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

In the Matter of the Accusation Against: Kevin E. Rine, M.D. Physician's and Surgeon's Certificate No. G 57924 Respondent.	Case No.: 800-2019-054598

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 April 6, 2022.

IT IS SO ORDERED: March 7, 2022.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
MICHAEL C. BRUMMEL
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KEVIN E. RINE, M.D.** **Golden Valley Health Center** **1500 Florida Ave.** **Modesto, CA 95350-4408** **Physician's and Surgeon's Certificate No. G 57924** Respondent.	Case No. 800-2019-054598 OAH No. 2021110438 **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 Rob Bonta, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

2. Respondent Kevin E. Rine, M.D. (Respondent) is represented in this proceeding by attorney Kat Todd, whose address is: 400 University Avenue, Sacramento, CA 95825-6502.

3. On or about July 21, 1986, the Board issued Physician's and Surgeon's Certificate No. G 57924 to Kevin E. Rine, 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. 800-2019-054598, and will expire on August 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-054598 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 September 28, 2021. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-054598 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. 800-2019-054598. 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. 800-2019-054598, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at an administrative hearing, complainant could establish a prima facie case or factual basis with respect to the charges and allegations in Accusation No. 800-2019-054598, a true and correct copy of which is attached hereto as Exhibit A, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2019-054598 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

14. 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.

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15. 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 57924 issued to Respondent Kevin E. Rine, M.D. is revoked. However, the revocations are stayed and Respondent is placed on probation for thirty-five months (35) months on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the

Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall

provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

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

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court

ordered criminal probation, payments, and other orders.

8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of

departure and return.

10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws;

General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

16. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-054598 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Kat Todd. 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: 12/29/2021

KEVIN E. RINE, M.D.
Respondent

I have read and fully discussed with Respondent Kevin E. Rine, 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: 12/30/2021

KAT TODD
Attorney for Respondent

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ENDORSEMENT

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

DATED: December 30, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2019-054598

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

In the Matter of the Accusation Against: **KEVIN E. RINE, M.D.** **Golden Valley Health Center** **1500 Florida Ave.** **Modesto, CA 95350-4408** **Physician's and Surgeon's Certificate No. G 57924,** Respondent.	Case No. 800-2019-054598 **ACCUSATION**

PARTIES

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

2. On or about July 21, 1986, the Medical Board issued Physician's and Surgeon's Certificate No. G 57924 to Kevin E. Rine, 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 August 31, 2023, 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 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

5. 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.

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DEFINITIONS

6. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

7. Alprazolam (Xanax®) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Xanax has the potential for abuse. Xanax 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.

8. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam, and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

9. Codeine phosphate/guaifenesin is a narcotic cough suppressant. It affects the signals in the brain that trigger cough reflex. Guaifenesin is an expectorant. It helps loosen congestion in the chest and throat making it easier to cough out through the mouth. Codeine and guaifenesin is a combination medicine used to treat cough and chest congestion cause by allergies, the common

cold, or the flu. Codeine/guaifenesin is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

10. Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

11. Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCPs) to Schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

12. Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.

Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonopin®, as drugs of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

13. "MME" is an abbreviation for the Morphine Milligram Equivalents used to evaluate the levels of opioids prescribed to a patient. The Centers for Disease Control recommends avoiding or carefully justifying any dosage greater than 90 MME/day.

14. MS Contin® (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The DEA has identified oxycodone as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The FDA has issued a black box warning for MS Contin® which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin® with benzodiazepines or other central nervous system (CNS) depressants.

15. Oxycodone (Oxaydo®, OxyCONTIN®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. When properly prescribed and indicated, oxycodone is used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate. Respiratory depression is the chief hazard from all opioid agonist preparations. The risk of respiratory depression and overdose is increased with the

concomitant use of benzodiazepines or when prescribed to patients with pre-existing respiratory depression. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. The DEA has identified oxycodone as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.)

16. Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, phentermine HCL is used as a short-term adjunct in a regiment of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

17. Soma®, a brand name for carisoprodol, is a muscle relaxant with a known potentiating effect on narcotics. It is a muscle relaxer that works by blocking pain sensations between the nerves and the brain. In December 2011, the FDA listed carisoprodol as a Schedule IV controlled substance (76 Fed.Reg. 77330 (Dec. 12, 2011).) Soma is also a dangerous drug pursuant to Business and Professions Code section 4022.

18. Suboxone® (buprenorphine and naloxone) is an opioid medication. The naloxone blocks the effect of the opioid medication, including pain relief or feelings of well-being, that can lead to opioid abuse. Suboxone is used to treat narcotic/opiate addition, and is not for use as a pain medication. Suboxone is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Tramadol (Ultram®) is a narcotic-like pain reliever used to treat severe pain. Tramadol has the potential for abuse. Tramadol 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.

FACTUAL ALLEGATIONS

Patient A[1]

20. On or about February 29, 2016, Patient A presented to Respondent for a total vaginal hysterectomy. In the subsequent weeks, Patient A checked in with Respondent's office, experiencing some vaginal pain, but was recovering from her surgery.

21. On or about March 7, 2016, Patient A presented to Respondent for follow-up one week after her vaginal hysterectomy. In the medical record, Respondent wrote "patient complains of nothing" and continued her prescriptions for Norco and Xanax.

22. On or about March 15, 2016, Patient A emailed Respondent and asked for a prescription of Norco.

23. On or about March 17, 2016, Patient A presented to Respondent for a postoperative visit complaining of vaginal pain that was improving, but still a concern for Patient A. Patient A stated that the pain was improving at the time of the visit. Respondent noted that the pain was "a little more pan than expected at this point," and planned to conduct an ultrasound to rule out a hematoma.

24. On or about March 31, 2016, Patient A emailed Respondent complaining of significant pain in her right side that was radiating down to her thigh/low pelvic area, causing continuous pain. Respondent explained that it was unclear why she was experiencing this level of discomfort and asked Patient A if she had a history of back problems before surgery. Respondent explained that the ultrasound was normal and that he would order an MRI of her lower back and pelvis.

25. On or about April 1, 2016, Respondent ordered an MRI to rule out the possibility of masses or disc problems.

26. On or about April 6, 2016, Patient A presented for a follow-up appointment related to her side pain. Patient A continued to complain of right-sided pain and reported that she needed Norco daily. Respondent noted that there was "no apparent cause for the postop pain" she was experiencing. Patient A's MRI did not reveal any positive findings related to her pain complaint.

[1] To protect the privacy of the patients, names are not identified in this Accusation.

Despite the absence of a known cause for her pain, Respondent noted that Patient A needed the Norco daily and continued to prescribe Norco to Patient A.

27. On or about April 22, 2016, Patient A presented to Respondent continuing to complain of right-sided pain. Respondent documented what he described as a "fairly benign" examination and planned a laparoscopy for Patient A related to lyses of adhesions, including a possible right oophorectomy.

28. On or about April 23, 2016, Patient A contacted Respondent requesting a renewal of her Norco.

29. On or about May 5, 2016, Patient A contacted Respondent by email complaining of increasing pain on her right side. Patient A complained that the pain was keeping her up at night and asked for additional pain medication to help her until her scheduled surgery.

30. On or about May 11, 2016, Patient A presented for a preoperative appointment for her upcoming laparoscopy procedure. Respondent continued to concomitantly prescribe Percocet, Norco, and Xanax to Patient A.

31. On or about May 12, 2016, Patient A requested a refill of her hydrocodone by email.

32. On or about May 13, 2016, Respondent performed a laparoscopy. Respondent removed multiple adhesions from Patient A and prescribed her pain medications post-surgery.

33. On or about May 23, 2016, Patient A presented to Respondent one-week post-laparoscopy. Respondent noted that Patient A was pain free and had no complaints. Patient A emailed Respondent prior to the appointment stating that she no longer needed a refill of her Percocet, and would just take the Norco. Respondent's office informed her that she could pick up the Norco prescription up at the front desk.

34. On or about May 25, 2016, Respondent documented referring Patient A to a pain specialist, but Patient A never met with the specialist.

35. On or about June 6, 2016, Patient A requested a refill of the prescription for Percocet.

36. On or about June 7, 2016, Patient A emailed Respondent requesting a refill of her prescription for Percocet.

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37. On or about June 22, 2016, Patient A requested refills of her pain medication. Respondent's office informed her that the refill was approved, but that Respondent had made an urgent request for a pain specialist to consult with her.

38. On or about June 28, 2016, Patient A requested a refill of her Percocet pending her consultation with pain management. Respondent approved the refill the following day.

39. On or about October 10, 2016, Respondent told Patient A that he would be unable to fill any additional pain medications.

40. On or about October 12, 2016, Respondent refused to refill any of Patient A's pain medications.

41. During the period of on or about January 6, 2016 through December 31, 2016, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/6/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	40	7	E.R.
1/20/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	40	3	E.R.
1/20/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
1/28/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	30	B.E., M.D.
2/12/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	40	3	Respondent
2/19/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
2/21/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	40	10	Respondent
3/1/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	40	6	Respondent
3/10/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	20	3	Respondent
3/17/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	30	7	Respondent
3/17/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
3/17/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
3/28/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	30	7	Respondent
3/28/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
4/4/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
4/8/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
4/17/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
4/18/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
4/25/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
5/2/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	P.D., M.D.
5/6/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	40	6	Respondent
5/13/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	40	6	Respondent
5/16/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	40	6	Respondent
5/19/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
5/23/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
5/26/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
6/2/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	8	Respondent
6/8/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
6/13/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
6/21/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
6/22/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
6/29/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
6/30/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
7/12/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
7/20/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
7/20/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
7/26/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	B.E., M.D.
7/29/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
8/3/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	10	Respondent
8/8/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
8/17/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
8/24/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
8/29/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
9/7/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
9/12/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
9/14/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
9/20/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
9/29/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-5 MG	30	5	Respondent
10/11/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
11/10/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	A.I., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
11/23/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	30	7	Respondent
12/2/2016	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
12/5/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	30	J.B., M.D.
12/9/2016	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
12/12/2016	ALPRAZOLAM	TAB	0.5 MG	60	30	S.A.
12/23/2016	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
12/31/2016	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.

42. On or about May 25, 2017, Patient A returned to Respondent for a routine wellness examination. Respondent documented that Patient A was referred, but never actually consulted with a pain management specialist.

43. During the period of on or about January 1, 2017 through December 20, 2017, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/1/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	30	J.B., M.D.
1/11/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
1/15/2017	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
1/24/2017	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
2/2/2017	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
2/8/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
2/18/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	30	J.B., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
2/20/2017	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
3/11/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
3/15/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	22	Respondent
4/12/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	22	Respondent
4/25/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
4/29/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	22	Respondent
5/25/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	30	Respondent
5/25/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
6/19/2017	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	30	5	J.B., M.D.
6/26/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	90	22	C.D., D.O.
6/29/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
7/26/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	C.D., D.O.
7/26/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	M.S., M.D.
8/24/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
8/24/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
9/20/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	A.I., M.D.
9/20/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	A.I., M.D.
10/13/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
10/13/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
11/7/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
11/7/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
12/1/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
12/14/2017	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
12/20/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.

44. During the period of on or about January 15, 2018 through December 3, 2018, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/15/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
2/1/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
3/1/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	M.S., M.D.
3/18/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
4/23/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
4/24/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
5/29/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	30	J.B., M.D.
5/29/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
7/8/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	30	J.B., M.D.
7/27/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
8/25/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	30	J.B., M.D.
9/12/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
10/12/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
10/23/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.
11/18/2018	BUTALBITAL ACETAMINOPHEN AND CAFFEINE			30	5	J.B., M.D.
12/3/2018	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
12/3/2018	ALPRAZOLAM	TAB	0.5 MG	60	30	J.B., M.D.

45. During the period of on or about January 6, 2019 through December 31, 2019, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/6/2019	ALPRAZOLAM	TAB	0.5 MG	60	29	J.B., M.D.
2/3/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
2/16/2019	ALPRAZOLAM	TAB	0.5 MG	60	29	J.B., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
3/10/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
3/28/2019	ALPRAZOLAM	TAB	0.5 MG	60	29	J.B., M.D.
4/28/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	J.B., M.D.
5/20/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
5/20/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
6/18/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
7/9/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
7/18/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
8/20/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
8/25/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
9/25/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
10/7/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
10/24/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
12/2/2019	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	30	S.H.
12/2/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
12/31/2019	ALPRAZOLAM	TAB	0.5 MG	60	30	S.A., M.D.

46. During the period of on or about January 9, 2020 through November 30, 2020, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/9/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
1/23/2020	OXYCODONE HCL	TAB	5 MG	10	2	P.D., M.D.
1/27/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
1/28/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
2/26/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
3/11/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	30	S.H.
4/2/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
5/1/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
5/3/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
6/16/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.H.
6/16/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.H.
7/21/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.A., M.D.
7/31/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	15	S.S.
8/24/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.S.
9/22/2020	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	CAP	300 MG-50 MG-40 MG	60	10	S.S.
10/1/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.S.
10/9/2020	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	10	1	S.S.
10/29/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.S.
11/30/2020	ALPRAZOLAM	TAB	0.5 MG	60	30	S.S.

47. During the period of on or about January 4, 2021 through June 7, 2021, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/4/2021	ALPRAZOLAM	TAB	0.5 MG	50	25	S.S.
2/8/2021	ALPRAZOLAM	TAB	0.5 MG	45	30	S.S.
3/10/2021	ACETAMINOPHEN, BUTALBITAL, AND CAFFEINE			60	10	S.S.
3/10/2021	ALPRAZOLAM	TAB	0.5 MG	45	22	S.S.
4/9/2021	ALPRAZOLAM	TAB	0.5 MG	30	30	S.S.
5/7/2021	ALPRAZOLAM	TAB	0.5 MG	30	30	S.S.
6/3/2021	ALPRAZOLAM	TAB	0.5 MG	10	10	S.S.
6/7/2021	ALPRAZOLAM	TAB	0.5 MG	30	30	S.S.

48. On or about April 8, 2021, Respondent was interviewed by the Board's investigator regarding the care provided to Patient A. Respondent stated that Patient A was a former patient, whom he treated for a laparoscopic bilateral tubal ligation in the past. Twelve years later, she returned, complaining of menorrhagia with pelvic pain. Respondent stated that she had an enlarged tender fibroid uterus, requiring a vaginal hysterectomy, which was confirmed as

adenomyosis. Respondent admitted that he never performed any urine toxicology screens on Patient A while prescribing her controlled substances. When asked why he was prescribing two different short-acting opiates, Respondent stated that Patient A agreed to take the hydrocodone and oxycodone on alternating days. Respondent stated that he was prescribing the lowest dose of controlled substances available to Patient A. He represented that he recommended NSAIDs, physical therapy, and weight management to Patient A following her laparoscopy.

Patient B

49. Patient B originally presented to Respondent in 2016 for prenatal care. Patient B was seen by Respondent for prenatal care, as well as by other providers at the same office. As outlined below, Patient B's treatment evolved from prenatal care to regular visits related to the prescribing of controlled substances to treat her pain. Patient B received treatment from M.Z., M.D. for mental health issues, and was regularly prescribed Clonazepam by that physician throughout the duration of Respondent's care of the patient.

50. On or about July 5, 2016, Patient B presented to Respondent for prenatal care. The record notes that Patient B was in her first trimester and she agreed to have lab work completed. The records for this visit contain an "Overview Addendum" from another physician, B.E., M.D., dated November 10, 2014. The note states that Patient B "[w]as taking Percocet, etc for her fibromyalgia for 3 years, Detoxed with Dr. [V.] and Suboxone. Also SJBH, third time in Utah. One month later, I received a call from [physician name redacted] in the East Bay that she was there, slurred speech, etc. He has been giving her pain pills, so she was informed through him that I will no longer prescribe medicines for her, he will prescribe." Another note contained in the record dated March 1, 2013, states that Patient B "Went through detox...after 3 years on narcotic meds—was on Suboxone and clonopin [*sic*]. Detoxed 2 more times. Was only on clonopin [*sic*], Cymbalta and Neurontin. Started back on oxycodone preparations in December 2012 by doctor in East Bay...Informed patient I will not be filling any narcotics or soma for her. Clonazepam use verified on CURES 11/10/14." Respondent did not document any review or consideration of this prior note at this visit, nor at any visit in the future. Despite Respondent's failure to

acknowledge these prior notes regarding Patient B's history of substance abuse, they were repeated approximately 200 times through Patient B's medical records.

51. On or about July 12, 2016, Patient B presented to Respondent for prenatal care with a history that included myocardial infarction, cardiac medication, mental illness, and three prior cesarean sections. Respondent directed Patient B to make an appointment with a cardiologist and to continue treatment for her mental health issues with M.Z., M.D. Respondent documented an increased risk for surgical complications and the possibility of placenta previa[2].

52. On or about October 11, 2016, Patient B telephoned Respondent's office to provide updates regarding her prior medical history and records from other providers. The records state that Patient B reported suffering two prior myocardial infarctions, in 1997 and 2003, during two prior deliveries.

53. On or about November 2, 2016, Patient B presented to Respondent for prenatal care following a recent diagnosis of placenta previa. Respondent provided Patient B education regarding the diagnosis of placenta previa.

54. During the period of on or about January 18, 2016 through December 23, 2016, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/18/2016	TRAMADOL HCL	TAB	50 MG	30	5	B.E., M.D.
2/3/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
3/4/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
4/4/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
4/27/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
5/12/2016	TRAMADOL HCL	TAB	50 MG	30	7	B.E., M.D.
5/20/2016	PHENTERMINE HCL	TAB	37.5 MG	30	30	B.E., M.D.
5/25/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
6/20/2016	PHENTERMINE HCL	TAB	37.5 MG	30	30	B.E., M.D.
6/23/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
7/25/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
8/23/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
9/21/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.

[2] Placenta previa is a condition in pregnant women where the placenta implants in the lower part of the uterus. The placenta either partially or completely covers the opening to the cervix. This is a problem because the baby must pass through the cervix during delivery.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
10/19/2016	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
12/23/2016	CLONAZEPAM	TAB	1 MG	93	31	M.Z., M.D.

55. On or about February 6, 2017, Patient B underwent a cesarean delivery due to placenta previa complications. Following her delivery, Patient B required a supra-cervical hysterectomy secondary to blood loss. During the surgery, a sponge was left in her abdominal cavity. Patient B also suffered a wound hematoma, developed a ventral wall hernia, and paraumbilical hernia.

56. March 16, 2017, Respondent prescribed Patient B #25 Oxycodone, a four-day supply.

57. March 20, 2017, Respondent prescribed Patient B #30 Oxycodone, a five-day supply.

58. On or about March 23, 2017, only three days later, Patient B telephoned Respondent to request additional Percocet. Respondent wrote that he "made a deal" with Patient B to make 120 Percocet "last for at least 20 days." Respondent prescribed Patient B #120 Oxycodone, a 20-day supply. Respondent continued to prescribe Patient B oxycodone on a regular basis.

59. On or about April 24, 2017, Patient B telephoned Respondent's office requesting that he provide a refill to her prescription for Percocet. The records state that Respondent was unable to fill the medication, as it was outside the scope of an obstetrician gynecologist. Respondent referred Patient B to her primary care physician for controlled substances. Patient B called again, persisting in her request for Percocet, and stating that the pain was due to her prior surgery.

60. On or about August 29, 2017, Patient B reported that her controlled substances were stolen, filed a police report, and requested 240 pills.

61. On or about September 15, 2017, Patient B telephoned Respondent's office requesting refills of her pain medications. Respondent was not available, and the on-call physician declined to refill her pain medications until Patient B could meet with Respondent. Patient B called again and was noted to be very upset that Respondent was out of town for two weeks and that she could not get more pain medicine. Patient B was told to contact her primary care physician or go to the emergency room if she needed treatment prior to Respondent's return to the office.

62. On or about October 5, 2017, Patient B presented complaining of back pain, head pain, crotch pain, and abdominal pain. Respondent ordered back x-rays, and consultations in neurology and pain management.

63. On or about October 11, 2017, Respondent's office called Patient B to tell her that there was "nothing found to explain her pain," in the recent x-rays and that she should obtain the neurology and pain management consultations.

64. On or about October 24, Patient B called Respondent's office requesting refills of her pain medications.

65. On or about October 25, 2017, Patient B telephoned Respondent's office again to request refills of her pain medications, stating that she was out of medication. The same day, Respondent prescribed Patient B #240 Oxycodone, a 20-day supply.

66. On or about November 1, 2017, Patient B telephoned Respondent's office again to request refills of her pain medications. Patient B stated that the prescription was not due until November 5, 2017, but she wanted to make sure there was no delay.

67. On or about December 1, 2017, Patient B contacted Respondent requesting a refill of her Oxycodone. Patient B stated that she was out of the medication and that if they didn't provide a refill she was going to the emergency room. Respondent provided Patient B an early refill of controlled substances and agreed to continue prescribing controlled substances pending her referral to pain management in January 2018.

68. On or about December 20, 2017, Patient B telephoned Respondent's office requesting additional pain medications prior to December 25, 2017. Patient B said that she would go through withdrawal if she did not receive the medication before December 24, 2017. Patient B was told that she would need to wait until Respondent returned on December 27, 2017. Respondent's office determined that Patient B had still not completed her pain management referral. Patient B called again on December 21, 22, and 26, 2017. On December 26th, she stated that she had a horrible Christmas weekend because she was out of the medication, was in pain and was going through withdrawal.

69. On or about December 27, 2017, Respondent wrote in the medical records that this was the "last time" he would write Patient B prescriptions for controlled substances.

70. During the period of on or about February 14, 2017 through December 27, 2017, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
2/14/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	72	6	P.S., M.D.
2/22/2017	CLONAZEPAM	TAB	1 MG	93	31	M.Z., M.D.
2/23/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	30	5	J.P., M.D.
2/28/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	15	4	D.T., M.D.
3/1/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	30	7	J.P., M.D.
3/6/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	40	6	J.P., M.D.
3/13/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	25	4	J.P., M.D.
3/16/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	25	4	Respondent
3/20/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	30	5	Respondent
3/24/2017	CLONAZEPAM	TAB	1 MG	93	31	M.Z., M.D.
3/24/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
4/10/2017	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
4/19/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
5/10/2017	ENDOCET	TAB	325 MG-10 MG	120	10	S.A.
5/10/2017	PHENTERMINE HCL	TAB	37.5 MG	30	30	S.A.
5/19/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
5/26/2017	ENDOCET	TAB	325 MG-10 MG	120	10	S.N., M.D.
6/12/2017	ENDOCET	TAB	325 MG-10 MG	120	10	S.A.
6/16/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
7/6/2017	PHENTERMINE HCL	TAB	37.5 MG	30	30	S.A.
7/10/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
7/10/2017	ENDOCET	TAB	325 MG-10 MG	120	10	S.A.
7/31/2017	ENDOCET	TAB	325 MG-10 MG	24	8	S.A.
8/4/2017	ENDOCET	TAB	325 MG-10 MG	120	10	S.A.
8/8/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
8/11/2017	PHENTERMINE HCL	TAB	37.5 MG	30	30	Respondent
8/13/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
8/29/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
8/31/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
9/18/2017	ENDOCET	TAB	325 MG-10 MG	240	20	S.A.
10/2/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
10/2/2017	PHENTERMINE HCL	TAB	37.5 MG	30	30	Respondent
10/5/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
10/25/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
10/30/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
11/15/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
11/26/2017	CLONAZEPAM	TAB	1 MG	9	3	B.W., M.D.
11/29/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
12/1/2017	PHENTERMINE HCL	TAB	37.5 MG	30	30	Respondent
12/5/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent
12/27/2017	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
12/27/2017	ENDOCET	TAB	325 MG-10 MG	240	20	Respondent

71. On or about January 10, 2018, Patient B called Respondent's office and stated that she would be late for her appointment due to an accident. Patient B presented to Respondent for pain medications after receiving a notice that her prior physician would no longer see her, and complaining of anxiety and depression. Respondent documented a discussion with Patient B regarding the need to decrease or stop the narcotics and noted that he believed she was dependent or addicted to narcotics. Patient B complained of anxiety and depression. Respondent wrote that he was concerned about serious withdrawal issues with Patient B and needed to find a resource

for her to reduce or stop using narcotics. Respondent prescribed Patient B Soma for the first time at this visit.

72. On or about January 11, 2018, Patient B telephoned Respondent requesting additional or stronger pain medications. Patient B stated that she only had 10 Percocet left and would not have enough to get her through the weekend.

73. On or about January 12, 2018, Patient B explained that she was going to run out of her controlled substances early, and in response, Respondent prescribed her MS Contin.

74. On or about January 18, 2018, Patient B presented to Respondent for help in managing her use of narcotics. Patient B was expected to seek a consultation from a mental health provider and report to the county rehabilitation program. Respondent noted that Patient B was currently taking MS Contin and needed to consult with both a mental health specialist and a pain management specialist. Respondent wrote "[m]ade deal with patient she will self-refer to both places and let me know about the appointments." Respondent stated "I am at a loss at this point as to what to do for this patient to get her off the meds. Need to find a resource for this patient to reduce or stop the narcotics..."

75. On or about January 25, 2018, Patient B walked into Respondent's office, without an appointment, complaining about swelling in her legs and back pain. Patient B requested additional Oxycodone and reported that she had not contacted the county rehabilitation program. Respondent's office told her that she needed to go to her primary care physician or the emergency room, as Respondent would not prescribe controlled substances to her any longer.

76. On or about January 26, 2018, Patient B reported to Respondent that she was self-treating by doubling her dosage of MS Contin. Respondent wrote in the record that he "told the patient [he is] unable to continue to give her narcotics anymore." Patient B called back the next day requesting narcotics and was told to that she would need to schedule an appointment to see Respondent in person.

77. On or about February 1, 2018, Patient B presented to Respondent to discuss her management of narcotics and continued complaints of pain. Respondent told her that he was not able to prescribe her any narcotics and that she needed to enter a pain management or

rehabilitation program to get off narcotics. Respondent documented a 20-minute face-to-face discussion with Patient B and ordered a CT of her abdomen/pelvis. Despite Respondent's warnings and documentation of a clear refusal to prescribe, Respondent continued to prescribe narcotics.

78. On or about February 15, 2018, Patient B presented complaining of pain in her vaginal area. Respondent prescribed medications for a yeast infection and told her that she needed to "taper down off the narcotics." Respondent planned to obtain a consultation from a physician in Modesto that specializes in the treatment of chronic pain. Despite Respondent's plan to reduce or eliminate Patient B's opiates, Respondent nearly doubled her dosage of Oxycontin. The pharmacy refused to release the narcotics absent specific approval from Respondent, as it was too early to refill the prescriptions. Respondent was not in the office when the pharmacy called for approval and another physician told Patient B to go to the emergency room if additional pain medications were needed prior to Respondent's return. Patient B continued to call the office asking for approval of the pain medications. The records from another physician at the practice state that Patient B "has been told multiple times that we are not able to do anything for her at this time...[she] is too early for refills" and was informed.

79. On or about February 20, 2018, Patient B telephoned Respondent requesting a refill of her Percocet, Oxycontin, and carisoprodol.

80. On or about February 21, 2018, Respondent wrote, "Patient is using meds in excess of what has been prescribed." Respondent noted that Patient B should go to the emergency room if she needed additional narcotics.

81. On or about April 9, 2018, Patient B presented to Respondent complaining of hot flashes and abdominal pain. Patient B reported that her pain was not controlled by the current dosage of narcotics and she wanted an increase in the potency of the prescribed narcotics. Respondent noted that the pain management referral was pending and that he spent 20 minutes with Patient B discussing her concerns.

82. On or about April 11, 2018, Patient B presented to Respondent complaining of pain. Respondent stated that he was very concerned about Patient B's opioid use disorder at this time in

her treatment. He reported speaking with her about treatment options for her addiction including inpatient, outpatient, and medication therapy. Respondent increased Patient B's prescription for oxycodone hcl-acetaminophen, as requested.

83. On or about April 30, 2018, Patient B presented to Respondent requesting a refill of her medications and complaining of pain. Respondent refilled her controlled substance medications and provided a list of resources to Patient B regarding opiate addiction.

84. On or about May 14, 2018, the pharmacy contacted Respondent for clarification, as Patient B was being prescribed 40 mg and 60 mg OxyContin concurrently, and was still seeking an early refill. Patient B contacted Respondent's office, stating that she was currently out of her OxyContin. Respondent refused to authorize the early refill, noting that it was filled on May 2, 2018, for a thirty-day supply.

85. On or about May 17, 2018, Patient B presented complaining of pain and requesting additional opiates. Respondent refilled Patient B's pain medications. Respondent stated that he believed Patient B was addicted to controlled substances at this time, but still felt an ethical obligation to treat her pain.

86. On or about June 8, 2018, Patient B called Respondent requesting a refill of her Percocet two days early. Respondent provided Patient B with an early refill of her Percocet. Respondent later stated that in retrospect, this was a red flag for diversion or abuse, and he should not have provided the early refill. Respondent explained that at the time, he did not recognize the importance of early refills as red flags for abuse of narcotics.

87. On or about June 16, 2018, Patient B and Respondent met by telephone. Respondent noted that he counseled Patient B again to seek help for her narcotic addiction. Respondent later stated that he was attempting to get Patient B to self-refer to the local county program for treatment of her addiction.

88. On or about June 28, 2018, Respondent refilled Patient B's pain medications, and referred her to a pain management physician. Patient B requested additional OxyContin, despite recently filling a prescription on June 15, 2018, for 120 pills that should have lasted 30 days.

89. On July 6, 2018, Patient B attempted to get an early refill of OxyContin again. Patient B stated that she was homebound with excruciating pain and was considering going to the hospital for treatment. Patient B told Respondent's office staff that she had a private conversation with Respondent, during which he approved her narcotics refills. She told Respondent's staff that she was a substance abuse counselor, knew the symptoms of withdrawal, and knew that she was experiencing withdrawal symptoms.

90. On or about July 17, 2018, Respondent planned to send Patient B a letter by certified mail dismissing her from the practice for non-compliance. Despite his plans, Respondent continued to prescribe Soma, OxyContin, and Percocet. Respondent later stated that he was worried that if he stopped prescribing Patient B controlled substances, she would suffer serious withdrawal, and he didn't want to abandon her.

91. On or about July 23, 2018, Patient B presented to Respondent for refills of her opiates. Respondent counseled her for 20 minutes on the need to consult with pain management, then provided her a prescription of oxycodone.

92. On or about August 8, 2018, Respondent wrote that he would not prescribe narcotics to Patient B. Nevertheless, Respondent continued to prescribe narcotics to Patient B.

93. On or about August 23, 2018, Patient B presented to Respondent seeking refills of her pain medications. Respondent noted that Patient B had a scheduled appointment with a pain management physician, and had been taking her father's narcotics in addition to those prescribed directly to her. Respondent refilled Patient B's pain medications.

94. On or about September 10, 2018, Patient B contacted Respondent's office stating that she had run out of her Percocet and Oxycontin early. Respondent's office noted that Patient B had made the same request for narcotics to another physician in the same group.

95. On or about October 11, 2018, Respondent documented that Patient B agreed to see an addiction specialist in five days.

96. On or about October 31, 2018, Respondent refilled Patient B's pain medications.

97. On or about November 16, 2018, Patient B presented to Respondent for tapering of her narcotics. Patient B complained that she needed larger amounts of opiates because the

tapering was occurring too fast. Respondent agreed to continue the current dose of narcotics pending her pain management consultation.

98. On or about December 5, 2018, Patient B presented for treatment related to pain and narcotic dependency. Respondent noted that it was too difficult to wean Patient B's medications and would continue prescribing narcotic medications.

99. December 17, 2018, Patient B presented to Respondent for a medication check on her narcotics. Respondent documented that she was waiting for a consultation with a pain management specialist and continued to prescribe Patient B narcotics.

100. During the period of on or about January 10, 2018 through December 25, 2018, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/10/2018	CARISOPRODOL	TAB	350 MG	9	3	Respondent
1/10/2018	PHENTERMINE HCL	TAB	37.5 MG	3	3	Respondent
1/12/2018	CARISOPRODOL	TAB	350 MG	81	27	Respondent
1/12/2018	MORPHINE SULFATE	TER	30 MG	60	30	Respondent
1/18/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
1/24/2018	PHENTERMINE HCL	TAB	37.5 MG	27	27	Respondent
1/25/2018	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
2/1/2018	OXYCONTIN	TER	40 MG	60	30	Respondent
2/6/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
2/7/2018	CARISOPRODOL	TAB	350 MG	90	30	Respondent
2/16/2018	CLONAZEPAM	TAB	1 MG	12	4	M.Z., M.D.
2/22/2018	CLONAZEPAM	TAB	1 MG	10	3	O.A.
2/22/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	30	10	O.A.
2/26/2018	CLONAZEPAM	TAB	1 MG	96	32	M.Z., M.D.
2/26/2018	PERCOCET	TAB	325 MG-10 MG	240	20	Respondent
3/1/2018	OXYCONTIN	TER	40 MG	60	30	Respondent
3/6/2018	CARISOPRODOL	TAB	350 MG	90	30	Respondent
3/16/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-7.5 MG	180	30	Respondent
3/16/2018	OXYCONTIN	TER	40 MG	120	30	Respondent
3/26/2018	CLONAZEPAM	TAB	1 MG	96	32	M.Z., M.D.
4/3/2018	SOMA	TAB	350 MG	139	24	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
4/9/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	30	Respondent
4/9/2018	OXYCONTIN	TER	40 MG	120	30	Respondent
5/1/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
5/2/2018	OXYCONTIN	TER	60 MG	60	30	Respondent
5/3/2018	CARISOPRODOL	TAB	350 MG	240	60	Respondent
5/14/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
5/17/2018	OXYCONTIN	TER	40 MG	120	30	Respondent
5/21/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
6/1/2018	CARISOPRODOL	TAB	350 MG	240	30	Respondent
6/8/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
6/13/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
6/15/2018	OXYCONTIN	TER	40 MG	120	30	Respondent
6/28/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
7/2/2018	CARISOPRODOL	TAB	350 MG	240	30	Respondent
7/11/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
7/11/2018	OXYCONTIN	TER	80 MG	60	30	Respondent
7/18/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
8/1/2018	OXYCONTIN	TER	80 MG	90	30	Respondent
8/3/2018	CARISOPRODOL	TAB	350 MG	240	30	Respondent
8/6/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
8/23/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
8/30/2018	OXYCONTIN	TER	80 MG	90	30	Respondent
9/1/2018	CARISOPRODOL	TAB	350 MG	240	30	Respondent
9/4/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
9/17/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	60	5	S.A.
9/28/2018	CARISOPRODOL	TAB	350 MG	240	30	Respondent
9/28/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	60	5	Respondent
9/28/2018	OXYCONTIN	TER	80 MG	90	30	Respondent
10/3/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
10/11/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	60	5	Respondent
10/16/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	R.G., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
10/16/2018	OXYCONTIN	TER	20 MG	40	20	R.G., M.D.
10/25/2018	OXYCONTIN	TER	60 MG	28	14	Respondent
10/29/2018	CARISOPRODOL	TAB	350 MG	120	30	Respondent
10/31/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
11/6/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	112	14	Respondent
11/7/2018	OXYCONTIN	TER	40 MG	28	14	Respondent
11/8/2018	OXYCONTIN	TER	10 MG	14	7	Respondent
11/16/2018	OXYCONTIN	TER	10 MG	28	14	Respondent
11/21/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	112	14	Respondent
11/22/2018	OXYCONTIN	TER	40 MG	28	14	Respondent
11/28/2018	CARISOPRODOL	TAB	350 MG	56	14	Respondent
11/28/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
12/5/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	112	14	Respondent
12/5/2018	OXYCONTIN	TER	80 MG	42	14	Respondent
12/17/2018	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	240	20	Respondent
12/17/2018	OXYCONTIN	TER	80 MG	84	28	Respondent
12/20/2018	CARISOPRODOL	TAB	350 MG	120	30	Respondent
12/25/2018	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.

101. On or about January 16, 2019, Respondent noted that Patient B had an appointment with pain management and refilled Patient B's pain medications.

102. On or about April 8, 2019, Respondent noted that Patient B had an appointment with pain management and refilled Patient B's pain medications.

103. On or about May 8, 2019, Patient B presented to Respondent for refills of her pain medications. Respondent documented a discussion of Naloxone and Patient B's plans to visit a pain psychiatrist in the next two weeks.

104. On or about June 5, 2019, Patient B presented to Respondent for refills of her pain medications. Respondent noted that Patient B's consultation with pain management was delayed until August and provided Patient B pain medications.

105. On or about September 13, 2019, Patient B presented to Respondent for refills of her pain medications and complaining of a recent kidney infection that required a stent placement.

Respondent noted that Patient B had an appointment with pain management and refilled Patient B's pain medications.

106. On or about October 25, 2019, Patient B presented to Respondent complaining of increasing amounts of pain in her left flank. Respondent noted that Patient B had an appointment with pain management and refilled Patient B's pain medications to prevent withdrawal.

107. On or about November 13, 2019, Patient B reported that all of her prescription medications were stolen, similar to her earlier report on August 29, 2017. Patient B stated that she had reported the theft to the police and that she had an appointment scheduled with an addiction specialist in one month. Respondent stated that he told her he was leaving the practice and would no longer be able to prescribe to her.

108. On or about November 25, 2019, Respondent informed Patient B that the addiction specialist had recommended that Patient B taper her Oxycodone.

109. On or about December 9, 2019, Patient B presented to Respondent for refills of her pain medications. Respondent agreed to refill her pain medications, until she completed her consultation with the pain management specialist on January 17, 2020.

110. On or about December 23, 2019, Patient B presented to Respondent complaining of a rash, determined to be shingles. Respondent treated Patient B's shingles and refilled her pain medications.

111. On or about December 30, 2019, Patient B presented to Respondent for a follow-up related to her recent shingles diagnosis. Respondent refilled her pain medications and planned for Patient B to get off narcotics and complete her pain management consultation on January 17, 2020.

112. During the period of on or about January 18, 2019 through December 13, 2019, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/18/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
1/18/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
1/21/2019	OXYCONTIN	TER	80 MG	84	28	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/23/2019	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
2/13/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
2/14/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
2/15/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
2/21/2019	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
3/13/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
3/13/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
3/21/2019	CLONAZEPAM	TAB	1 MG	120	30	M.Z., M.D.
3/25/2019	CARISOPRODOL	TAB	350 MG	63	15	Respondent
5/10/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
5/10/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
5/13/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
5/20/2019	CLONAZEPAM	TAB	1 MG	30	8	M.Z., M.D.
5/20/2019	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
5/29/2019	CODEINE PHOSPHATE/GUAIFENESIN	SOL	10 MG/5 ML-100 MG/5 ML	120	4	S.A.
6/9/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
6/9/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
6/10/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
6/17/2019	CLONAZEPAM	TAB	1 MG	30	10	M.Z., M.D.
6/27/2019	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
7/8/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
7/8/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
7/16/2019	CLONAZEPAM	TAB	1 MG	30	8	M.Z., M.D.
7/29/2019	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
8/6/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
8/6/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
8/6/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
8/27/2019	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.
9/6/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
9/6/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
9/6/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
9/25/2019	CLONAZEPAM	TAB	1 MG	90	30	M.Z., M.D.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
10/4/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
10/4/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
10/4/2019	OXYCONTIN	TER	80 MG	84	28	Respondent
10/25/2019	CLONAZEPAM	TAB	1 MG	60	20	M.Z., M.D.
11/1/2019	CARISOPRODOL	TAB	350 MG	120	30	Respondent
11/1/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
11/13/2019	CLONAZEPAM	TAB	1 MG	60	30	Respondent
11/14/2019	CARISOPRODOL			120	30	Respondent
11/14/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
11/14/2019	OXYCONTIN	TER	80 MG	84	30	Respondent
12/6/2019	PHENTERMINE HCL	CAP	15 MG	30	30	Respondent
12/9/2019	CLONAZEPAM	TAB	1 MG	120	40	Respondent
12/12/2019	CARISOPRODOL			120	30	Respondent
12/12/2019	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	180	30	Respondent
12/13/2019	OXYCONTIN	TER	80 MG	38	13	Respondent

113. During the period of on or about January 2, 2020 through December 15, 2020, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/2/2020	CARISOPRODOL			120	20	Respondent
1/3/2020	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	83	14	Respondent
1/3/2020	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-10 MG	42	7	Respondent
1/6/2020	CLONAZEPAM	TAB	1 MG	120	40	Respondent
1/8/2020	OXYCONTIN	TER	80 MG	62	20	Respondent
1/21/2020	CARISOPRODOL			120	30	Respondent
1/24/2020	PHENTERMINE HCL	TAB	37.5 MG	30	30	Respondent
1/30/2020	CLONAZEPAM	TAB	1 MG	120	30	Respondent
2/10/2020	BUPRENORPHINE-NALOXONE	FIL	8 MG-2 MG	30	10	N.K., M.D.
2/18/2020	CARISOPRODOL			120	30	S.A.
3/9/2020	CLONAZEPAM	TAB	1 MG	45	23	S.A.
3/18/2020	CARISOPRODOL			120	30	S.A.
3/25/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.

4/16/2020	CARISOPRODOL			120	30	S.A.
4/22/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
5/15/2020	PHENTERMINE HCL	TAB	37.5 MG	30	30	Respondent
5/16/2020	CARISOPRODOL	TAB	350 MG	120	30	S.A.
5/24/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
6/24/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
6/26/2020	CARISOPRODOL	TAB	350 MG	120	30	S.A.
7/25/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
8/21/2020	CARISOPRODOL	TAB	350 MG	120	30	S.A.
8/28/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
10/6/2020	CARISOPRODOL	TAB	350 MG	120	30	S.A.
10/6/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
11/9/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
12/14/2020	CLONAZEPAM	TAB	1 MG	90	30	S.A.
12/15/2020	CARISOPRODOL	TAB	350 MG	120	30	S.A.

114. During the period of on or about January 14, 2021 through June 18, 2021, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/14/2021	CARISOPRODOL	TAB	350 MG	120	30	S.A.
1/14/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.
2/13/2021	CARISOPRODOL	TAB	350 MG	120	30	S.A.
2/13/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.
3/16/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.
3/17/2021	CARISOPRODOL	TAB	350 MG	120	30	S.A.
4/19/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.
4/20/2021	CARISOPRODOL	TAB	350 MG	120	30	S.A.
5/19/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.
5/23/2021	CARISOPRODOL	TAB	350 MG	120	30	S.A.
6/10/2021	BUPRENORPHINE-NALOXONE	TAB	8 MG-2 MG	60	30	G.B., D.O.
6/18/2021	CLONAZEPAM	TAB	1 MG	90	30	S.A.

115. On or about April 8, 2021, Respondent was interviewed by the Board's investigator regarding the care provided to Patient B. Respondent stated that Patient B returned to him in 2018 for treatment related to her chronic use of opioids. Respondent admitted that he did not know how to manage a patient who had opioid overuse and the potential for the misuse of opioids. Respondent stated that he decided to stop prescribing Patient B opioids in February

2018, but continued prescribing controlled substances as Patient B was pending a consultation with a general surgeon and was attending narcotics anonymous meetings. Respondent stated that he was aware of Patient B's prior history with addiction to controlled substances in 2013 and 2014, and that he referred her to pain management specialists in 2018 and 2019. Respondent admitted that he never used a pain contract or urine toxicology screens during the time he prescribed controlled substances to Patient B. Respondent stated that he relied on a verbal agreement with her that he would be the only person prescribing opioids. Respondent told investigators that he believed 360 Percocet a month would not be a safe amount of acetaminophen. Respondent stated that he regretted the "lack of tapering" in the prescribing of controlled substances to Patient B. Respondent decided to cease prescribing opioids to Patient B in February 2018, but then continued to treat her while she sought a consultation for an umbilical hernia. Respondent admits that prior to November of 2019, he never obtained any advice from pain management or addiction specialists in the care and treatment of Patient B.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

116. Respondent Kevin E. Rine, M.D. has subjected his Physician's and Surgeon's Certificate No. G 57924 to disciplinary action under section 2227, as defined by section 2234, subdivision (b), of the Code, in that he committed act(s) and/or omission(s) amounting to gross negligence in the care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 19 through 115, which are hereby incorporated by reference and realleged as if fully set forth herein, and as alleged hereafter:

Departures Related to Patient A

117. Respondent failed to appropriately prescribe controlled substances to Patient A, by consistently prescribing controlled substances to Patient A in excess of 50 MME/day. Respondent, an OB/GYN, who admittedly had no training in pain management or addiction medicine, prescribed controlled substances to Patient A for years. Respondent failed to utilize and/or document consideration of the use of naloxone for Patient A, to protect her from the risk of overdose. Respondent failed to document a single urine drug toxicology screen during the entire

time that he prescribed controlled substances to Patient A, which could have alerted him to the possibility of diversion or abuse. Respondent failed to document a treatment plan related to Patient A's use of controlled substances. Respondent failed to document a pain management contract with Patient A related to her opioid dependence. Respondent failed to review CURES and/or document review of CURES while prescribing controlled substances to Patient A. Respondent failed to appropriately prescribe controlled substances to Patient A, which constitutes gross negligence.

Departures Related to Patient B

118. Patient B presented to Respondent complaining of post-operative pain from a recent cesarean section, followed by a hysterectomy. Respondent prescribed Patient B controlled substances, not for a few months, but for years in response to her complaints of pain. Respondent did not have any training or continuing education in pain management or addiction medicine. Respondent's records contained references to her prior addiction to controlled substances, but Respondent did not document any consideration of her history of addiction prior to prescribing her opiates. Respondent increased her opiates, continued her opiate prescriptions for years, and failed to document any consideration of a recurrence of her addiction to controlled substances. At nearly every visit, Respondent prescribed Patient B controlled substances greatly in excess of the recommended threshold of 50 MME/day. For example, in December of 2018, Respondent, an obstetrician/gynecologist, prescribed Patient B controlled substances totaling 680 MME/day. Although Respondent documented concerns regarding Patient B's addiction and made referrals to pain management, he failed to require that Patient B actually follow through with treatment for addiction. Patient B failed to obtain pain management consultations or get substance abuse treatment and Respondent continued to prescribe controlled substances. Respondent did not prescribe naloxone to Patient B until May 8, 2019, more than two years after he initiated opiate treatment for Patient B. Respondent failed to utilize urine drug toxicology screens in the treatment of Patient B to prevent diversion and/or abuse of controlled substances. Respondent failed to document a treatment plan relating to Patient B's use of controlled substances and her opiate addiction. Respondent failed to review and/or document review of the CURES database

while prescribing controlled substances to Patient B. Respondent failed to document an awareness that other physicians were also concurrently prescribing controlled substances to Patient B. Respondent failed to document any awareness of Patient B's increased risk of death or respiratory depression while taking combinations of opioids, benzodiazepines, and carisoprodol. Respondent failed to appropriate prescribe controlled substances to Patient B, which constitutes gross negligence.

119. Respondent prescribed phentermine to Patient B, despite her history of cardiovascular disease, high blood pressure, and drug abuse. Respondent failed to review the CURES database and/or failed to document review of the CURES database while prescribing phentermine to Patient B. If Respondent had reviewed the CURES database, he would have learned that other providers were simultaneously providing Patient B prescriptions for phentermine. Respondent failed to utilize urine drug toxicology screens while prescribing phentermine to Patient B, to ensure that the medication was not being abused and/or diverted by Patient B. Respondent failed to document any non-pharmaceutical attempts by Patient B to lose weight prior to prescribing phentermine. Respondent failed to appropriately prescribe phentermine to Patient B, and/or adequately monitor Patient B while taking phentermine, which constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

120. Respondent Kevin E. Rine, M.D. has subjected his Physician's and Surgeon's Certificate No. G 57924 to disciplinary action under section 2227, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 19 through 119, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

121. Respondent Kevin E. Rine, M.D. has subjected his Physician's and Surgeon's Certificate No. G 57924 to disciplinary action under section 2227, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A and Patient B, as more particularly alleged in paragraphs 19 through 119, 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 Number G 57924, issued to Respondent Kevin E. Rine, M.D.;

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

3. Ordering Respondent Kevin E. Rine, 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: SEP 28 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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