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

In the Matter of the Accusation Against: Lawrence A. Price, M.D. Physician's and Surgeon's Certificate No. G15724 Respondent	Case No. 800-2018-044702

DECISION

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

This Decision shall become effective at 5:00 p.m. on

February 11, 2021.

IT IS SO ORDERED February 4, 2021.

MEDICAL BOARD OF CALIFORNIA

By: _____
William Prasifka, Executive Director

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7549
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against: **LAWRENCE A. PRICE, M.D.** **971 Chandler Rd.** **Quincy, CA 95971-9305** **Physician's and Surgeon's Certificate No. G 15724** Respondent.	Case No. 800-2018-044702 OAH No. 2020050355 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

///

2. Respondent Lawrence A. Price, M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On or about October 29, 1968, the Board issued Physician's and Surgeon's Certificate No. G 15724 to Lawrence A. Price, 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. 800-2018-044702, and will expire on February 28, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-044702 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 April 21, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-044702 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-044702. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

///

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-044702, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2018-044702, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 15724 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

RESERVATION

13. 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

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal

action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 15724 issued to Respondent Lawrence A. Price, 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. 800-2018-044702 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. 800-2018-044702 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dominique A. Pollara. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/2/2020

LAWRENCE A. PRICE, M.D.
Respondent

I have read and fully discussed with Respondent Lawrence A. Price, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 12/2/2020

DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/2/2020

Respectfully submitted,

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

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

SA2019103949
34505479.docx

Exhibit A

Accusation No. 800-2018-044702

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
RYAN J. MCEWAN
Deputy Attorney General
State Bar No. 285595
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7548
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2018-044702
LAWRENCE A. PRICE, M.D. **971 Chandler Rd.** **Quincy, CA 95971-9305** Physician's and Surgeon's Certificate No. G 15724, Respondent.	**ACCUSATION**

PARTIES

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

2. On or about October 29, 1968, the Medical Board issued Physician's and Surgeon's Certificate No. G 15724 to Lawrence A. Price, 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 February 28, 2021, unless renewed.

///

///

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 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:

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

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

"(b) Gross negligence.

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

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

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

///

"(d) Incompetence.

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

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

". . ."

6. 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."

7. 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."

8. 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.

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

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

///

///

///

DEFINITIONS

9. **Alprazolam** (generic name for the drug Xanax) 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, subdivision (d).

10. **Carisoprodol** (generic name for the drug Soma) 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.

11. **Cyclobenzaprine** (generic name for Flexeril) is a centrally acting skeletal muscle relaxant. Cyclobenzaprine may have drug interactions with central nervous system depressants. It is a dangerous drug pursuant to Business and Professions Code section 4022.

12. **Diazepam** (generic name for the drug Valium) is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Meniere's disease. It is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. **Fentanyl** (generic name for the drug Duragesic) 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, subdivision (c).

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

14. **Hydrocodone bitartrate with acetaminophen** (generic name for the drugs Vicodin, Norco, and Lortab) is 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. 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).

15. **Hydromorphone hydrochloride** (generic name for the drug Dilaudid) 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, subdivision (b).

16. **Lorazepam** (generic name for Ativan) 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 California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. **Methadone** (generic name for the drug Symoron) 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 Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to California Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. **Morphine sulfate** (generic name for the drugs Kadian, MS Contin, and MorphaBond ER) 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. Morphine sulfate 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 California Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. **Oxycodone** (generic name for Oxycontin, Roxicodone, and Oxecta) is a short acting opioid analgesic used to treat moderate to severe pain. It is a high risk drug 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 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, subdivision (b).

20. **Oxycodone and acetaminophen** (generic name for Endocet and Percocet) is an opioid analgesic combination product used to treat moderate to severe pain. Oxycodone and 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).

21. **Zolpidem tartrate** (generic name for Ambien): 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

(Repeated Negligent Acts)

22. 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 Patients A, B, C, and D.[2] The circumstances are as follows:

23. Respondent is a physician and surgeon, board certified in internal medicine, who at all times relevant to the charges brought herein worked under the Plumas District Hospital – Rural Health Center in Quincy, California.

Patient A

24. Patient A is a 56-year old male who first sought treatment from Respondent in 1996. Patient A continued to see Respondent as a primary care physician and for regular and ongoing pain management. Patient A's diagnoses included: lumbosacral spondylosis with radiculopathy of L5 and S1 nerve roots, spinal stenosis at L4-5 lateral recess stenosis L4-5, right foot crush injury, degenerative joint disease, other chronic pain and major depressive disorder, recurrent, moderate. Patient A had a history of multiple back surgeries.

25. Available patient records indicate that Respondent treated Patient A for pain management from at least 2012 through 2018. Throughout this time, Respondent prescribed very high dosages of opioids in combination with sedatives. Respondent would typically see Patient A every one to three months for medication refills.

26. For example, on or around January 7, 2016, Respondent saw Patient A for a chief complaint of "med refill." The examination states, "No change in chronic low back or neck pain. No long track signs." The assessment states, "Other chronic pain, and Major depressive disorder, recurrent, moderate." Respondent documented the current medications as: diphenhydramine 50 mg daily; sertraline 50 mg daily; gemfibrozil 600 mg twice a day; Oxycontin 60 mg every 8 hours; Endocet 5/325 mg every 6 hours; and lorazepam 2 mg daily. The daily morphine

///

///

[2] Patient names are redacted to protect privacy.

milligram equivalent (MME) for these prescriptions was 300 mg.[3] Respondent refilled the prescriptions for Oxycontin and Endocet.

27. Similarly, on or around June 4, 2018, Respondent saw Patient A for a chief complaint of "med refill." The current medications documented by Respondent included Endocet 5/325 mg twice a day; Oxycontin 40 mg every 8 hours, lorazepam 1 mg twice a day, cyclobenzaprine 10 mg 3 times a day. The MME for these prescriptions was 195 mg. Respondent refilled Patient A's prescriptions.

28. From on or about March 5, 2013, through November 25, 2013, Respondent saw Patient A approximately 9 times for pain management or "med refills." For the 2013 calendar year, Respondent wrote Patient A: 11 prescriptions for Oxycontin 60 mg for a total of 990 tablets; 11 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 1,320 tablets; and 11 prescriptions for lorazepam 2 mg for a total of 990 tablets.

29. From on or about January 6, 2014, through December 8, 2014, Respondent saw Patient A approximately 10 times for pain management or "med refills." For the 2014 calendar year, Respondent wrote Patient A: 10 prescriptions for Oxycontin 60 mg for a total of 900 tablets; 10 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 1,110 tablets; and 12 prescriptions for lorazepam 2 mg for a total of 1,020 tablets.

30. From on or about January 6, 2015, through December 10, 2015, Respondent saw Patient A approximately 12 times for pain management or "med refills." For the 2015 calendar year, Respondent wrote Patient A: 14 prescriptions for Oxycontin 60 mg for a total of 1,179 tablets; 1 prescription for 18 tablets of Oxycontin 30 mg; 13 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 960 tablets; and 12 prescriptions for lorazepam 2 mg for a total of 630 tablets.

31. From on or about January 7, 2016, through October 17, 2016, Respondent saw Patient A approximately 9 times for pain management or "med refills." For the 2016 calendar year,

[3] The Centers for Disease Control and Prevention (CDC) recommends that clinicians avoid increasing prescribed opiates beyond 90 MME per day. Doses above 50 MME per day confer an increased risk of overdose of at least twice that of a dose less than 20 MME per day. The CDC states that higher dosages have not been shown to reduce pain over the long-term and that higher opioid dosages place the patient at higher risk of overdose death.

Respondent wrote Patient A: 13 prescriptions for Oxycontin 60 mg for a total of 1,177 tablets; 13 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 810 tablets; 7 prescriptions for lorazepam 2 mg for a total of 260 tablets; and 6 prescriptions for lorazepam 1 mg for a total of 360 tablets. During this time, he would often meet with Patient A and give him prescriptions for sequential months.

32. From on or about January 11, 2017, through October 2, 2017, Respondent saw Patient A approximately 4 times for pain management or "med refills." For the 2017 calendar year, Respondent wrote Patient A: 12 prescriptions for Oxycontin 60 mg for a total of 1,113 tablets; 12 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 720 tablets; and 12 prescriptions for lorazepam 1 mg for a total of 720 tablets. During this time, he would meet with Patient A quarterly and give him prescriptions for three sequential months.

33. From on or about January 17, 2018, through June 4, 2018, Respondent saw Patient A approximately 3 times for pain management or "med refills." For the first five months of 2018, Respondent wrote Patient A: 5 prescriptions for Oxycontin 40 mg for a total of 413 tablets; 5 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 240 tablets; and 5 prescriptions for lorazepam 1 mg for a total of 300 tablets. During this time, he would meet with Patient A and give him prescriptions for sequential months.

34. Throughout the relevant period, Respondent's visit summaries for Patient A indicate that he would consume 1-2 alcoholic drinks per day. Indeed, on or around March 12, 2018, in response to an Annual Drug and Alcohol (SBIRT) and Depression Screening, Patient A stated that he would drink daily. When asked how many times in the past year he had 5 or more drinks in one day, Patient A checked the box for "1 or more." When asked how many times in the past year he had used a recreational drug or used a prescription medication for nonmedical reasons, Patient A checked the box for "1 or more." The questionnaire did not provide a box for greater frequency of alcohol or drug use.

35. In addition, Respondent rarely ordered toxicology screens for Patient A. It appears that Respondent ordered only one toxicology screen for Patient A from 2012 to 2018, which showed a positive result for alcohol.

36. Despite Respondent's regular drinking habits—which are chronicled in the visit summaries, drug and alcohol survey, and toxicology screen—Respondent did not document any discussions with Patient A regarding the risk of drinking alcohol while taking controlled substances. Further, during an interview with Board investigators on April 11, 2019, Respondent admitted that he did not assess Patient A (or his patients generally) for addiction risk.

37. During the relevant time, Respondent did not have a signed pain management contract with Patient A. This was apparently brought to Respondent's attention—who noted it in an April 30, 2015 visit summary—but it appears that Respondent and Patient A did not execute an agreement until January 2019, well after the Board began investigating and collecting documents from Respondent.

38. During Respondent's care and treatment of Patient A, he failed to refer Patient A to a pain management specialist. Respondent also failed to discuss the health and overdose risks of taking high-dose opioids in combination with a benzodiazepine.

39. Respondent's care and treatment of Patient A departed from the standard of care in that:

A. Respondent prescribed very high dosages of opioids—that far exceeded the 90 MME threshold recommended by the CDC—in combination with a benzodiazepine;

B. Respondent failed to perform periodic urine toxicology screens during chronic opioid therapy;

C. Respondent failed to check the CURES database;

D. Respondent failed to have a pain management agreement in place with Patient A; and

E. Respondent failed to create a long-term pain management plan and/or evaluate the value of continuing high-dose opioids for Patient A.

Patient B

40. Patient B is a deceased male who first sought treatment from Respondent on or about January 18, 2012, when Patient B was 61 years old. Respondent treated Patient B from 2012 to 2016. Patient B's diagnoses included: cervical spinal stenosis, kyphosis, depression, cervical spondylosis and myelopathy, and chronic pain syndrome.

41. During their first visit in January 2012, Patient B reported to Respondent that his then-current pain medications included only 5 tablets per day of Norco (hydrocodone bitartrate with acetaminophen) 7.5 mg – 750 mg. Over the next several months and years, Respondent (and a physician assistant under his supervision) drastically increased the amount of opioids prescribed to Patient B. Respondent made (or allowed) these changes typically without any documented rationale. Respondent also added alprazolam, a benzodiazepine, to Patient B's prescriptions. By August 2013, Respondent was prescribing a monthly regimen that included: 135 tablets of oxycodone hcl-acetaminophen 325 mg – 5 mg; 90 tablets of morphine sulfate 60 mg; and 90 tablets of alprazolam 0.5 mg.

42. Respondent continued to treat Patient B for pain management through July 2016, a few weeks prior to Patient B's death. Throughout this time, Respondent prescribed very high dosages of opioids in combination with sedatives such as benzodiazepines. Although there were periods when midlevel's under Respondent's supervision would see Patient B, Respondent would typically see Patient B every one to four months for medication refills.

43. For example, on or around September 9, 2014, Respondent saw Patient B at the Plumas District Hospital as an outpatient for a chief complaint of "med refill." Patient B's pain index was 8. Respondent documented the current medications as: gabapentin 3 mg 3 times a day; alprazolam 0.5 mg 4 times a day; diazepam 10 mg twice a day; and oxycodone 30 mg every 4 hours. Respondent noted that Patient B "returns after 2 weeks. He is getting pain coverage with the oxycodone 30 mg taking up to 8 tablets daily with permission to take 2 at a time at times. This totals 112 tablets for 2 weeks. He had significant depressive symptoms last visit despite sertraline 50 mg daily for a few months. We have increased him to 100 mg. He does not feel any clear difference." The visit summary also states that Patient B "drinks wine" and "reports regular alcohol use." The assessment/plan was "depression and chronic pain syndrome." Respondent renewed the oxycodone prescription for 112 tablets of the 30 mg dosage.

44. Following the meeting on September 9, 2014, described above, Respondent continued to see Patient B regularly for pain management over the next few months. On or around March 24, 2015, however, Patient B went to Dr. J.S., a doctor of osteopathic medicine in the same

hospital as Respondent, for pain management while Respondent was away. Dr. J.S. expressed great concern in his visit summary about the medication regimen that Patient B had been receiving from Respondent. In particular, Dr. J.S. noted, "I am concerned about [Patient B's] cognition. His thinking is slow perseverative and basically focused on getting a higher dose of medication. . . . His speech pattern suggests either hypothyroidism or benzo effect to me, the latter being more likely." For the plan, Dr. J.S. wrote:

> "#1 chronic pain secondary to stenosis and severe scoliosis. No focal neurologic deficits. Patient is on 500-600 morphine equivalence in a 24-hour period. Discussed for 45 minutes to an hour his need to reduce his morphine equivalence do [sic] his risk for respiratory suppression. Patient is also on benzodiazepine which increases that risk even more. Patient likely does have chronic pain and will need to visit multifactorial treatment plan that would include a lessening his opiates. Likely a component of hyper aesthesias secondary to opiate use. At this time I will decrease his opiates by 20% every month."

45. On or around April 8, 2015, Dr. J.S. saw Patient B for a second time. He noted that in the previous month Patient B took 4 tablets per day of morphine sulfate 100 mg and two tablets per day of Dilaudid 4 mg. For the treatment plan, Dr. J.S. stated, "Today's reduction will be no Dilaudid. We'll refill morphine with plans to decrease by 20% next month." Dr. J.S. further noted that Patient B was "resistant to the plan" and that there was "some confusion on [the] last plan." Specifically, Patient B "thought he was to continue taking his current dose of medication after explaining to him for an hour and a half our plan for reduction. Will start his withdrawal plan today with a 20% reduction every month to every 2 months to help with severe withdrawals given his age."

46. On or around May 5, 2015, Patient B returned to Respondent with a chief complaint of "med refills." Respondent noted that Patient B "[r]eturns after a month he saw Dr. [J.S.] for several visits" and that "his Dilaudid was stopped so he has been taking a great deal of ibuprofen and having a lot of pain. Mention was made of a referral to a pain specialist but he hasn't heard anything." Respondent renewed the prescription for Dilaudid (hydromorphone hcl)—which Dr. J.S. had discontinued—without stating the rationale. Respondent also refilled Patient B's prescriptions for alprazolam and morphine sulfate. Respondent did not reduce the amount or dosage of morphine sulfate, despite Dr. J.S.'s written plan to do so.

47. On or around May 18, 2015, Patient B's ex-fiancé spoke to hospital staff to inform Respondent that Patient B had been "drinking excessively and falling down as well." The hospital staff made the following note: "MD is made aware."[4]

48. On or around June 2, 2015, Respondent saw Patient B and again refilled the same prescription dosages and amounts for morphine sulfate, Dilaudid, and alprazolam. Respondent did not document a discussion concerning the report of excessive drinking and falling down. Nor did Respondent document a discussion regarding the use of alcohol with controlled substances. Respondent continued to see Patient B and provide similar prescriptions until approximately July 13, 2016.

49. From on or about April 11, 2013, through December 18, 2013, Respondent saw Patient B approximately 7 times for pain management or "med refills." For the 2013 calendar year, Respondent wrote Patient B: 8 prescriptions for hydrocodone bitartrate-acetaminophen 500 mg – 10 mg for a total of 960 tablets; 1 prescription for 120 tablets of hydrocodone bitartrate-acetaminophen 325 mg – 10 mg; 5 prescriptions for oxycodone hcl-acetaminophen 325 mg – 10 mg for a total of 780 tablets; 1 prescription for 135 tablets of oxycodone hcl-acetaminophen 325 mg – 5 mg; 2 prescriptions for morphine sulfate 60 mg for a total of 180 tablets; 1 prescription for 90 tablets of morphine sulfate 100 mg; and 1 prescription for 186 tablets of methadone hcl 10 mg.

50. In addition, during the last 7 months of 2013, a physician assistant under Respondent's supervision also wrote Patient B: 4 prescriptions for morphine sulfate 100 mg for a total of 360 tablets; 1 prescription for 90 tablets of morphine sulfate 60 mg; 3 prescriptions for oxycodone hcl-acetaminophen 325 mg – 10 mg for a total of 420 tablets; 2 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 135 tablets; 1 prescription for 42 tablets of methadone hcl 10 mg; 1 prescription for 90 tablets of alprazolam 0.5 mg; and 1 prescription for 60 tablets of alprazolam 0.25 mg.

51. From on or about January 14, 2014, through December 15, 2014, Respondent saw Patient B approximately 12 times for pain management or "med refills." For the 2014 calendar year, Respondent wrote Patient B: 15 prescriptions for oxycodone hcl 30 mg for a total of 1,538

[4] Patient B's fiancé raised similar concerns in 2013.

tablets; 9 prescriptions for alprazolam 0.5 mg for a total of 990 tablets; 8 prescriptions for diazepam 10 mg for a total of 484 tablets; 1 prescription for 248 tablets of methadone hcl; 1 prescription for 180 tablets of hydrocodone bitartrate-acetaminophen 325 mg – 10 mg; and 1 prescription for 60 tablets of morphine sulfate 100 mg.

52. In addition, during the 2014 calendar year, a physician assistant under Respondent's supervision also wrote Patient B: 6 prescriptions for oxycodone hcl 15 mg for a total of 624 tablets; 3 prescriptions for oxycodone hcl 30 mg for a total of 280 tablets; 2 prescriptions for alprazolam 0.5 mg for a total of 240 tablets; 2 prescriptions for diazepam 10 mg for a total of 120 tablets; and 1 prescription for 10 fentanyl patches 75 mcg/hour.

53. From on or about January 13, 2015, through October 20, 2015, Respondent saw Patient B approximately 7 times for pain management or "med refills." For the 2015 calendar year, Respondent wrote Patient B: 11 prescriptions for hydromorphone hcl 4 mg for a total of 1,290 tablets; 9 prescriptions for morphine sulfate 100 mg for a total of 990 tablets; 9 prescriptions for alprazolam 0.5 mg for a total of 1,080 tablets; and 1 prescription for 90 tablets of oxycodone hcl 30 mg.

54. From on or about January 7, 2016, through July 13, 2016, Respondent saw Patient B approximately 3 times for pain management or "med refills." During that time, Respondent wrote Patient B: 7 prescriptions for hydromorphone hcl 4 mg for a total of 1,050 tablets; 7 prescriptions for morphine sulfate 100 mg for a total of 840 tablets; and 7 prescriptions for alprazolam 0.5 mg for a total of 1,050 tablets.

55. During his treatment of Patient B, Respondent failed to refer him to a pain management specialist.

56. Respondent's care and treatment of Patient B departed from the standard of care in that:

A. Respondent prescribed very high dosages of opioids—that far exceeded the 90 MME threshold recommended by the CDC—in combination with benzodiazepines;

B. Respondent checked the CURES database only twice near the beginning of treating Patient B for 3-4 years;

C. Respondent failed to discuss the overdose risks of taking high-dose opioids in combination with large amounts of sedatives and steady alcohol use;

D. Respondent failed to discuss the risks of addiction associated with taking high-dose opioids in combination with sedatives;

E. Respondent failed to have a pain management agreement in place with Patient B; and

F. Respondent failed to create a long-term pain management plan.

Patient C

57. Patient C is a 59-year old female who has received treatment from Respondent since at least 2003. Available patient records indicate that Respondent treated Patient C on a regular basis for pain management from at least 2015 through 2018, and intermittently for a few years before then. Her diagnoses included chronic pain syndrome, low back pain, insomnia, hepatitis C, recurrent deep vein thrombosis, and migraine headaches. Patient C had a history of failed back surgery that resulted in a CSF leak.

58. From at least 2015 through 2018, Respondent prescribed very high dosages of opioids in combination with sedatives to Patient C. Respondent would typically see Patient C every one to three months for medication refills.

59. For example, on or around March 7, 2016, Respondent saw Patient C for a medication refill. The "current medications" for opioid and sedative medications were documented as: promethazine 12.5 mg every 6 hours, Dilaudid 8 mg every 4 hours, morphine sulfate IR 30 mg 2 tablets every 4 hours, Soma 350 mg 3 times a day, zolpidem 10 mg 1 tablet each bedtime, and diazepam 10 mg twice a day. Respondent noted, "She is now almost 56. She is tolerating her current doses but we reviewed the fact that if she gets a few years older we will need to be reducing her dosing due to age effects. Medications have been effective in controlling pain in combination with other modalities. Treatment is enabling the patient to engage in activities of daily living that would otherwise be impossible. The patient's affect has not been changed by the medication."

60. The above prescription regimen has an MME of 550 mg daily. In addition, Respondent prescribed opioids (hydromorphone hcl and morphine sulfate) in combination with a

benzodiazepine (diazepam) and a muscle relaxant (Soma), which is a highly addictive and dangerous mix also called the "Holy Trinity."

61. Pharmacy records from a visit with Respondent in May 2018 show prescriptions for 30 tablets of diazepam 5 mg, 93 tablets of Dilaudid 8 mg, 90 tablets of Soma 350 mg, 333 tablets of morphine sulfate 30 mg immediate release. This combination again fits the "Holy Trinity" label. Respondent prescribed similar regimens dating back to at least 2015.

62. From on or about February 26, 2015, through December 14, 2015, Respondent saw Patient C approximately 5 times for pain management or "med refills." For the 2015 calendar year, Respondent wrote Patient C: 19 prescriptions for morphine sulfate 30 mg for a total of 3,360 tablets; 10 prescriptions for Dilaudid 8 mg for a total of 915 tablets; 10 prescriptions for diazepam 10 mg for a total of 690 tablets; 9 prescriptions for carisoprodol 350 mg for a total of 810 tablets; and 7 prescriptions for zolpidem tartrate 10 mg for a total of 210 tablets.

63. From on or about March 7, 2016, through October 25, 2016, Respondent saw Patient C approximately 7 times for pain management or "med refills." For the 2016 calendar year, Respondent wrote Patient C: 20 prescriptions for morphine sulfate 30 mg for a total of 3,480 tablets; 11 prescriptions for carisoprodol 350 mg for a total of 990 tablets; 10 prescriptions for Dilaudid 8 mg for a total of 900 tablets; 5 prescriptions for zolpidem tartrate 10 mg for a total of 330 tablets; and 4 prescriptions for diazepam 10 mg for a total of 480 tablets.

64. From on or about January 16, 2017, through November 29, 2017, Respondent saw Patient C approximately 5 times for pain management or "med refills." For the 2017 calendar year, Respondent wrote Patient C: 24 prescriptions for morphine sulfate 30 mg for a total of 3,969 tablets; 12 prescriptions for carisoprodol 350 mg for a total of 1,080 tablets; 7 prescriptions for hydromorphone hcl 8 mg for a total of 639 tablets; 5 prescriptions for Dilaudid 8 mg for a total of 450 tablets; 3 prescriptions for zolpidem tartrate 10 mg for a total of 270 tablets; and 3 prescriptions for diazepam 5 mg for a total of 390 tablets.

65. From on or about February 7, 2018, through July 9, 2018, Respondent saw Patient C approximately 4 times for pain management or "med refills." For the first 5 months of 2018, Respondent wrote Patient C: 8 prescriptions for morphine sulfate 30 mg for a total of 1,572

tablets; 6 prescriptions for hydromorphone hcl 8 mg for a total of 558 tablets; 5 prescriptions for carisoprodol 350 mg for a total of 450 tablets; 5 prescriptions for diazepam 5 mg for a total of 150 tablets; 3 prescriptions for Belsomra 10 mg for a total of 90 tablets; and 2 prescriptions for zolpidem tartrate 10 mg for a total of 180 tablets.

66. From 2015 to 2018, Respondent did not order any toxicology screens. An earlier toxicology screen from November 2014 was positive for methadone, which was inconsistent with Patient C's prescriptions.

67. Patient C signed one pain management contract in April 2015.

68. During Respondent's care and treatment of Patient C, he failed to refer Patient C to a pain management specialist.

69. Respondent's care and treatment of Patient C departed from the standard of care in that:

A. Respondent prescribed very high dosages of opioids—that far exceeded the 90 MME threshold recommended by the CDC—in combination with a benzodiazepine and a muscle relaxant;

B. Respondent failed to perform periodic urine toxicology screens during chronic opioid therapy;

C. Respondent failed to check the CURES database; and

D. Respondent failed to discuss the overdose risks of taking high-dose opioids in combination with large amounts of sedatives.

Patient D

70. Patient D is a 64-year old female who began seeing Respondent for treatment in or around 1995. Patient D's diagnoses included chronic pain syndrome (apparently due to low back pain) and COPD. She had a history of spinal stenosis and degenerative disc disease.

71. Available patient records indicate that Respondent treated Patient D for pain management since at least 2004. Respondent saw Patient D intermittently from 2013 to 2015, and regularly from 2016 through at least 2018. Throughout this time, Respondent prescribed very

high dosages of opioids in combination with sedatives to Patient D. From 2016-2018, Respondent would typically see Patient D every one to three months for medication refills.

72. For example, on or around February 21, 2017, Respondent saw Patient D for a medication refill. The "current medications" for opioid and sedative medications were documented as: cyclobenzaprine 10 mg 3 times a day; diazepam 5 mg twice a day; Endocet 5/325 mg every 6 hours; and morphine sulfate ER 60 mg every 8 hours. Respondent noted that Patient D's "[p]ain control was fair to good on current medications" and that she "had a fall last night while getting up during the night, falling onto her back." Respondent refilled Patient D's opiate prescriptions and changed her prescription for cyclobenzaprine to Soma, another muscle relaxant.

73. The above prescription regimen far exceeds the daily MME thresholds recommended by the CDC. In addition, Respondent prescribed opioids (Endocet and morphine sulfate) in combination with a benzodiazepine (diazepam) and a muscle relaxant (Soma), which is a highly addictive and dangerous mix also called the "Holy Trinity."[5] Respondent prescribed similar drugs and dosages during his ongoing treatment of Patient D.

74. From on or about July 7, 2013, through October 10, 2013, Respondent saw Patient D approximately 3 times for pain management or "med refills." For the 2013 calendar year, Respondent wrote Patient D: 5 prescriptions for diazepam 5 mg for a total of 450 tablets; 4 prescriptions for carisoprodol 350 mg for a total of 480 tablets; 3 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 450 tablets; 2 prescriptions for morphine sulfate 100 mg for a total of 180 tablets; and 1 prescription for 90 tablets of morphine sulfate 60 mg.

75. From on or about January 6, 2014, through October 20, 2014, Respondent saw Patient D approximately 6 times for pain management or "med refills." For the 2014 calendar year, Respondent wrote Patient D: 5 prescriptions for diazepam 5 mg for a total of 426 tablets; 4 prescriptions for morphine sulfate 100 mg for a total of 360 tablets; 4 prescriptions for oxycodone

[5] Indeed, in or around July 2018, the local Sheriff's Department brought Patient D to the emergency room "for very irregular behavior"—running around in her front yard naked—and the attending physician wrote: "I wonder if her combination of Soma, benzodiazepines, and morphine may have possibly resulted in her altered mental status yesterday as well."

hcl-acetaminophen 325 mg – 5 mg for a total of 480 tablets; 4 prescriptions for eszopiclone 3 mg for a total of 120 tablets; and 1 prescription for 30 tablets of oxycodone hcl 10 mg.

76. From on or about October 8, 2015, through November 9, 2015, Respondent saw Patient D approximately 2 times for pain management or "med refills." For the 2015 calendar year, Respondent wrote Patient D: 3 prescriptions for diazepam 5 mg for a total of 180 tablets; 3 prescriptions for morphine sulfate 60 mg for a total of 270 tablets; 3 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 240 tablets; and 3 prescriptions for eszopiclone 2 mg for a total of 90 tablets.

77. From on or about January 7, 2016, through December 14, 2016, Respondent saw Patient D approximately 7 times for pain management or "med refills." For the 2016 calendar year, Respondent wrote Patient D: 13 prescriptions for morphine sulfate 60 mg for a total of 1,170 tablets; 13 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 1,170 tablets; 9 prescriptions for diazepam 5 mg for a total of 540 tablets; and 6 prescriptions for eszopiclone 2 mg for a total of 180 tablets.

78. From on or about February 27, 2017, through October 25, 2017, Respondent saw Patient D approximately 4 times for pain management or "med refills." For the 2017 calendar year, Respondent wrote Patient D: 12 prescriptions for morphine sulfate 60 mg for a total of 1,080 tablets; 12 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 1,080 tablets; 12 prescriptions for diazepam 5 mg for a total of 705 tablets; 10 prescriptions for carisoprodol 350 mg for a total of 900 tablets; and 1 prescription for 45 tablets of hydrocodone bitartrate-acetaminophen 325 mg – 10 mg.

79. From on or about January 24, 2018, through July 9, 2018, Respondent saw Patient D approximately 4 times for pain management or "med refills." For the first 5 months of the 2018 calendar year, Respondent wrote Patient D: 5 prescriptions for morphine sulfate 60 mg for a total of 450 tablets; 5 prescriptions for diazepam 5 mg for a total of 225 tablets; 5 prescriptions for carisoprodol 350 mg for a total of 450 tablets; 4 prescriptions for oxycodone hcl-acetaminophen 325 mg – 5 mg for a total of 360 tablets; and 2 prescriptions for oxycodone hcl-acetaminophen 325 mg – 7.5 mg for a total of 360 tablets.

80. In or around May 2010, a urine toxicology screen was positive for opiates as well as methamphetamine. Respondent did not document a discussion concerning the use of illicit drugs while he was prescribing opiates and sedatives.

81. Patient D frequently reported running out of her prescriptions early. For example, during an April 2018 office visit to Respondent, Patient D requested—and Respondent provided—a higher dose of Percocet 10 days prior to her refill date. Similarly, in or around May 2016, Patient D called hospital staff to inform them (and Respondent) that she was out of her medications and going through withdrawals. Respondent also noted during office visits in April 2011, August 2012, and April 2014 that Patient D had gone through her medications early. During that April 2014 visit, Respondent further noted that Patient D's speech was "slurred and somewhat obtunded" and that he had "to keep reminding her to speak up a little and enunciate."

82. Respondent checked the CURES database only twice during his ongoing treatment of Patient D.

83. During Respondent's care and treatment of Patient D, he failed to refer Patient D to a pain management specialist.

84. Respondent's care and treatment of Patient D departed from the standard of care in that:

A. Respondent prescribed very high dosages of opioids—that far exceeded the 90 MME threshold recommended by the CDC—in combination with a benzodiazepine and a muscle relaxant;

B. Respondent rarely checked the CURES database; and

C. Respondent failed to discuss the overdose risks of taking high-dose opioids in combination with large amounts of sedatives, even though Patient D was particularly at risk as a patient with COPD.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

85. Respondent is further 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 Patients A, B, C, and D, as more particularly alleged in paragraphs 24 through 84, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

86. Respondent is further subject to disciplinary action under Code sections 2227 and 2234, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 24 through 85, above, which 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 No. G 15724, issued to Lawrence A. Price, M.D.;

2. Revoking, suspending or denying approval of Lawrence A. Price, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Lawrence A. Price, 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: APR 21 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SA2019103949
33951847.docx