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

In the Matter of the Accusation Against: Dwain William Rickertsen, M.D. Physician's and Surgeon's Certificate No. A 45073 Respondent.	Case No.: 800-2017-039105

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 4, 2022.

IT IS SO ORDERED: February 4, 2022.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **DWAIN WILLIAM RICKERTSEN, M.D.** 9701 Collier Avenue Live Oak, CA 95953-9670 Physician's and Surgeon's Certificate No. A 45073 Respondent.	Case No. 800-2017-039105 OAH No. 2021050157 **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 John S. Gatschet, Deputy Attorney General.

2. Respondent Dwain William Rickertsen, M.D. ("Respondent") is represented in this proceeding by attorney Dominique A. Pollara, whose address is:

Pollara Law Group
100 Howe Avenue, Suite 165N
Sacramento, CA 95825

3. On or about July 25, 1988, the Board issued Physician's and Surgeon's Certificate No. A 45073 to Dwain William Rickertsen, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-039105, and will expire on April 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-039105 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 December 2, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-039105 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. 800-2017-039105. 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.

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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. 800-2017-039105, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the Accusation, 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. 800-2017-039105 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.

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. A 45073 issued to Respondent Dwain William Rickertsen, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule IV and V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or

cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Respondent shall immediately surrender Respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules (IV and V) authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. 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.

4. 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.

5. 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.

6. MEDICAL EVALUATION AND TREATMENT. Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, Respondent shall undergo a medical evaluation to determine if he has a hearing loss by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician with any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, Respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If Respondent is required by the Board or its designee to undergo medical treatment, Respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of Respondent's choice. Upon approval of the treating physician, Respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee

or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports, if needed by the Board, to the Board or its designee indicating whether or not the Respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment that the Board or its designee deems necessary.

If, prior to the completion of probation, Respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over Respondent's license and the period of probation shall be extended until the Board determines that Respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

A medical evaluation that is performed 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, may be accepted towards the fulfillment of this condition if the medical evaluation determines that Respondent has no hearing loss and does not require on-going evaluation for hearing loss.

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

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

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change.

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

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

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

10. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

11. 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.

12. 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.

13. 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.

14. 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..

15. 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.

16. 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.

17. 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.

18. 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.

19. 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. 800-2017-039105 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 11/9/2021

DWAIN WILLIAM RICKERTSEN, M.D.
Respondent

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

DATED: 11/9/21

DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 11-9-2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7546
Facsimile: (916) 327-2247

Attorneys for Complainant

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

In the Matter of the Accusation Against: **Dwain William Rickertsen, M.D.** 12140 New York Ranch Rd. Jackson, CA 95642-9407 Physician's and Surgeon's Certificate No. A 45073, Respondent.	Case No. 800-2017-039105 **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 25, 1988, the Medical Board issued Physician's and Surgeon's Certificate Number A 45073 to Dwain William Rickertsen, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2022, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

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

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
>
> ....

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

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

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7. Section 2228.1 of the Code, states in pertinent part:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PERTINENT DRUG DEFINITIONS

8. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

9. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination

product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[1] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

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

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

12. Alprazolam – Generic name for Xanax. Alprazolam is a member of the benzodiazepine family and is an anti-anxiety medication used for the short-term management of severe anxiety and panic attacks. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Phenergan Codeine Cough Syrup – Generic name for Codeine with Promethazine. Phenergan Codeine Cough Syrup is a narcotic combination drug used for the short-term treatment of cough, congestion and allergy relief. Phenergan Codeine Cough Syrup is classified as a Schedule I controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.15 (c) and a dangerous drug pursuant to Business and Professions Code section 4022.

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[1] Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

14. Temazepam – Generic name for Restoril. Temazepam is a member of the benzodiazepine family and is a sleeping medication used for the short-term management of insomnia. Temazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Codeine with Acetaminophen – Generic name for the drugs Tylenol with Codeine #3 ("Tylenol #3") and Tylenol with Codeine #4 ("Tylenol #4"). Codeine is an opioid pain medication used to treat mild to moderate pain. As with other opiate-based painkillers, chronic use of codeine can cause physical dependence. Codeine with acetaminophen is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13, subdivision (e). Codeine with acetaminophen is a dangerous drug pursuant to Business and Professions Code section 4022, and is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e).

FACTUAL ALLEGATIONS

Patient 1

16. Patient 1 has a prior medical history which included a massive motor vehicle accident in 1996, where he had suffered a head injury and severe full body trauma. Patient 1 had an abscess on his head treated in 2009. In 2014, Patient 1 was in another motor vehicle accident. According to CURES[2], between January 30, 2014, and January 7, 2015, the Respondent consistently prescribed hydrocodone with acetaminophen, alprazolam, and carisoprodol to Patient 1 each month. In January 2015, Patient 1 was in a third motor vehicle accident caused by a drunk driver and was seen in the emergency room. Following the emergency room visit, on or about January 14, 2015, the Respondent saw Patient 1 in clinic. Of note, are the following closely spaced prescriptions for hydrocodone in August and September 2014:

[2] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

Date	Prescription	Drug	Quantity	MED[3]	Acetaminophen
8/7/2014	30 days	10/325 mg hydrocodone with acetaminophen	300 tablets	150 MED	5,875 mg APAP[4]
8/27/2014	30 days	10/325 mg hydrocodone with acetaminophen	120 tablets	200 MED	6,500 mg APAP
9/2/2014	30 days	10/325 mg hydrocodone with acetaminophen	240 tablets	171 MED	5571 mg APAP
9/16/2014	30 days	10/325 mg hydrocodone with acetaminophen	240 tablets	--	--

The hydrocodone with acetaminophen prescriptions were filled at two different pharmacies, Safeway and Savesave, were all issued by the Respondent and the prescriptions greatly increased Patient 1's MED. In addition, assuming that Patient 1 took all of the medications that he received, it placed his daily intake of acetaminophen over 4000 mg.

17. According to Respondent's January 14, 2015, charting note, Patient 1's x-rays were negative and indicated that he was normal. The Respondent documented that Patient 1 had initially felt he was paralyzed after the January 2015 accident but that movement had returned to his extremities. The Respondent documented that Patient 1 had returned to work with some back pain, and that Patient 1 reported sinus pressure, congestion, and a productive cough. The Respondent documented that Patient 1 was a smoker. The Respondent failed to document how

[3] Morphine Equivalent Dose ("MED"), is a numerical standard against which most opiods can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg. per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17. The State of Washington provides a free MED tool at www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm, which is widely used in the medical community.

[4] Abbreviation for acetaminophen

long Patient 1 had been experiencing symptoms for his sinus pressure, congestion, and his productive cough. The Respondent documented that Patient 1 had "point tenderness L upper back," knee pain, and that his lungs sounded "rhonchi" The Respondent prescribed 300 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and 90 tablets of .5 mg alprazolam. The Respondent also prescribed antibiotics[5] to deal with a diagnosis of acute bronchitis. As prescribed, Patient 1 had a MED of 100 in combination with a benzodiazepine and a muscle relaxer.

18. Between January 2015 and September 2015, the Respondent on a monthly basis, prescribed 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and 60 tablets of .5 mg alprazolam to Patient 1.[6] On or about September 14, 2015, Respondent's colleague, Doctor A, prescribed 240 tablets of 10/325 mg oxycodone with acetaminophen to Patient 1 after Patient 1 reported that he had suffered a back injury. Patient 1 had previously filled Respondent's prescription for 240 tablets of 10/325 mg hydrocodone with acetaminophen on or about September 3, 2015. On or about October 6, 2015, Patient 1 filled a new prescription for 240 tablets of 10/325 mg hydrocodone with acetaminophen, issued by Respondent, after Patient 1 reported to the Respondent that Percocet made him too sleepy and he requested Norco. Patient 1 continued to receive prescriptions for alprazolam and carisoprodol from Respondent during that time. In the Respondent's October 6, 2015, progress note he failed to document whether Patient 1 was instructed to destroy the Percocet and/or document whether he was concerned that the Patient reported as being too sleepy after receiving Percocet. Patient 1 also informed Respondent that he had a rash and the Respondent diagnosed it as dermatitis and prescribed an antibiotic[7], an antifungal and a steroid.

19. On or about November 12, 2015, the Respondent saw Patient 1 in clinic. The Respondent appeared to electronically cut and paste the general examination portions of Dr. A's September 14, 2015, progress note into his current note. The Respondent also appeared to

[5] The Respondent prescribed the Z-Pak, Zithromax, a widely used antibiotic for treatment of bronchitis, pneumonia, and infections of the ears and lungs.

[6] MED of 80, in combination with a benzodiazepine and muscle relaxer.

[7] The Respondent prescribed Bactram, a combination antibiotic consisting of sulfamethoxazole and trimethoprim.

template the rest of the exam with terms like "tightness of PVM's." The Respondent documented "rhonchi", diagnosed bronchitis and prescribed a Z-Pak. The Respondent failed to diagnose a duration of symptoms related to bronchitis. The Respondent continued to prescribe 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol and 60 tablets of .5 mg alprazolam. On November 23, 2015, Patient 1 contacted the clinic and stated he was still sick and requesting another prescription for a Z-Pak and Phenergan with codeine cough syrup. The Respondent, without doing any additional work-up or seeing the patient, issued another prescription for a Z-Pak and Phenergan with codeine cough syrup.

20. On or about December 7, 2015, Patient 1 was seen in clinic by a physician assistant under Respondent's supervision. The physician assistant documented that Patient 1 had a chief complaint of "cold or flu for 3 wks." and noted that the "Z-pak (*sic*) helped a little." The physician assistant documented that Patient 1 was still sick but failed to document any additional symptom details. The physician assistant refilled Patient 1's Phenergan with codeine cough syrup and prescribed antibiotics.[8] During that period in 2015, Patient 1 called in for early refills twice and on or about October 15, 2015, reported his controlled medications were stolen from his truck. A copy of the October 14, 2015, police record is contained in Patient 1's chart and states that Patient 1 reported a burglary but there is no other information contained in the police record. On or about December 8, 2015, Patient 1 requested more Phenergan with codeine syrup after he stated his bottle shattered and the Respondent wrote him another prescription for Phenergan with codeine cough syrup. Respondent refilled Patient 1's prescriptions for 120 tablets of 350 mg carisoprodol, 240 tablets of 10/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg alprazolam the next day on December 9, 2015, by phone.

21. On or about January 4, 2016, Patient 1 was seen in clinic by Respondent for a back injury caused when Patient 1 tugged at a starter cord on a lawn mower. The Respondent documented that Patient 1 went to worker's compensation, that Patient 1 needed a refill of Percocet and that workmen's compensation would not give Patient 1 anything stronger than Motrin. According to CURES, Patient 1 received 30 tablets of 10/325 mg oxycodone with

[8] The physician assistant prescribed Levaquin, a fluoroquinolone antibiotic.

acetaminophen on or about December 17, 2015, but Respondent makes no mention of this prescription in the records. In addition, Respondent failed to note any of the previous concerns that Patient 1 was made sleepy by Percocet when Respondent's colleague, Doctor A, previously prescribed Percocet. The Respondent documented that he prescribed 40 tablets of 10 mg oxycodone for ten days and continued Patient 1 on carisoprodol. On or about January 5, 2016, Patient 1 called in to the Respondent's clinic and stated that oxycodone caused him a bad migraine and that he wanted hydrocodone with acetaminophen. According to the telephone note, the Respondent requested that Patient 1 bring in his oxycodone prescription and then Respondent would re-issue a Norco prescription. According to the note, Patient 1 "paused for a second" and then stated he had disposed of them in kitty litter. The Respondent refused to issue the hydrocodone with acetaminophen prescription because the patient needed to bring in the oxycodone.

22. On or about January 7, 2016, Patient 1 returned to Respondent's clinic. The Respondent documented that Patient 1 was given oxycodone but that he had "threw(sic) them away." The kitty litter story is not mentioned in the progress note. The Respondent documented that Patient 1 wanted Norco, that he was in a previous motor vehicle accident in October 2014, and that he had injured himself at work. The Respondent also documented that Patient 1, "was using meds with increased amount," and being followed at workers compensation clinic. The Respondent documented that Patient 1 had head and neck tenderness, joint pain and back pain. The Respondent documented that Patient 1 consumed alcohol and was a smoker. The Respondent continued Patient 1's prescriptions for 120 tablets of 350 mg carisoprodol, 240 tablets of 10/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg alprazolam. Despite receiving a monthly prescription of medications, Patient 1 received a refill of 120 tablets of 350 mg carisoprodol, 240 tablets of 10/325 mg hydrocodone with acetaminophen and 60 tablets of .5 mg alprazolam, 3 days early on February 4, 2016.

23. On February 17, 2016, Patient 1 called in to clinic and stated that his current alprazolam prescription was not working well and he requested an increase in dosage. According to the telephonic note, the patient had come to clinic but was turned away because the

Respondent's schedule was booked. Despite providing a prescription for 60 tablets of .5 mg alprazolam on February 4, 2016, the Respondent prescribed 90 tablets of 1 mg alprazolam on February 18, 2016. This in effect tripled Patient 1's dosage. The Respondent did not see Patient 1 in clinic prior to this rapid increase and continued to prescribe Norco and Soma to Patient 1. In addition, on Patient 1's CURES there is documentation that a different physician provided Patient 1 with 20 tablets of 10/325 mg oxycodone with acetaminophen on or about February 15, 2016. On or about March 1, 2016, the Respondent by telephone authorized Patient 1 to refill his 90 tablets of 1 mg alprazolam and 120 tablets of 350 mg prescriptions, still without seeing him in clinic.

24. In February 2016, Respondent's practice received a letter addressed to Respondent from Express Scripts. The Express Scripts letter noted that Patient 1 was receiving an opioid analgesic in combination with a benzodiazepine and carisoprodol. The letter included a prescription profile that Patient 1 was receiving three short acting opioids in Norco, Percocet[9] and oxycodone, a narcotic in Codeine cough syrup, alprazolam and carisoprodol at the same time. The letter specifically stated that Patient 1 was receiving a combination of medications known as the "Houston Cocktail" or "Holy Trinity" which the letter noted has a, "strong abuse potential and addictive central nervous system depressant effects may result in an increased risk of serious adverse drug events." The letter went on to note, "(i)n light of the risks of addiction, abuse, and misuse and the greater risks of overdose and death associated with this combination, please consider whether changes in therapy are warranted."

25. On March 3, 2016, Respondent saw Patient in clinic for low back pain and a request for a refill of hydrocodone with acetaminophen. The Respondent failed to document any information related to the February 2016 Express Scripts letter regarding the dangerous medication combination or that Patient 1 was receiving drugs from other providers. The review of systems and examination appeared to be electronically cut and pasted from previous notes. The Respondent continued Patient 1 on Norco, Soma, and alprazolam. There is no

[9] This documented that Percocet was being provided from another physician outside of Respondent's practice.

documentation that Patient 1 was dealing with a cough and/or in respiratory distress at the March 3, 2016, visit. The Respondent failed to document that he analyzed or assessed why he had tripled Patient 1's alprazolam prescription. On March 4, 2016, Patient 1 called into Respondent's clinic and requested a refill of Phenergan with codeine cough syrup. The Respondent authorized Patient 1 to receive Phenergan with codeine cough syrup despite no clinical rationale present for the medication. On March 17, 2016, the Respondent again authorized a refill of Phenergan with codeine cough syrup despite no clinical rationale present for the medication and also authorized Patient 1's refill of 90 tablets of 1 mg alprazolam. Between March 2016 and May 2017, the Respondent repeatedly prescribed Phenergan with codeine cough syrup to Patient 1.

26. On or about May 9, 2016, the Respondent saw Patient 1 in clinic for an infected bite on the back of his ear. The Respondent documented that the ear area was swollen and that there was tenderness present. The Respondent also documented that Patient 1 had a cough and was congested but did not document any information related to the duration of the symptoms. On or about May 10, 2016, the Respondent documented that Patient 1 was present for possible excision and electronically copied and pasted information from the previous note. The Respondent did not document a procedure note for the incision and drainage of the ear lesion. The Respondent prescribed 40 tablets of 10/325 mg oxycodone with acetaminophen despite prescribing a month's prescription of hydrocodone with acetaminophen only 11 days earlier. If Patient 1 took the oxycodone with acetaminophen and hydrocodone with acetaminophen as prescribed his MED was 140 and his acetaminophen intake was 3,900 mg. The Respondent also prescribed antibiotics.[10] On May 20, 2016, the Respondent refilled Patient 1's Bactrim prescription and Phenergan with codeine cough syrup prescription without seeing him in clinic. On or about June 1, 2016, Patient 1 called into Respondent's clinic and requested a refill of antibiotics and Percocet. Despite Patient 1 refilling Respondent's prescription for 240 tablets of 10/325 mg hydrocodone with acetaminophen on or about May 27, 2016, the Respondent prescribed 80 tablets of 10/325 mg oxycodone with acetaminophen and an additional prescription of Bactrim. The Respondent did not see Patient 1 in clinic prior to issuing those prescriptions. If Patient 1

[10] The Respondent prescribed Rocephin and Bactrim.

took the oxycodone with acetaminophen and hydrocodone with acetaminophen as prescribed his MED was 140, his acetaminophen intake was 3,900 mg and he continued to receive Soma and alprazolam.

27. On or about June 20, 2016, Patient 1 presented at Respondent's clinic with a chief complaint of chest cold. The Respondent documented that Patient 1 had a cough, congestion for three-to-four days and had missed work for the last two days. The Respondent also documented that Patient 1 had chronic back pain. Despite Patient 1 recently receiving three previous courses of antibiotics, the Respondent again prescribed antibiotics.[11] The Respondent refilled Patient 1's monthly prescription of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and 90 tablets of 1 mg alprazolam. The Respondent did not document any information related to the recent prescriptions for oxycodone with acetaminophen and whether the oxycodone with acetaminophen prescriptions were now part of Patient 1's on-going chronic treatment plan. The Respondent also documented that he prescribed Phenergan with codeine cough syrup to Patient 1. On July 1, 2016, Patient 1 called Respondent's clinic and requested a refill of oxycodone with acetaminophen. Respondent's colleague, Doctor A, provided a prescription of 80 tablets of 10/325 mg oxycodone with acetaminophen without reviewing Patient 1's prior medications. As noted above, Patient 1's MED remained 140.

28. On or about July 5, 2016, Patient 1 presented at Respondent's clinic for recurrent cough, body ache, fatigue, headaches and congestion. The Respondent noted that Doctor A refilled Patient 1's Percocet on July 1, 2016. The Respondent prescribed antibiotics and a steroid.[12] The Respondent also provided Patient 1 with more Phenergan with codeine cough syrup. The Respondent documented that Patient 1's Percocet was now being continued for back pain. There is no further analysis into Patient 1's chronic pain treatment plan. On July 14, 2016, Patient 1 called into Respondent's clinic and stated he was almost better but still had a cough. Respondent provided another prescription for Phenergan with codeine cough syrup. On July 19, 2016, Patient 1 presented at Respondent's clinic and saw Respondent's physician assistant.

[11] The Respondent prescribed Levaquin.
[12] The Respondent prescribed Rocephin, Levaquin, and Medrol.

Despite previously receiving a monthly refill of hydrocodone with acetaminophen on June 24, 2016, Patient 1 requested a refill five days early after stating that on or about July 17, 2016, his buddies had thrown him in a lake and his pills were in his pocket. The physician assistant early refilled Patient 1's hydrocodone with acetaminophen prescription. Seven days after seeing the physician assistant, Patient 1 called into Respondent's clinic and requested a refill of oxycodone with acetaminophen. On July 28, 2016, the Respondent refilled Patient 1's 80 tablet of 10/325 mg oxycodone with acetaminophen prescription, continuing Patient 1 on an MED of 140, with two short action opioids, in combination with Soma and alprazolam. The Respondent did not document anything related to the Patient's July 19, 2016, claim that allowed him to have his medication refilled early.

29. On August 16, 2016, Patient 1 presented at Respondent's clinic with a complaint of "not feeling well." The Respondent documented that Patient 1 had finished his antibiotics, and was requesting another refill of Phenergan with codeine cough syrup. The Respondent documented that Patient 1 should stop Percocet for back pain and continue with only hydrocodone with acetaminophen. There is no further analysis provided. Patient 1 was to continue with 3 mg of alprazolam and 1400 mg of carisoprodol a day. On or about August 23, 2016, Patient 1 contacted Respondent's clinic and asked for a refill of Percocet. The telephonic note documents that Respondent noted that Patient 1 was not to take both hydrocodone with acetaminophen and oxycodone with acetaminophen and that the prescription was switched. On or about September 2, 2016, Patient 1 presented at Respondent's clinic for a work note and prescription refill. Respondent documented that Patient 1 requested a refill of Norco for back pain despite receiving a month prescription of 240 tablets of 10/325 mg hydrocodone with acetaminophen on or about August 16, 2016, just two weeks earlier. The Respondent documented that he would refill Patient 1's Norco prescription, which Patient 1 refilled on or about September 14, 2016, and he documented that Patient 1 should start a monthly prescription of 80 tablets of 10/325 mg oxycodone with acetaminophen. There is no documentation related as to why Respondent was modifying Patient 1's treatment plan to take a daily prescription of two

short acting narcotics with an MED of 119[13] in combination with 3 mg of alprazolam and 1400 mg of Soma. Nor is there any reference to Respondent's notation from August 23, 2016, that Respondent had stated Patient 1 was not to take both Norco and Percocet at the same time.

30. On or about September 23, 2016, Respondent's physician assistant refilled Patient 1's prescription for Phenergan with codeine cough syrup. On or about September 27, 2016, Patient 1 contacted Respondent's clinic and stated that he had spilled his cough syrup and needed a refill. The Respondent authorized a new refill of Phenergan with codeine cough syrup. On or about September 28, 2016, the pharmacy called Respondent's clinic and noted that Patient 1 had just picked up the cough syrup prescription on September 27, 2016, because they did not have it in stock on September 23, 2016. According to the note, the Respondent determined he was not comfortable with giving the refill based on this new information that the Patient may be misusing medications. In September 2016, Respondent's practice received a letter addressed to Respondent's physician assistant who was misidentified as a physician from Express Scripts. The Express Scripts letter noted that Patient 1 was receiving an opioid analgesic in combination with a benzodiazepine and carisoprodol. The letter included a prescription profile that Patient 1 was receiving two short acting opioids in Norco and Percocet, a narcotic in Codeine cough syrup, alprazolam and carisprodol. The letter specifically stated that Patient 1 was receiving a combination of medications known as the "Houston Cocktail" or "Holy Trinity" which has a, "strong abuse potential and addictive central nervous system depressant effects may result in an increased risk of serious adverse drug events." The letter went on to note, "(i)n light of the risks of addiction, abuse, and misuse and the greater risks of overdose and death associated with this combination, please consider whether changes in therapy are warranted."[14]

31. On or about November 2, 2016, Patient 1 called into Respondent's clinic. The note to the Respondent from his staff person read as follows:

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[13] The oxycodone with acetaminophen prescription was now documented for thirty days as opposed to the previous prescriptions which had been documented for only twenty days, causing the 80 tablets of oxycodone with acetaminophen to be more spread out.

[14] A third letter from Express Scripts address to Respondent's physician assistant was received in March 2017, that made similar statements.

"now patient is calling to ask for more refill Percocet for the tooth cracked on sat, this is the third or fourth time in past two weeks he has asked for this refill that you said no more of, that you stopped per your chart notes. What do you want to do? Please note this pt has had refills on Percocet and/or norco on these dates: 07/01, 07/05, 07/14, 07/19, 07/28, 08/02, 08/16, 09/02, 09/12, 10/11, and refilled the codeine with Phenergan syrup on: 07/19, 08/02, 08/16, 09/23, 09/27, 10/25 per chart."

The telephonic note documented that Respondent reviewed the note on November 2, 2016, at approximately 1:44 p.m. On November 3, 2016, the Respondent saw Patient 1 in clinic for complaint of cough, congestion, sore throat and body aches. The Respondent documented that Patient 1 had chronic back pain and tooth pain with a crown procedure scheduled for November 22, 2016. The Respondent noted that Patient 1 had Pheneregan with codeine refilled on 07/19, 08/02, 08/16, 09/23, 09/27, and 10/25. The Respondent documented that he would start Percocet, despite already prescribing it previously, and continue Soma and Norco. The Respondent did not document the September 2016 letter from Express Scripts in the note, nor did he document any analysis on whether or not Patient 1 was misusing controlled substances as implied in the November 2, 2016, telephonic note. The Respondent did not address Patient 1's incessant receipt of codeine cough syrup. The Respondent also prescribed antibiotics.[15] On November 4, 2016, Patient 1 contacted Respondent's clinic and Respondent's physician assistant again refilled his Phenergan with codeine cough syrup prescription.

32. On or about November 10, 2016, Patient 1 contacted the clinic regarding a hydrocodone with acetaminophen refill. The telephonic note documented that the Respondent's November 3, 2016, oxycodone with acetaminophen prescription is to be the last prescription for Percocet as the Respondent will not fill it anymore. On or about December 6, 2016, without seeing Patient 1 in clinic, the Respondent continued Patient 1 on monthly prescriptions of 240 tablets of 10/325 mg Norco, 120 tablets of 350 mg Soma, and 90 tablets of 1 mg Xanax. On or about December 20, 2016, Patient 1 called the clinic after being late to his appointment. The staff person documented that he would need to reschedule or go to the emergency room. The staff member documented that Patient 1, "was angry and raised his voice, I told him if he gets any louder I would have to call the police." Respondent next saw Patient 1 on December 23, 2016,

[15] The Respondent prescribed a Z-Pak.

for a chief complaint of being sick with cough and congestion. The Respondent prescribed antibiotics, Z-Pak, and Phenergan with codeine cough syrup. The Respondent continued Patient 1 on Norco, Soma, and Xanax. Between December 2016, and April 4, 2017, the Respondent prescribed monthly prescriptions of 240 tablets of 10/325 mg Norco, 120 tablets of 350 mg Soma, and 90 tablets of 1 mg Xanax to Patient 1. The Respondent also provided additional prescriptions for Phenergan with codeine cough syrup during that time.

33. On April 11, 2017, the Respondent documented that he saw Patient 1 in clinic for congestion and cough. Respondent documented both that, Patient 1 was taking oxycodone with acetaminophen in addition to Norco, Xanax and Soma and that oxycodone with acetaminophen had been discontinued. Despite those counter notations and the November 3, 2016, note in which Respondent stated he would not prescribe Percocet further, Respondent prescribed 80 tablets of 10/325 Percocet to Patient 1. Patient 1 also received 80 tablets of 10/325 mg oxycodone with acetaminophen on May 9, 2017, from Respondent's physician assistant. Patient 1 received 80 tablets of 10/325 mg oxycodone with acetaminophen from Respondent on June 13, 2017, and July 26, 2017. This was in addition and on top of the Respondent's monthly prescription of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 120 tablets of 350 mg carisoprodol, and 90 tablets of 1 mg alprazolam. On or about April 11, 2017, the Respondent prescribed an antibiotic, a Z-Pak, and Phenergan with codeine cough syrup for Patient 1's cough and congestion. On or about April 20, 2017, Patient 1 called Respondent's clinic to request a refill of his antibiotics and Phenergan with codeine cough syrup. Respondent, without requiring a visit to clinic, started Patient 1 on a new antibiotic, Levaquin, and refilled Patient 1's codeine cough syrup.

34. On or about June 12, 2017, Patient 1 contacted Respondent's office and stated he had lost his Xanax prescription while on vacation. Patient 1 had received a full prescription for 90 tablets of 1 mg Xanax on or about May 31, 2017. The next day, June 13, 2017, Patient 1 was seen in clinic for a medication refill. The Respondent documented that he refilled 80 tablets of 10/325 mg Percocet, 120 tablets of 350 mg carisoprodol, and 90 tablets of 1 mg Xanax in the

chart note. The Respondent did not document anything related to Patient 1 losing his Xanax medication and/or how he counseled Patient 1 to be more responsible with his medication.

35. According to CURES and in a telephonic note from June 13, 2017, Respondent documented that he had increased Patient 1's prescription to 120 tablets of 10/325 mg oxycodone with acetaminophen. Respondent also continued Patient 1's 240 tablets of 10/325 mg hydrocodone with acetaminophen prescription, which Patient 1 filled on June 28, 2017. In addition on or about July 26, 2017, Patient 1 filled Respondent's prescriptions for 120 tablets of 10/325 mg oxycodone with acetaminophen, 240 tablets of 10/325 mg hydrocodone with acetaminophen, a bottle of Codeine with Phenergan cough syrup, and 120 tablets of 350 mg carisprodol. Patient 1 continued to receive 3 mg of alprazolam per day through June and July 2017 from Respondent. There is no documentation in Respondent's June or July 2017 progress notes related to why Patient 1's opioid prescriptions were being increased. If taken as prescribed, Patient 1 was again receiving an MED of 140, and consuming 3900 mg if APAP, while in combination with a narcotic in codeine cough syrup, a muscle relaxer, and a benzodiazepine. Following the June and July 2017 appointments, Respondent continued to prescribe alprazolam and carisoprodol to Patient 1 through October 2017 in the form of refills.

36. On September 30, 2020, the Respondent was interviewed by the Medical Board. The Respondent stated that he failed to perform any additional work-up of Patient 1's report of pain, including advanced medical imaging, between January 2014 and October 2017. The Respondent admitted that he prescribed codeine cough syrup on 14 different occasions to Patient 1 for pain management despite failing to document that the cough syrup was part of Patient 1's chronic pain management treatment plan. The Respondent admitted never having a chest x-ray performed on Patient 1 between January 2014 and October 2017 despite repeatedly prescribing antibiotics for cough and congestion. The Respondent admitted that between January 2014 and October 2017 that he never reviewed CURES, nor performed urine toxicology on patient 1 as part of periodic review.

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Patient 2

37. On or about December 3, 2015, Patient 2 presented at Respondent's clinic to begin treatment with the Respondent. The Respondent documented that Patient 2 had been a bad car accident in 2000 with ongoing neck and thoracic pain. The Respondent documented that Patient 2 had anxiety, hypothyrodisim, hypertriglycerides, and fell into a bonfire in 2003 and suffered burns on her buttocks. The Respondent documented that Patient 2 occasionally consumed alcohol and was a light smoker. The Respondent documented that Patient 2 was taking Norco, Xanax, and Soma. The Respondent's general examination noted that she had tightness of cervical paravertebral muscles under neck and that she had tightness of PVM[16]'s, of lumbar under back. The Respondent failed to perform work-up regarding Patient 2's history of anxiety. The Respondent did not document performing any other work-up, including whether he ordered specialized medical imaging, and he did not document reviewing Patient 2's previous medical history. The Respondent began prescribing controlled substances to Patient 2.

38. Between December 2015 and July 2017, on a monthly basis the Respondent prescribed 240 tablets of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 1 mg alprazolam and 120 tablets of 350 mg carisoprodol to Patient 2. As prescribed, Patient 2 was receiving an MED of 80 in combination with a muscle relaxer and a benzodiazepine. During the Respondent's care and treatment of Patient 2, it appears that the Respondent often electronically cut and pasted information from previous notes. For example, the history of present illness for January 22, 2016, May 16, 2016, June 23, 2016, and September 6, 2016, are the same. In addition, the general examinations for January 22, 2016, May 16, 2016, June 23, 2016, and September 6, 2016, are the same. Despite seeing Patient 2 on multiple visits over 2016, the Respondent failed to document a justification for Patient 2's continued 3 mg Xanax prescription aside from appears stressed and anxious.

39. Between December 2015 and July 2017, Patient 2 used four pharmacies to obtain her medications. Between December 2015 and July 2017, the Respondent failed to review and/or investigate repeated red flags exhibited by Patient 2 during her chronic pain management

[16] An Abbreviation for Paravertebral Muscle.

treatment. For example, on November 22, 2016, Patient 2 claimed that she needed an early refill of her medications because her pharmacy was going to be closed over the Thanksgiving holiday. Respondent's staff person verified that the Patient was incorrect and that the pharmacy was open. In addition, between December 2015 and July 2017, the Respondent often refilled Patient 2's medication early. For example, Patient 2 received 240 tablets of 10/325 mg Norco on October 27, 2016, November 23, 2016, and December 21, 2016, which indicated early refills.

40. On or about May 18, 2017, Patient 2 presented at Respondent's clinic with a boil and/or tender lump near her bikini line. The Respondent documented that the general exam of Patient 2 was non-specific. The Respondent documented that Patient 2 had folliculitis but failed to provide details regarding the duration of her illness and whether the condition was getting worse. The Respondent also failed to document laterality and it is unclear from his note whether she had one area of concern or a more diffuse rash. The respondent prescribed two consecutive days of intramuscular injections of Rocephin and a ten-day course of Bactrim. On or about July 6, 2017, Patient 2 presented with left ear pain. The Respondent failed to document details regarding Patient 2's ear pain including the duration of the condition. The Respondent documented on examination that Patient 2's left tympanic membrane was dull but did not document that the membrane was red. The Respondent prescribed an antibiotic, Cefuroxime, and a steroid, Medrol. It is unclear from the records why the Respondent prescribed a steroid.

41. Between December 2015 and July 2017, the Respondent failed to document why Patient 2 remained on a morphine equivalent dose of 80. Between December 2015 and July 2017, the Respondent failed to document why Patient 2 required repeated monthly prescriptions of 90 tablets of 1 mg alprazolam and/or why her level of anxiety required such a prescription. Between December 2015 and July 2017, the Respondent failed to document why Patient 2 required 120 tablets of 350 mg carisprodol and/or the reasons that supported the long-term use of this prescription. Between December 2015 and July 2017, the Respondent did not document whether he provided informed consent to Patient 2 regarding the concomitant use of opioids, benzodiazepines and muscle relaxers.

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42. On September 30, 2020, the Respondent was interviewed by the Medical Board. The Respondent admitted that he did not perform any advanced medical imaging during his care and treatment of Patient 2. The Respondent stated he did not try any non-opiate medications and/or non-opiate treatments while prescribing controlled substances to Patient 2. The Respondent did not check CURES while prescribing to this patient, did not calculate Patient 2's morphine equivalent dose, and did not perform urine toxicology screening on this patient. The Respondent failed to document that he attempted to send Patient 2 to a pain management specialist and/or document that a pain management specialist was unavailable in his area of practice.

Patient 3

43. On or about November 14, 2014, the Respondent first saw Patient 3 in his clinic for sinusitis. Patient 3 had a history which included a motor vehicle accident in 2009, compression fractures of the T2, T3 and T5 vertebra, and recurrent kidney stones. The Respondent took over Patient 3's care and began prescribing controlled substances. For example, as a result of Respondent's prescriptions, Patient 3 received 90 tablets of 1 mg alprazolam and 90 tablets of 350 mg carisoprodol on November 23, 2014, and 240 tablets of 10/325 mg hydrocodone with acetaminophen on November 24, 2014. According to a treatment note documented November 24, 2014, Patient 3 was seen in clinic for a sinus infection. The Respondent documented a medical history of back pain, headaches and degenerative disease. The Respondent documented that Patient 3 had tightness of cervical paravertebral muscles in his neck examination. The Respondent documented that Patient 3 had back pain that required Norco and Soma and documented that Patient 3 had anxiety, which required Xanax. The Respondent did not document any additional work-up, including radiological imaging and/or assessing the level and duration of Patient 3's anxiety. The Respondent did document that he was stopping Patient 3's Percocet prescription.

44. On December 4, 2014, there is a chart note that Patient 3 contacted Respondent's clinic and requested a refill of Percocet because he was still in pain related to passing a kidney stone. On or about December 9, 2014, as a result of Respondent's prescription, Patient 3 received 180 tablets of 10/325 mg oxycodone with acetaminophen. The Respondent failed to provide

documentation if the Percocet were to be taken instead of Norco. If the Norco and Percocet was taken as prescribed, Patient 3 received per day an MED of 170, and Patient 3 would have consumed 4550 mg of APAP, while in combination with 3 mg of alprazolam and 1050 mg of carisoprodol. The Respondent next saw Patient 3 on December 19, 2014. The Respondent continued Patient 3 on Norco, Soma, and Xanax.

45. On January 16, 2015, the Respondent saw Patient 3 in clinic. The Respondent documented that Patient 3 had two renal stones, had a stent and was scheduled for lithotripsy, (a procedure where ultrasound shock waves are used to disintegrate a kidney or other such stone), with a urologist. The Respondent documented that Patient 3 had spasms along his cervical chain muscles. The Respondent's general examination appeared electronically cut and pasted from the December 19, 2014, note. The Respondent prescribed 240 tablets 10/325 mg hydrocodone with acetaminophen, 90 tablets of 10 mg oxycodone hcl, 90 tablets of 1 mg alprazolam, and 90 tablets of 350 mg carisoprodol. The Respondent failed to document why he was adding oxycodone to Patient 3's chronic pain regimen. If taken as prescribed, Patient 3 was now receiving an MED of 125 from two short acting opioids in combination with Xanax and Soma.

46. According to CURES, Patient 3, filled a prescription from Respondent for 240 tablets of 10/325 mg hydrocodone with acetaminophen on or about January 19, 2015. Despite this being a prescription scheduled to last 30 days, on or about February 11, 2015, Patient 3 contacted Respondent's clinic requesting an early refill of hydrocodone with acetaminophen. On or about February 16, 2015, Patient 3 received an early refill of 240 tablets of 10/325 mg hydrocodone with acetaminophen. On or about February 17, 2015, Patient 3 requested a refill of 120 tablets of 10 mg oxycodone hcl and received that medication on or about February 19, 2015. On or about February 23, 2015, Patient 3 contacted Respondent's clinic and requested that he receive 2 mg Xanax, three times a day, rather 1 mg of Xanax three times a day. On or about February 25, 2015, the Respondent documented that Patient 3 was seen in clinic for chief complaint of allergies and Xanax dose. The Respondent documented that Patient 3 had seasonal allergies, was scheduled for a March 18, 2015 lithotripsy, and was using over the counter medication, which was not helping. Under review of symptoms, the Respondent documented that Patient 3 had

watery eyes, runny nose, and back pain. The February 25, 2015, general examination portion of the progress note appears to be electronically cut and pasted from the visit on January 16, 2015. The Respondent continued Patient 3's Norco prescription and increased Patient 3's Xanax prescription to 2 mg, three times a day, for "Panic attack." The Respondent failed to document any information related to Patient 3's panic attack, which would justify the doubling Patient 3's alprazolam prescription. In addition, the Respondent failed to document providing Patient 3 informed consent regarding the potential dangers of taking two short acting opioids with an MED of 140 in combination with 1050 mg of carisoprodol and 6 mg of Xanax.

47. On or about March 18, 2015, Patient 3 received an eight-day prescription for 36 tablets of 30/300 mg codeine phosphate with acetaminophen from his urologist who was performing the lithotripsy. Patient 3 received 240 tablets of 10/325 mg hydrocodone with acetaminophen on or about March 13, 2015, and 120 tablets of 10 mg oxycodone hcl on or about March 19, 2015, from Respondent. If taken as prescribed, Patient 3 received a daily MED of 160 between March 18, 2015, and March 25, 2015, while in combination with 1050 mg of carisoprodol and 6 mg of Xanax. The Respondent did not see Patient 3 in clinic in March or April 2015, and allowed for refills of multiple controlled substances to occur through telephone encounters with Patient 3.

48. On or about May 4, 2015, the Respondent documented seeing Patient 3 in clinic for allergies, and documented that Patient 3 was present with seasonal allergies, had a headache, was congested, and that he needed a refill of Xanax and Soma. The Respondent documented that Patient 3 had watery eyes, runny nose, back pain and had anxiety. The general examination appeared to be electronically cut and pasted from the February 25, 2015, note. The Respondent diagnosed Patient 3 with sinusitis and prescribed Augmentin, Nasonex, and Medrol. In addition, the Respondent also noted that a Z-Pak should be prescribed. The Respondent failed to document a medical history of Patient 3's sinusitis, including the duration of symptoms and an explanation on why or why not Patient 3's condition required the use of antibiotics.

49. On or between May 4, 2015, and August 8, 2015, the Respondent prescribed 240 tablets of 10 mg oxycodone hcl, 960 tablets of 10/325 mg hydrocodone with acetaminophen, 360

tablets of 360 mg carisoprodol, and 360 tablets of 2 mg alprazolam to Patient 3. On July 10, 2015, Patient 3 contacted Respondent's clinic and requested a 30-day supply of 30 mg. temazepam for sleep. Respondent had last seen Patient 3 in clinic on May 4, 2015, and there is no mention in the notes regarding Patient 3's need for sleep medication. On or about July 10, 2015, Patient 3 filled the prescription for 30 tablets of 30 mg temazepam after Respondent provided a prescription. At this point, Patient 3 was receiving a daily MED of 140 from two short acting opioids, in combination with two benzodiazepines and a muscle relaxer. There is no documentation from July 10, 2015, that Patient 3 was provided informed consent regarding the dangers of consuming two opioids, two benzodiazepines, and a muscle relaxer in combination. On or about July 29, 2015, the Respondent next saw Patient 3 in clinic. The Respondent documented that Patient 3's chief complaint was refills and that Patient 3 has neck pain and frequent headaches. In addition, the Respondent documented that Patient 3 had degenerative disc disease, that he was scheduled to see a specialist and that he was requesting an MRI of the cervical spine. The Respondent ordered an MRI of the cervical spine, refilled Patient 3's Norco, Soma and Xanax prescriptions and provided a trigger point injection. The Respondent documented that Patient 3 had received temazepam but failed to provide any documentation to justify the prescription or explain why it was being added to Patient 3's treatment regimen.

50. On or about August 7, 2015, Patient 3 has a MRI over cervical spine completed. The MRI occurred over nine months after Respondent began prescribing multiple controlled substances to Patient 3. The MRI findings revealed that Patient 3 had degenerative disc disease, pain, and that there was normal alignment of the cervical vertebral bodies. The impression noted that, "(n)ormal MRI of the cervical spine with no disc herniations or acute bony fractures." Between August 7, 2015, and March 14, 2016, the Respondent continued to prescribe monthly prescriptions of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 2 mg alprazolam, and 90 tablets of carisoprodol. In addition, on or about October 28, 2015, and December 21, 2015, Patient 3 received 30 tablets of temazepam from Respondent's prescriptions. In addition, on or about January 21, 2016, Patient 3 received 120 tablets of 10 mg oxycodone from Respondent. On March 14, 2016, Respondent's office received a telephonic contact from

Patient 3 stating that his pharmacy was not refilling his Xanax. Upon further investigation, the note documented that Patient 3 had last received 90 tablets of 2 mg alprazolam on February 15, 2016, and had attempted to refill it on March 9, 2016, which was too early. On or about March 28, 2016, Patient 3 telephonically contacted Respondent's clinic and reported he was passing a kidney stone and requested a prescription for oxycodone hcl. The Respondent provided a prescription and on or about March 29, 2016, Patient 3 filled that prescription for 120 tablets of 10 mg oxycodone hcl. Patient 3 was still receiving Norco, Xanax and Soma. The Respondent did not require that Patient 3 be seen in clinic regarding the early Xanax refill or his request for oxycodone.

51. On about April 22, 2016, the Respondent next saw Patient 3 in clinic for flu symptoms. The Respondent documented that Patient 3 was ill with influenza. The Respondent's progress note failed to mention Patient 3's early refill request for Xanax from March 2016 and failed to mention and/or justify Patient 3's telephonic request for oxycodone from March 2016. The Respondent documented that Patient 3 was having difficulty swallowing and under review of symptoms documented a sore throat. However, under general examination the Respondent noted that Patient 3's pharynx was normal. The Respondent did document that Patient 3's oral cavity was red and irritated. The Respondent, despite documenting a normal pharynx, prescribed a Z-Pak for pharyngitis. The Respondent continued Norco, Soma, and Xanax as previously prescribed.

52. On or between April 29, 2016, and July 21, 2017, the Respondent and the physician assistant he supervised, continued to provide Patient 3 with monthly prescriptions of 240 tablets of 10/325 mg hydrocodone with acetaminophen, 90 tablets of 350 mg carisoprodol, and 90 tablets of 2 mg Xanax. In addition on or about April 29, 2016, June 28, 2016, August 3, 2016, September 6, 2016, November 7, 2016, December 12, 2016, January 19, 2017, February 21, 2017, April 14, 2017, the Respondent prescribed 120 tablets of 10 mg oxycodone hcl to Patient 3. There is no evidence that Respondent provided a tapering dose regimen of oxycodone before discontinuing the oxycodone prescription in April 2017. On or between November 2014 through July 2017, Patient 3 used five different pharmacies to fill prescriptions from the Respondent. On

or between November 2014 through July 2017, Patient 3 often attempted to receive and/or received early refills of controlled substances. On or between November 2014 through July 2017, the Respondent often cut and pasted portions of Patient 3's examinations from previous progress notes into future progress notes. During that time, the Respondent failed to document Patient 3's pain levels and/or function on pain medication. During that time, the Respondent failed to document Patient 3's anxiety levels and the Respondent failed to provide any justification for the continued prescribing of high dose Xanax aside from the conclusory statements of "anxiety" and "panic attacks." Finally, on or between November 2014 through July 2017, the Respondent failed to document Patient 3's level of muscle pain and/or muscle spasm in such a way to support a long-term monthly prescription of carisoprodol. The Respondent continued prescribing Soma and Xanax through prescription refills until October 14, 2017.

53. On September 30, 2020, the Respondent was interviewed regarding the care and treatment of Patient 3. The Respondent acknowledged that aside from Patient 3's past history of compression fracture and the August 2015 MRI, that he did not perform any other work-up of Patient 3's pain conditions. The Respondent acknowledged that the August 2015 MRI, while showing degenerative disc disease, did not reveal any acute findings. The Respondent stated that he was unaware that Patient 3's MED was 140 between January 2015 and June 2016. The Respondent stated he was unaware that he doubled Patient 3's Xanax prescription in February 2015 despite Respondent's medical documentation clearly showing that he increased the medication. At the interview, the Respondent stated that in February 2015, he prescribed Norco, oxycodone, Xanax and Soma to Patient 3 to treat back pain, neck pain, kidney stones and migraines. The Respondent failed to mention "panic attack" which was documented in the February 25, 2015, chart note for the reason that the Respondent was prescribing Xanax.

54. At the September 30, 2020, interview the Respondent acknowledged that he did not check CURES while prescribing controlled substances to Patient 3. The Respondent acknowledged that he did not perform urine toxicology screening while prescribing controlled substances to Patient 3. The Respondent acknowledged that he failed to calculate morphine-equivalent doses for Patient 3 while prescribing Norco and oxycodone. The Respondent

acknowledged that he did not send Patient 3 to physical therapy. The Respondent acknowledged that he did not send Patient 3 for a psychiatric evaluation and that he did not attempt any non-opiate pain therapies aside from ibuprofen. The Respondent stated he sent Patient 3 for a pain management referral one time in July 2015 as documented in his July 29, 2015, progress note. Following the July 29, 2015, visit, the Respondent did not see Patient 3 in his clinic until January 8, 2016. The Respondent failed to document anything related to the pain management visit in his January 8, 2016, chart note.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

55. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

56. Complainant realleges paragraphs 17 to 54, and those paragraphs are incorporated by references as if fully set forth herein.

57. Respondent's license is subject to disciplinary action because he committed gross negligence during the care and treatments of Patients 1, 2, and 3, in the following distinct and separate ways:

a. By repeatedly prescribing high dose opioids in combination with sedatives and muscle relaxers between January 2014 and October 2017, to Patient 1 despite multiple indications that the prescriptions were dangerous as prescribed;

b. By repeatedly failing to adequately justify the long term use of multiple controlled substances, including but not limited to justifying the prescription of multiple short acting opioids at the same time, justifying the monthly prescription of carisoprodol, and/or the justifying the monthly prescription of alprazolam, which also included the tripling of the dosage in February 2016, between January 2014 and October 2017, to Patient 1;

c. By failing to monitor and adjust Patient 1's chronic pain management treatment plan between January 2014 and October 2017, despite multiple incidents of Patient 1 requiring

early refills and/or exhibiting signs that he was misusing medication and/or using multiple pharmacies and/or receiving prescriptions from other medical providers;

d. By failing to properly document a history and physical, treatment plan and/or perform periodic review of Patient 1's chronic pain management regiment and/or Patient 1's anxiety medication between January 2014 and October 2017;

e. By failing to perform proper documentation of Patient 1's treatment between January 2014 and October 2017, because Respondent electronically cut and pasted previous notes, and/or failing to document a procedure note for an incision and drainage;

f. By repeatedly prescribing antibiotics to Patient 1 between January 2014 and October 2017 without detailing sufficient information to support the continued prescribing of antibiotics and/or ordering chest imaging when confronted with Patient 1's constant recurring respiratory infections.

g. By repeatedly failing between January 2014 and October 2017, to provide Patient 1 with adequate informed consent regarding the dangers of using concomitant controlled substances;

h. By repeatedly failing to refer Patient 1 for specialized pain management treatment with a pain management expert and/or document why a referral was not possible;

i. By repeatedly prescribing high dose opioids in combination with sedatives and muscle relaxers between December 2015 and July 2017, to Patient 2 despite multiple indications that the prescriptions were dangerous as prescribed;

j. By repeatedly failing to adequately justify the long-term use of controlled substances, including justifying the monthly prescription of Norco, justifying the monthly prescription of carisoprodol, and/or justifying the monthly prescription of alprazolam between December 2015 and July 2017, to Patient 2;

k. By failing to monitor and adjust Patient 2's chronic pain management treatment plan between December 2015 and July 2017, despite Patient 2 receiving early refills of medications and receiving controlled substances from multiple pharmacies;

l. By failing to properly document a history and physical, treatment plan and/or perform periodic review of Patient 2's chronic pain management regiment and/or Patient 2's anxiety medication between December 2015 and July 2017;

m. By failing to perform proper documentation of Patient 2's treatment between December 2015 and July 2017, because Respondent electronically cut and pasted previous notes, and/or failing to document the location of folliculitis;

n. By repeatedly prescribing antibiotics to Patient 2 between December 2015 and July 2017, without detailing sufficient justification and by way of example, prescribing a 10-day course of oral antibiotics plus two days of IM Rocephin for folliculitis and cefuroxime for an ear infection instead of amoxicillin;

o. By repeatedly failing between December 2015 and July 2017, to provide Patient 2 with adequate informed consent regarding the dangers of using concomitant controlled substances;

p. By repeatedly failing to refer Patient 2 for specialized pain management treatment with a pain management expert and/or document why a referral was not possible;

q. By repeatedly prescribing high dose opioids in combination with sedatives and muscle relaxers between November 2014 and October 2017, to Patient 3 despite multiple indications that the prescriptions were dangerous as prescribed;

r. By repeatedly failing to adequately justify the long term use of multiple controlled substances, including but not limited to failing to justify the prescription of multiple short acting opioids at the same time, failing to justify the monthly prescription of carisoprodol, failing to justify the monthly prescription of alprazolam, which also included doubling of the dosage in February 2015, and/or failing to justify the prescriptions for temazepam, between November 2014 and October 2017, to Patient 3;

s. By failing to monitor and adjust Patient 3's chronic pain management treatment plan between November 2014 and October 2017, despite multiple incidents of Patient 3 requiring early refills and/or exhibiting signs that he was misusing medication and/or using multiple pharmacies and/or receiving prescriptions from other medical providers;

t. By failing to properly document a history and physical, treatment plan and/or perform periodic review of Patient 3's chronic pain management regiment and/or Patient 3's anxiety medication between November 2014 and October 2017;

u. By failing to perform proper documentation of Patient 3's pain management treatment between November 2014 and October 2017, because the Respondent electronically cut and pasted previous notes;

v. By repeatedly prescribing antibiotics to Patient 3 between January 2014 and October 2017, without detailing sufficient information to support the prescribing of antibiotics;

w. By repeatedly failing between November 2014 and October 2017, to provide Patient 3 with adequate informed consent regarding the dangers of using concomitant controlled substances; and,

x. By repeatedly failing to refer Patient 3 for specialized psychiatric treatment with a psychiatric expert and/or document why a referral was not possible.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

58. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), in that the Respondent committed repeated negligent acts during the care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

59. Complainant realleges paragraphs 17 to 57, and those paragraphs are incorporated by reference as if fully set forth herein. Each of the instances of gross negligence are also considered separate and distinct negligent acts and are incorporated by reference as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Record Keeping)

60. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records during his care and treatment of Patients 1, 2, and 3. The circumstances are as follows:

61. Complainant realleges paragraphs 17 to 59, and those paragraphs are incorporated by references 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 A 45073, issued to Dwain William Rickertsen, M.D.;

2. Revoking, suspending or denying approval of Dwain William Rickertsen, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Dwain William Rickertsen, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Dwain William Rickertsen, M.D., if placed on probation for five years or more, to notify his patients pursuant to Business and Professions Code § 2228.1; and

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

DATED: DEC 02 2020

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

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