsequent dates of service, Respondent copied identical vital signs, chief complaints, assessments and review of systems.

49. On or about September 21, 2015, Respondent saw Patient B for a follow up visit. Under miscellaneous notes, Respondent documented "NEED FOR CONTINUING OPIOID TREATMENT: At this time, continuing opioid therapy is indicated to treat chronic pain, to reduce pain perception and to optimize functional status." However, Respondent failed to document Patient B's functional status. Under medication use, Respondent documented "Opioid

Tolerant State without evidence of drug abuse or diversion. Continue current regimen." Respondent has the same entry on February 8, 2016, April 4, 2016, and subsequent visits thereafter. Respondent failed to document that Patient B was taking phentermine.

50. On or about October 19, 2015, Respondent saw Patient B for a follow up visit Respondent continued to copy entries from previous visits. Respondent documented "Ankylosing spondylitis of unspecified sites in spine" as a diagnosis for the first time. Respondent failed to document blood tests, diagnostic imaging or other consultant notes to support the diagnosis. Respondent failed to document any radiological evidence, modified Schober test, lateral spine motion testing, occipital to wall testing, and chest expansion measurement.

51. On or about March 7, 2016, Respondent saw Patient B for a follow up visit. Respondent continued to copy entries from previous visits. Respondent prescribed Reglan and Zantac for Patient B. Respondent failed to document his reason for prescribing these medications.

52. Respondent continued seeing Patient B for follow up visits on April 4, May 5, June 2, July 6, August 24, September 21, October 19, November 16, December 15, 2016; and January 12, February 16, March 17, 2017. During these visits, Respondent continued to prescribe Norco, Oxycodone, Valium, Reglan, Zantac, Xanax and carisoprodol without adequate documentation of his rationale for continued opioid therapy, periodic review, or adequate monitoring. Respondent continued to copy entries from previous visits.

53. On or about December 14, 2016, Patient B had a urine toxicology test. The report dated December 20, 2016 indicated that Patient B was positive for amphetamines, cocaine, and clonazepam. Patient B had subsequent urine toxicology tests on Oct 18, 2016; January 12, February 16, April 12, May 10, 2017, August 1, September 1, October 26, 2017. During this period, Patient B tested positive for Tramadol, marijuana, cocaine, phentermine, and was non-compliant with her oxycodone prescription. Respondent failed to discuss with Patient B why she tested positive for drugs that Respondent did not prescribe to her. Respondent continued to prescribe controlled substances to Patient B despite Patient B's non-compliance with her pain contract.

54. On or about March 17, 2017, Respondent saw Patient B for a follow up visit. Under miscellaneous notes, Respondent documented "Medication Refill", "Request DNA test for metabolism", "Patient did not see Dr. Kaplan. Patient was only re-tested on the 12th of January 2017 after failed utox results." Respondent documented his diagnosis as scoliosis, but failed to document his examination or imaging that supports his diagnosis. Respondent does not indicate what is the purpose of the DNA test.

55. On or about April 12, 2017, Respondent saw Patient B or a follow up visit. Respondent documented a disorganized physical examination that included examination of the eyes, ear, nose, mouth, and throat, respiratory, MSK with documentation of grip strength, and range of motion. However, he only copied the entries from the March 17, 2017 physical examination. Respondent also documented a neurological examination that was incomplete. Respondent documented a psychiatric examination, but only repeated the information in the neurological examination.

56. On or about May 10, 2017, Respondent saw Patient B for a follow up visit. Respondent continued to copy entries from previous visits, including identical grip strength test results entries for the last three visits.

57. On or about June 7, 2017, Respondent saw Patient B for an office visit. Respondent billed the encounter as CPT code 99215-office visit[7]. However, Respondent's documentation failed to support the 99215-office visit. Respondent copied entries from previous visits, without any substantive differences from encounter to encounter. Respondent failed to document Patient B's past medical history. Respondent had copied the same encounter note entries on January 19, September 27, and October 24, 2017.

58. On or about December 21, 2017 and December 28, 2017, Respondent prescribed oxycodone 20 mg, 90 tablets within days of each prescription.

59. On or about November 22, 2017, Respondent saw Patient B for an office visit. Respondent billed the encounter as CPT code 99215-office visit. However, Respondent failed to

[7] CPT Code 99215 requires comprehensive level of documentation 18 + exam elements; 4+ history of present illness or a 40 minute face-to-face visit with more than 20 minutes spent on counselling.

document anything regarding the visit. Respondent prescribed Tramadol and Oxycodone during this visit without maintaining documentation.

60. The Medical Board obtained certified pharmacy profiles pertaining to Patient B, from the dates of November 11, 2014, to October 26, 2017. During this period, Respondent prescribed large amounts of a variety of controlled substances to Patient B. During the aforementioned time, Respondent prescribed or re-filled the following controlled substances to Patient B:

Date Filled	Prescription	Quantity	Dosage	Schedule
November 11, 2014	Carisoprodol	60 tablets	350 milligrams	IV
November 11, 2014	Hydrocodone bitartrate-acetaminophen	90 tablets	325 milligram / 10 milligram	III
November 11, 2014	Diazepam	90 tablets	10 milligram	IV
November 14, 2014	Temazepam	30 tablets	30 milligrams	IV
November 17, 2014	Oxycodone	150 tablets	30 milligrams	II
December 9, 2014	Diazepam	90 tablets	10 milligram	IV
December 9, 2014	Carisoprodol	60 tablets	350 milligrams	IV
December 9, 2014	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
December 13, 2014	Temazepam	30 tablets	30 milligrams	IV
December 13, 2014	Oxycodone	150 tablets	30 milligrams	II
January 5, 2015	Carisoprodol	60 tablets	350 milligrams	IV
January 5, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
January 12, 2015	Diazepam	90 tablets	10 milligram	IV
January 12, 2015	Temazepam	30 tablets	30 milligrams	IV
January 12, 2015	Oxycodone	150 tablets	30 milligrams	II
February 2, 2015	Carisoprodol	60 tablets	350 milligrams	IV
February 2, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
February 9, 2015	Temazepam	30 tablets	30 milligrams	IV
February 9, 2015	Diazepam	90 tablets	10 milligram	IV

February 10, 2015	Oxycodone	150 tablets	30 milligrams	II
March 2, 2015	Carisoprodol	60 tablets	350 milligrams	IV
March 2, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
March 9, 2015	Oxycodone	150 tablets	30 milligrams	II
March 9, 2015	Temazepam	30 tablets	30 milligrams	IV
March 9, 2015	Diazepam	90 tablets	10 milligram	IV
March 30, 2015	Carisoprodol	60 tablets	350 milligrams	IV
March 30, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
April 6, 2015	Diazepam	90 tablets	10 milligram	IV
April 6, 2015	Oxycodone	150 tablets	30 milligrams	II
April 22, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
April 27, 2015	Carisoprodol	60 tablets	350 milligrams	IV
May 4, 2015	Diazepam	90 tablets	10 milligram	IV
May 4, 2015	Oxycodone	150 tablets	30 milligrams	II
May 19, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
May 26, 2015	Carisoprodol	60 tablets	350 milligrams	IV
June 1, 2015	Diazepam	90 tablets	10 milligram	IV
June 1, 2015	Oxycodone	150 tablets	30 milligrams	II
June 5, 2015	Oxycodone	150 tablets	30 milligrams	II
June 16, 2015	Temazepam	30 tablets	30 milligrams	IV
June 16, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
June 29, 2015	Oxycodone	150 tablets	30 milligrams	II
June 29, 2015	Diazepam	90 tablets	10 milligram	IV
July 2, 2015	Carisoprodol	60 tablets	350 milligrams	IV
July 14, 2015	Temazepam	30 tablets	30 milligrams	IV
July 14, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III

July 27, 2015	Diazepam	90 tablets	10 milligram	IV
July 27, 2015	Carisoprodol	60 tablets	350 milligrams	IV
July 27, 2015	Oxycodone	150 tablets	30 milligrams	II
August 10, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
August 24, 2015	Alprazolam	90 tablets	2 milligrams	IV
August 24, 2015	Diazepam	90 tablets	10 milligram	IV
August 24, 2015	Oxycodone	150 tablets	30 milligrams	II
September 7, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
September 21, 2015	Alprazolam	90 tablets	2 milligrams	IV
September 21, 2015	Diazepam	90 tablets	10 milligram	IV
September 21, 2015	Carisoprodol	60 tablets	350 milligrams	IV
September 21, 2015	Temazepam	30 tablets	30 milligrams	IV
October 2, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
October 19, 2015	Alprazolam	90 tablets	2 milligrams	IV
October 19, 2015	Carisoprodol	60 tablets	350 milligrams	IV
October 19, 2015	Temazepam	30 tablets	30 milligrams	IV
October 19, 2015	Oxycodone	150 tablets	30 milligrams	II
October 19, 2015	Diazepam	90 tablets	10 milligram	IV
October 30, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
November 16, 2015	Alprazolam	90 tablets	2 milligrams	IV
November 16, 2015	Oxycodone	150 tablets	30 milligrams	II
November 23, 2015	Carisoprodol	60 tablets	350 milligrams	IV
November 23, 2015	Diazepam	90 tablets	10 milligram	IV
November 28, 2015	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
December 14, 2015	Oxycodone	150 tablets	30 milligrams	II
December 16, 2015	Alprazolam	90 tablets	2 milligrams	IV

December 26, 2015	Carisoprodol	60 tablets	350 milligrams	IV
December 26, 2015	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
December 26, 2015	Diazepam	90 tablets	10 milligram	IV
January 11, 2016	Oxycodone	120 tablets	30 milligrams	II
January 25, 2016	Diazepam	90 tablets	10 milligram	IV
January 25, 2016	Carisoprodol	60 tablets	350 milligrams	IV
January 25, 2016	Hydrocodone bitartrate-acetaminophen	150 tablets	325 milligram / 10 milligram	III
February 8, 2016	Oxycodone	120 tablets	30 milligrams	II
February 8, 2016	Alprazolam	90 tablets	2 milligrams	IV
February 20, 2016	Diazepam	90 tablets	10 milligram	IV
February 20, 2016	Carisoprodol	60 tablets	350 milligrams	IV
February 20, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
March 7, 2016	Oxycodone	120 tablets	30 milligrams	II
March 7, 2016	Alprazolam	90 tablets	2 milligrams	IV
March 21, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
April 4, 2016	Alprazolam	90 tablets	2 milligrams	IV
April 4, 2016	Oxycodone	120 tablets	30 milligrams	II
April 19, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
May 4, 2016	Alprazolam	90 tablets	2 milligrams	IV
May 5, 2016	Oxycodone	90 tablets	30 milligrams	II
May 17, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
June 1, 2016	Alprazolam	90 tablets	2 milligrams	IV
June 7, 2016	Oxycodone	90 tablets	30 milligrams	II
June 14, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
June 30, 2016	Diazepam	90 tablets	10 milligram	IV
July 7, 2016	Oxycodone	120 tablets	30 milligrams	II

July 12, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
July 27, 2016	Diazepam	90 tablets	10 milligram	IV
July 27, 2016	Oxycodone	120 tablets	30 milligrams	II
August 9, 2016	Hydrocodone bitartrate-acetaminophen	90 tablets	325 milligram / 10 milligram	III
August 24, 2016	Diazepam	90 tablets	10 milligram	IV
August 24, 2016	Oxycodone	120 tablets	30 milligrams	II
September 6, 2016	Hydrocodone bitartrate-acetaminophen	90 tablets	325 milligram / 10 milligram	III
September 21, 2016	Oxycodone	120 tablets	30 milligrams	II
September 21, 2016	Diazepam	90 tablets	10 milligram	IV
October 4, 2016	Hydrocodone bitartrate-acetaminophen	90 tablets	325 milligram / 10 milligram	III
October 19, 2016	Diazepam	90 tablets	10 milligram	IV
November 16, 2016	Oxycodone	120 tablets	30 milligrams	II
November 22, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
December 15, 2016	Diazepam	90 tablets	10 milligram	IV
December 15, 2016	Oxycodone	120 tablets	30 milligrams	II
December 20, 2016	Hydrocodone bitartrate-acetaminophen	120 tablets	325 milligram / 10 milligram	III
January 12, 2017	Diazepam	90 tablets	10 milligram	IV
January 19, 2017	Oxycodone	120 tablets	30 milligrams	II
February 7, 2017	Diazepam	90 tablets	10 milligram	IV
February 16, 2017	Oxycodone	90 tablets	30 milligrams	II
February 16, 2017	Tramadol	120 tablets	50 milligrams	IV
March 7, 2017	Diazepam	60 tablets	10 milligram	IV
March 16, 2017	Oxycodone	90 tablets	30 milligrams	II
March 16, 2017	Tramadol	120 tablets	50 milligrams	IV
April 3, 2017	Diazepam	60 tablets	10 milligram	IV
April 12, 2017	Oxycodone	90 tablets	30 milligrams	II

April 12, 2017	Tramadol	120 tablets	50 milligrams	IV
April 26, 2017	Diazepam	60 tablets	10 milligram	IV
May 9, 2017	Tramadol	120 tablets	50 milligrams	IV
May 10, 2017	Oxycodone	90 tablets	30 milligrams	II
May 26, 2017	Diazepam	90 tablets	10 milligram	IV
June 6, 2017	Tramadol	120 tablets	50 milligrams	IV
June 7, 2017	Oxycodone	90 tablets	30 milligrams	II
June 23, 2017	Diazepam	90 tablets	10 milligram	IV
July 3, 2017	Tramadol	90 tablets	50 milligrams	IV
July 5, 2017	Oxycodone	90 tablets	30 milligrams	II
July 20, 2017	Diazepam	90 tablets	10 milligram	IV
July 31, 2017	Tramadol	90 tablets	50 milligrams	IV
August 1, 2017	Oxycodone	90 tablets	30 milligrams	II
August 17, 2017	Diazepam	90 tablets	10 milligram	IV
August 26, 2017	Tramadol	90 tablets	50 milligrams	IV
August 31, 2017	Oxycodone	90 tablets	30 milligrams	II
September 18, 2017	Diazepam	90 tablets	10 milligram	IV
September 22, 2017	Tramadol	90 tablets	50 milligrams	IV
September 27, 2017	Oxycodone	90 tablets	20 milligrams	II
October 16, 2017	Diazepam	90 tablets	10 milligrams	IV
October 19, 2017	Tramadol	90 tablets	50 milligrams	IV
October 26, 2017	Oxycodone	90 tablets	20 milligrams	II

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter. Respondent failed to document an accurate medication profile.

b. Respondent billed for services not actually rendered and/or documented. Respondent failed to document the appropriate level of service, and overbilled.

c. Respondent failed to discuss and document the possibility of drug diversion after the initial urine drug screen was positive or abnormal. Respondent failed to document his rationale why he continued to prescribe opioids despite violation of the pain contract.

d. Respondent failed to perform and/or document an appropriate functional status and physical examination on an ongoing basis. Respondent failed to document imaging and/or diagnostic testing sufficient to warrant the use of chronic opioid therapy.

e. Respondent failed to document his basis for the ankylosing spondylitis diagnosis.

f. Respondent prescribed large amounts of opioids to Patient B without adequate documentation, basis or periodic review.

Patient C

62. Respondent documented that Patient C was his patient from May 7, 2008 to July 12, 2017. Respondent failed to keep clinic notes for a majority of patient encounters during this period. In his interview with the Board, Respondent stated that he does not know where the clinic notes for these visits are located.

63. On or about December 3, 2013, Respondent saw Patient C for a follow up visit. Patient C's medication list consisted of the following: Oxycontin 80 mg, #150 per month, 1 application orally five times per day, Soma 350 mg # 120, 1 tab QID, Norco 10/325 2 tabs TID #80, Ambien CR 12.5mg #30, Xanax 1mg 1 TID #90, and Valium 10 mg 1 BID. Respondent failed to calculate the total morphine equivalent (MED) for Patient C on this date, which was 660 MED. Respondent also failed to keep notes and/or documentation for this encounter date.

64. On or about June 17, 2014, Respondent documented a "PR-2 Report". Respondent documented the purpose of the visit was "Outpatient visit". Respondent documented the subjective complaint as "right shoulder and neck sharp, stabbing pain, stiffness, weakness, and generalized discomfort. This patient has had a good, but partial response to medication." Respondent prescribed Oxycontin at unsafe levels when he prescribed Oxycontin 80mg PRN #150 to Patient C.

65. During the period of July 15, 2014 to July 12, 2017, Respondent documented "PR-2 Reports". Respondent documented the purpose of these visits were for "Outpatient visit(s)". Respondent documented identical entries under the heading, "subjective complaint" for substantially all these visits. Respondent prescribed Oxycontin at unsafe levels when he prescribed Oxycontin 80mg PRN #150 to Patient C. Respondent also prescribed multiple opioids and benzodiazepines concurrently without calculating the total morphine equivalent (MED) and without adequate supporting documentation.

66. On or about June 20, 2014, August 12, 2014, October 8, 2014, June 16, 2015, October 12, 2015, May 16, 2017, and July 12, 2017, Patient C was non-compliant in urine drug screens. The urine drug screens indicated that Patient C was not taking the opioids prescribed and/or was taking controlled substances Respondent did not prescribe. Respondent failed to document Patient C's non-compliance and discuss non-compliance with Patient C. Respondent failed to act on Patient C's non-compliance.

67. During the period of December 2014 to July 2017, Respondent documented "Encounter Reviews". Respondent's entries on all these encounter reviews were substantially identical. Respondent also failed to keep adequate and complete documentation and complete charts for each visit when he failed to document physical examinations and his findings.

68. On or about April 21, 2015, Respondent documented a "PR-2 Report". Respondent documented the purpose of the visit was "Outpatient visit". Respondent copied entries under "subjective complaint" from previous PR-2 Reports. Respondent prescribed Oxcontin 80mg PRN #150, Norco 10/325mg PRN #180, Lunesta 2mg GHS PRN (no # stated), Xanax 1 mg TID in order to reduce anxiety, Valium 10mg TID #90. Respondent prescribed an unsafe combination of opioids and benzodiazepines when he prescribed two concomitant benzodiazepines and three concomitant sedative hypnotic drugs. Respondent also failed to calculate the MED.

69. On or about May 16, 2017, Respondent documented a "PR-2 Report". Respondent documented the purpose of the visit was "Outpatient visit". Respondent copied entries under "subjective complaint" as previous PR-2 Reports. Under "Treatment Plan", Respondent documented "Norco 10/325 mg p.r.n. #120 no refills for relief of breakthrough pain", and

"OxyContin 80 mg p.r.n. #120 no refills for relief of generalized discomfort, complex regional pain disorder, and cancer pain." Respondent failed to document supporting documentation to justify the use of chronic high dose opioids for Patient C's history of thyroid cancer. Respondent failed to document indication of malignancy or spread of the cancer, except the repeated use of the phrase "bilateral cancer pain", which is not supported by Respondent's documentation.

70. On or about July 12, 2017, Respondent documented a "PR-2 Report". Respondent documented the purpose of the visit was "Outpatient visit". Under subjective complaint, Respondent documented "Patient [C] was at UC Davis Medical Center for cervical spinal surgery. During that inpatient stay, patient [C] gave UC Davis her sob story about needing more medication, Responding to this (sic) history by the patient, UC Davis gave liquid Oxycodone. Therefore breaking the contract with us while doing that." Respondent failed to understand the nature of pain contracts.

71. On or about July 14, 2015, Respondent prescribed Oxycontin at unsafe levels when he prescribed Oxycontin 80 mg PRN #150 to Patient C. Respondent also prescribed multiple opioids and benzodiazepines concurrently without calculating the total morphine equivalent (MED) and without adequate supporting documentation.

72. On or about November 4, 2015, Respondent prescribed unsafe levels of multiple opioids and benzodiazepines concurrently without adequate supporting documentation.

73. On or about December 2, 2015, Respondent saw Patient C for a follow up visit. Respondent failed to document any clinic note to document the encounter.

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter Respondent billed for services without adequate documentation.

b. Respondent failed to discuss and document the possibility of drug diversion after the initial urine drug screen was positive or abnormal. Respondent failed to document his rationale why he continued to prescribe opioids despite Patient C's non-compliant urine drug screens.

c. Respondent failed to perform and/or document an appropriate functional status and physical examination on an ongoing basis.

d. Respondent prescribed large amounts of opioids to Patient C without adequate documentation, basis or periodic review.

e. Respondent prescribed dangerous combinations and/or dosages of opioid and sedative hypnotic medications.

Patient D

75. Patient D was Respondent's patient from August 16, 2012 to January 3, 2018. During this period, Respondent billed the visits as CPT codes, 99215 and 99358[8], without adequate supporting documentation to justify the level of billing. On June 2, 2014, July 2, 2014, August 5, 2014, September 3, 2014, October 29, 2014, April 13, 2016, and subsequent visits thereafter, Respondent documented "PR-2 reports". Respondent documented identical subjective complaints, "Neck and low back sharp, stabbing pain, stiffness, weakness and generalized discomfort. This patient has had a good, but partial response to treatment." Respondent also documented identical objective findings in each visit, "Augmented touch-floor gap and reduced bilateral straight-leg raising measurements. Tender, painful bilateral cervical and lumbosacral paraspinal muscular spasms were noted. Reduced sensation and strength in the distribution of the bilateral C7, bilateral C8, bilateral T1 bilateral L4, bilateral L5, and bilateral S1 spinal nerve roots. Absent bilateral deep tendon reflexes."

76. In June 2015, Respondent prescribed Oxycontin 80mg #120 30 days and oxycodone HCL, 10/325 #120/30 days in an unsafe quantity. Respondent failed to calculate the total morphine equivalent (MED) for Patient D on this date, which was 540 MED.

77. In May of 2015, Respondent prescribed three sedative hypnotic drugs in an unsafe combination, when he prescribed alprazolam, carisoprodol, and zolpidem simultaneously.

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[8] Current Procedural Terminology (CPT) code 99358 is used for a prolonged service provided that is neither face-to-face in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time.

78. In July of 2015, Respondent prescribed the "Holy Trinity", an unsafe combination of Soma, opioids and benzodiazepines when he prescribed carisoprodol, alprazolam, and Oxycontin.

79. On or about September 3, 2014, Patient D was found to be non-compliant when he tested positive for THC[9]. The urine drug screens indicated that Patient D was taking a controlled substance Respondent did not prescribe. Respondent failed to document Patient D's non-compliance and discuss non-compliance with Patient D. Respondent failed to act on Patient D's non-compliance.

80. In a letter received by Respondent on November 19, 2014, Paladin Managed Care Services (Paladin) denied services after performing a retrospective review of Respondent's October 29, 2014 Patient D visit. Paladin concluded that Respondent did not list opioid risk stratification; Patient D did not appear to meet criteria for chronic opioid therapy; Respondent failed to measure improvement correlated to opioid use; Respondent failed to document utilization of CURES report and documentation of results; Respondent failed to taper Patient D to lowest effective dose.

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter Respondent billed for services without adequate documentation.

b. Respondent failed to discuss and document the possibility of drug diversion after Patient D's urine drug screen was abnormal. Respondent failed to document his rationale why he continued to prescribe opioids despite Patient D's non-compliant urine drug screen.

c. Respondent prescribed large amounts of opioids to Patient D without adequate documentation, basis or periodic review.

d. Respondent prescribed dangerous combinations and/or dosages of opioid and sedative hypnotic medications.

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[9] Tetrahydrocannabinol, a crystalline compound that is the main active ingredient of cannabis.

Patient E

82. On or about August 13, 2010, Respondent saw Patient E for an initial visit. Patient E was a 57-year-old male at the time. Respondent documented that Patient E had "polycythemia vera, dysuria, DVT, insomnia, hypertension, chronic pain syndrome, arryhytmia, and GERD". Respondent saw Patient E from August 13, 2010 to February 1, 2016. From July 9, 2014 and subsequently thereafter, Respondent documented identical miscellaneous notes, "S--Neck and low back sharp, stabbing pain, stiffness, weakness and generalized discomfort. Then patient had a good, but partial response to treatment" and "O-Reduced ROM of the cervical and lumbosacral spines in all planes, bilateral C6- and SI spinal nerve root radiculopathies, and absent bilateral ankle and biceps deep tendon reflexes. This patient also had tender, painful bilateral cervical and lumbosacral paraspinal muscular spasms, augmented touch-floor gap, and reduced bilateral straight-leg raising measurements." From September 4, 2014 to December 11, 2014, Respondent documented identical readings for blood pressure, pulse, and respiration. From January 21, 2015 and subsequently thereafter, Respondent documented identical readings for blood pressure, pulse, and respiration. During the period of 2014 to 2016, Respondent prescribed and refilled Patient E's prescription for various opioids without accurate and appropriate supporting documentation.

83. On or about October 7, 2015, Respondent prescribed Oxycontin 80mg #120 30 days and oxycodone HCL, 10/325 #120/30 days in an unsafe quantity. Respondent failed to calculate the total morphine equivalent (MED) for Patient E on this date, which was 540 MED.

84. In September and October of 2015, Respondent prescribed sedative hypnotic drugs, benzodiazepines, and opioids in an unsafe combination, when he prescribed promethazine/codeine, diazepam, Oxycontin, and hydrocodone simultaneously.

85. In September of 2015, Respondent prescribed the "Holy Trinity", an unsafe combination of Soma, opioids and benzodiazepines when he prescribed carisoprodol, diazepam, and Oxycontin.

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

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a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter Respondent billed for services without adequate documentation.

b. Respondent failed to document and/or administer urine drug tests.

c. Respondent prescribed large amounts of opioids to Patient E without adequate documentation, basis or periodic review. Respondent failed to list opioid stratification. Patient E did not appear to meet criteria for chronic opioid therapy. Respondent failed to measure improvement correlated to opioid use; Respondent failed to document utilization of CURES reports and documentation of results; Respondent failed to taper Patient E to lowest effective dose.

d. Respondent prescribed dangerous combinations and/or dosages of opioid and sedative hypnotic medications.

Patient F

87. On or about March 23, 2015, Respondent saw Patient F for an initial visit. Patient F was at the time of the visit, a then a 56-year-old female who established care with Respondent for management of chronic pain. Respondent documented that Patient F's medical records came from Sacramento Family Medical Clinic. Respondent documented that Patient F was involved in a motor vehicle accident sometime in 2010, which resulted in multiple injuries to Patient F's knees and shoulders, weight gain, falls, reduced range of motion of the cervical spine and low back spine. Respondent documented that Patient F was prescribed methadone for reduction of neck and back pain. Patient F has had aseptic necrosis of the head and neck of the femur, and cannot walk. Respondent failed to document and perform an adequate review of prior medical history when he failed to document: enlarged thyroid/thyroid mass, avascular necrosis femur, fracture radius, endometrial hyperplasia, and back pain. Respondent failed to document that Patient F had central cord syndrome, a bad left knee awaiting replacement, and numerous bone fractures. Respondent failed to document a detailed musculoskeletal and neurologic examination, examination and/or discussion of skin breakdown, and documentation of examination of the heart, lungs, and abdomen. During this visit, Respondent also prescribed methadone, Ambien,

and Xanax, without documenting the rationale, appropriateness of the dose, risks and benefits, and urine screens. Respondent prescribed methadone without obtaining an EKG for QT prolongation or discussion of cardiac risk factors. Respondent failed to discuss obtaining basic metabolic panel, complete blood count, urinalysis results from the referring provider. Respondent saw Patient F from March 23, 2015 to November 13, 2017.

88. On or about March 20, 2015, Respondent saw Patient F for a follow up visit. Respondent documented that "Patient to be rechecked"; "Patient fell down, partly because of anxiety, and patient would now like a slightly increased dose of Xanax"; "Patient's Medications include Methadone 10mg 2 tablets 4 times a day"; "Xanax 1mg BID #60x5." Respondent prescribed unsafe medications that increased Patient F's risks of falling.

89. On or about March 23, 2015, Respondent saw Patient F for a follow up visit. Respondent documented under problems list, status "inactive" displacement of cervical intervertebral disc without myelopathy. Respondent failed to document Patient F's current medication list.

90. On or about April 29, 2015, Respondent saw Patient F for a follow up visit. Respondent documents "no chronic health problems have been listed." Respondent failed to document the avascular necrosis hip, central cord syndrome and low back pain. Respondent copied vital signs from previous visits and subsequent "encounter reviews" or office notes are all virtually identical without physical examination documented. Respondent documented current medications including Ambien, Xanax and methadone, but failed to document diagnosis associated for each medication.

91. Respondent saw Patient F from March 23, 2015 to October 18, 2017. Respondent billed for CPT Code 99215 without adequate supporting documentation. Respondent also overprescribed unsafe levels of opioids without adequate documentation of medical indication for chronic opioid therapy. Respondent never checked CURES, and never checked with Patient F if she received opioids from other sources.

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92. On or about August 17, and September 14, 2017, Respondent began to taper down Patient F's methadone, morphine, oxycodone, and Percocet, but failed to document the rationale in his chart notes.

93. On or about November 13, 2017, Patient F was non-compliant when the urine drug screens indicated that Patient F was taking a controlled substance Respondent did not prescribe. Respondent failed to document Patient F's non-compliance and discuss non-compliance with Patient F. Respondent failed to act on Patient F's non-compliance.

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter Respondent billed for services without adequate documentation.

b. Respondent failed to document and/or administer urine drug tests. Respondent failed to discuss and document the possibility of drug diversion after Patient F's urine drug screen was abnormal. Respondent failed to document his rationale why he continued to prescribe opioids despite Patient F's non-compliant urine drug screen.

c. Respondent prescribed large amounts of opioids to Patient F without adequate documentation, basis or periodic review. Respondent failed to list opioid stratification. Patient F did not appear to meet criteria for chronic opioid therapy. Respondent failed to measure improvement correlated to opioid use; Respondent failed to document utilization of CURES reports and documentation of results; Respondent failed to taper Patient F to lowest effective dose.

d. Respondent prescribed dangerous combinations and/or dosages of opioid and sedative hypnotic medications.

Patient G

95. Respondent saw Patient G for an initial visit on July 23, 2012. Respondent documented that he saw Patient G for office visits during the period of July 23, 2012 to December 18, 2017. Respondent documented "IMPRESSION: Prior interbody fusion surgery at L4-5 and

L5-S1 levels. No MR scan evidence for discitis or clumping of nerves within the thecal sac. There is an enhancing nerve within the thecal sac at L4-5 level. This presumably relates to postoperative changes but difficult to exclude element of neuritis. No evidence for high-grade spinal stenosis, recurrent disc herniation or high-grade of foraminal narrowing." In the intake form, Patient G lists down several medications, allergies, and surgeries and medical conditions. Respondent failed to document "Foot drop right, numbness in right foot" in his chart notes as indicated by Patient G in the intake form. Respondent's medical record only contained encounter review notes for June 24, 2014 onwards. Respondent billed for virtually all visits under CPT Code 99215 without adequate documentation.

96. On or about July 22, 2014 Respondent saw Patient G for a follow up visit, Respondent documented that Patient G had a history of back pain and laminectomy fusion. Respondent incorrectly documented "No chronic health problems have been listed." Respondent copies this entry into all his subsequent encounter review chart notes. Respondent failed to document Patient G's allergies to Tetracycline, E-mycin, Elavil, Neurontin, Vicodin, Darvocet (various preparations) and Adhesive tape. Respondent incorrectly lists down allergies to Ceclore, codeine, and methadone as allergies recorded in 2017. Respondent copied this entry on the August 20, September 17, 2014 and January 12, 2015 visits. Respondent also failed to document Patient G's surgical history in his encounter review notes. Respondent only started documenting Patient G's surgical history in January 23, 2017. Respondent also failed to document past medical history. In the section entitled "miscellaneous notes" Respondent documented:

i. S -Low back sharp, slabbing pain, stiffness, weakness and generalized discomfort. This patient has had a good but partial response to treatment.

ii. O - Reduced ROM of the lumbosacral spine and reached sensation and strength in the distribution of the right SI spinal nerve root. This patient has also had absent right DTR and tender, painful bilateral lumbosacral paraspinal muscular spasms.

iii. Patient tried Duragesic patches 75 mcg and ii did not help with her pain. I am taking her back to 100 mcg where she was doing fine on that dosage.

iv. T-Patient is to return to clinic in 30 days for medication refills.

Respondent repeats the above entry in subsequent encounter review chart notes dated September 17, 2014, May 7, 2015, July 2, 2015, October 1, 2015, November 5, 2015, January 28, 2016, May 26, 2016, October 24, 2015, and September 18, 2017.

97. Respondent prescribed diazepam, carisoprodol, and fentanyl, to Patient G from November 11, 2014 to October 20, 2017. Respondent failed to document supporting documentation to support his prescriptions. In January 13 2015, Respondent failed to document his prescription for carisoprodol, diazepam and fentanyl. In January 2017, February 15, and March 2017, Respondent failed to document Celebrex and Soma. Respondent prescribed an unsafe combination of the "Holy Trinity" when he prescribed fentanyl, diazepam and carisoprodol. Respondent failed to document urine drug screens consistently to monitor compliance. Respondent ordered a urine test for May 26, 2016 which did not include test for Fentanyl, and Soma.

98. From August 2016 to December 2016, Respondent documented identical vital signs that showed identical blood pressure readings, respiration, pulse, weight and BMI.

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

a. Respondent failed to maintain accurate and adequate records. Respondent failed to maintain accurate notes for each encounter and relied on identical entries for each encounter Respondent billed for services without adequate documentation.

b. Respondent failed to document and/or administer urine drug tests.

c. Respondent prescribed large amounts of opioids to Patient G without adequate documentation, basis or periodic review. Respondent failed to list opioid stratification. Patient G did not appear to meet criteria for chronic opioid therapy. Respondent failed to measure improvement correlated to opioid use; Respondent failed to document utilization of CURES reports and documentation of results; Respondent failed to taper Patient F to lowest effective dose.

d. Respondent prescribed dangerous combinations and/or dosages of opioid and sedative hypnotic medications.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

100. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient A, B, C, D, E, F, and G, as more particularly alleged hereinafter. Paragraphs 31 through 99, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE
(Excessive Prescribing)

101. Respondent is further subject to disciplinary action under sections 2227, 2234 and 725, in that he has excessively prescribed controlled substances and dangerous drugs to Patient A, B, C, D, E, F, and G, as more particularly alleged hereinafter. Paragraphs 31 through 99, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Prescribing Controlled Substances Without Appropriate Examination or Medical Indication)

102. Respondent is further subject to disciplinary action under sections 2227, 2234 and 2242, in that he has prescribed controlled substances and dangerous drugs to Patient A, B, C, D, E, F, and G, as more particularly alleged hereinafter. Paragraphs 31 through 99, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

103. Respondent's license is subject to disciplinary action under section 2266, of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patient A, B, C, D, E, F, and G, as more particularly alleged hereinafter. Paragraphs 31 through 99, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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SIXTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

104. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 31 through 99, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 14089, issued to Paul E. Kaplan, M.D.;

2. Revoking, suspending or denying approval of Paul E. Kaplan, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Paul E. Kaplan, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: July 12, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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