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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: Michael Anthony Simental, M.D. Physician's and Surgeon's Certificate No. A 86750 Respondent.	Case No. 800-2021-077874

DECISION

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

This Decision shall become effective at 5:00 p.m. on June 1, 2022.

IT IS SO ORDERED May 25, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: MICHAEL ANTHONY SIMENTAL, M.D. P.O. Box 78642 Corona, CA 92877-0154 Physician's and Surgeon's Certificate No. A 86750, Respondent.	Case No. 800-2021-077874 OAH No. 2021120328 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. 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 Rebecca L. Smith, Deputy Attorney General.

2. Michael Anthony Simental, M.D. (Respondent) is represented in this proceeding by attorneys Peter R. Osinof and Edward Idell, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, CA 90071-1562.

3. On or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate No. A 86750 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in the Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874 and will expire on February 28, 2024, unless renewed.

JURISDICTION

4. Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874 was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on January 5, 2022. Respondent timely filed his Notice of Defense contesting the Second Amended Accusation and Petition to Revoke Probation. A copy of the Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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CULPABILITY

8. Respondent understands that the charges and allegations in the Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

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

CONTINGENCY

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 86750, issued to Respondent Michael Anthony Simental, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of Six Thousand, Seven Hundred Fifty-Five and No Cents ($6,755.00) prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Second Amended Accusation and Petition to Revoke Probation, No. 800-2021-077874 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorneys Peter R Osinoff and Edward Idell I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California

DATED 5/11/2022

MD

MICHAEL ANTHONY SIMENTAL, M.D.
Respondent

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

DATED _____

PETER R OSINOFF
EDWARD IDELL
Attorney for Respondent

ENDORSEMENT

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

DATED _____

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

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

DATED: _____

MICHAEL ANTHONY SIMENTAL, M.D.
Respondent

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

DATED: 5-11-22

PETER R. OSINOFF
EDWARD IDELL
Attorney for Respondent

ENDORSEMENT

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

DATED: 5/11/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation and Petition to Revoke Probation No. 800-2021-077874

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6540
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Second Amended Accusation and Petition to Revoke Probation Against: **MICHAEL ANTHONY SIMENTAL, M.D.** **P.O. Box 78642** **Corona, CA 92877-0154** **Physician's and Surgeon's Certificate No. A 86750,** Respondent.	Case No. 800-2021-077874 **SECOND AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

1. William Prasifka (Complainant) brings this Second Amended Accusation and Petition to Revoke Probation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate Number A 86750 to Michael Anthony Simental, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2022, unless renewed.

DISCIPLINARY HISTORY

3. Effective on or about December 22, 2016, in a prior disciplinary action entitled, *In the Matter of the Accusation Against Michael Anthony Simental, M.D.* before the Board in Case No. 18-2012-226103 (2016 Decision), Respondent's Physician's and Surgeon's Certificate was

revoked, but that revocation was stayed, and he was placed on probation for two years, with terms and conditions, for unprofessional conduct, including gross negligence, repeated negligent acts and excessive prescribing in the care and treatment of three patients. That decision is now final and is incorporated by reference as if fully set forth. A true and correct copy of the 2016 Decision is attached hereto as Exhibit A.

4. Effective on or about August 9, 2019, in a prior disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against Michael A. Simental, M.D.* ("PTR") before the Board, in Case Number 800-2018-049419 (2019 Decision), Respondent's Physician's and Surgeon's Certificate was revoked, but the revocation was stayed, and he was placed on probation for five years, with terms and conditions, for unprofessional conduct. A true and correct copy of the 2019 Decision is attached hereto as Exhibit B and is incorporated herein by reference as if fully set forth. All the charges and allegations in the PTR are admitted pursuant to section 12 of the 2019 Decision.

5. On or about May 20, 2021, the Board issued a Cease Practice Order prohibiting Respondent from engaging in the practice of medicine based upon his failure to obey Probationary Condition No. 5, the successful completion of the Clinical Competence Assessment Program, as set forth in the 2019 Decision. A true and correct copy of the 2021 Cease Practice Order is attached hereto as Exhibit C and is incorporated herein by reference as if fully set forth.

JURISDICTION

6. This Second Amended Accusation and Petition to Revoke Probation 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.

7. Section 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

8. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

9. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

10. Section 822 of the Code states:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing section shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

11. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

(1) An initial negligent diagnosis followed by an act or omission medically

appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

12. Section 2266 of the Code states:

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

13. Section 2228.1 of the Code states:

(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.

14. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription

drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

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

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

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

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

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

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

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

15. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

16. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

17. Section 4021 of the Code states:

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

18. Section 4022 of the Code provides:

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

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

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

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

DRUG DEFINITIONS

19. Fentanyl is a synthetic opioid that was developed for pain management treatment of cancer patients, applied in a patch on the skin. It is 80-100 times stronger than morphine and has driven a steep rise in opioid overdoses since 2013. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and is a dangerous drug pursuant to Business and Professions Code section 4022.

20. Fluoxetine, also known by the brand name Prozac, is an antidepressant and belongs to the selective serotonin reuptake inhibitors (SSRIs) group. It is a dangerous drug pursuant to Business and Professions Code section 4022.

21. Hydrocodone acetaminophen, also known by the brand name Norco, is an opioid pain reliever. It has a high potential for abuse. In 2013, hydrocodone-acetaminophen was a Schedule III Controlled Substance. Commencing on October 6, 2014, hydrocodone-acetaminophen became classified as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Hydromorphone, also known by the brand name Dilaudid, is an opioid pain reliever. It has a high potential for abuse and use may lead to severe psychological or physical dependence. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and is a dangerous drug pursuant to Business and Professions Code section 4022.

23. Methocarbamol is a muscle relaxant. It is a dangerous drug pursuant to Business and Professions Code section 4022

24. Morphine sulfate, also known by the brand name MS Contin, is an opioid pain reliever. It has high potential for abuse. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(L), and is a dangerous drug pursuant to Business and Professions Code section 4022.

25. Phentermine is a stimulant similar to an amphetamine. It acts as an appetite suppressant by affecting the central nervous system. It is used medically as an appetite suppressant for short-term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (b)(f)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Robaxin is a muscle relaxant. It is a dangerous drug pursuant to Business and Professions Code section 4022.

27. Temazepam is a benzodiazepine medication. It is generally indicated for the short-term treatment of insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29), and a dangerous drug as defined in Business and Professions Code section 4022.

28. Zolpidem, also known by the brand name Ambien, is a sedative drug primarily used for the treatment of trouble sleeping. Its hypnotic effects are similar to those of the benzodiazepine class of drugs. It is a Schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(32), and a dangerous drug pursuant to Business and Professions Code section 4022.

COST RECOVERY

29. Business and Professions Code section 125.3 states that:

> (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.
>
> (b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.
>
> (c) A certified copy of the actual costs, or a good faith estimate of costs where

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

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

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

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

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

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

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

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

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

FIRST CAUSE TO REVOKE PROBATION

(Failure to Successfully Complete PACE Program)

30. Respondent's probation is subject to revocation because he failed to comply with Condition 5 of the 2019 Decision's Disciplinary Order (Condition 5) in that he failed to successfully complete the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine. The circumstances are as follows:

31. At all times after the effective date of the 2019 Decision, Condition 5 stated, in pertinent part:

> "Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.
>
> ". . .
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> "Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.
>
> "If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period."

32. Respondent attended the Physician Assessment and Clinical Education Program at University of California, San Diego (PACE) on January 13, 14, 15 and 19, 2021. Respondent failed to successfully complete PACE.

33. Respondent's performance during PACE was evaluated by PACE faculty and directors. They concluded that Respondent's overall performance was unsatisfactory. Respondent's evaluators at PACE found that his overall performance was inconsistent with the ability to safely and successfully practice medicine.

A. During PACE, Respondent underwent a neuropsychological evaluation, the results of which revealed issues with his performance across the domains of attention, information processing speed, and executive functioning (which make him more vulnerable to inattention or sloppy performance, particularly under time demand). Respondent's condition renders him prone to difficulties when faced with novel and complex scenarios that require speeded problem solving, a situation often faced by physicians, wherein recognition of unexpected situations and quick troubleshooting to correct for errors and

make alternative plans are crucial.

B. During PACE, Respondent performed a complete history and physical examination of a 57-year-old male mock patient, during which he demonstrated poor physical examination skills. Several areas of the physical examination were either not performed or in need of improvement. On the HEENT exam, Respondent did not perform a fundoscopic exam. On the neck exam, he palpated anteriorly only. On the lung exam, he auscultated over the gown anteriorly - over cardiac locations. On the examination of the patient's abdomen, he listened over the gown and he palpated prior to auscultation with improper technique. On the nervous system exam, he tested sensation with monofilament over the face and extremities; he tested lower extremity reflexes but did no further neurological exam. Finally, Respondent did not demonstrate appropriate draping as he did not undrape to auscultate the patient.

C. Respondent underwent an oral clinical examination and was presented with six patient scenarios. Respondent failed the oral clinical examination. Respondent's performance during these oral clinical examinations revealed unsatisfactory medical knowledge and clinical judgment in discussing clinical situations. He consistently had difficulty answering direct questions regarding common symptoms, work-up, and treatment, requiring repetition of the same question numerous times, yet he was still unable to answer. Respondent was also very dependent on diagnosis and treatment algorithms within the Kaiser system and was unable to answer questions regarding treatment because he was not familiar with the current formulary. He also repeatedly stated that his current diagnostic and treatment choices are influenced by what he had "seen on the news" or "seen on TV."

D. Respondent completed five standardized patient encounters (SPE). Regarding interview skills, Respondent lacked detail in his history taking. Regarding physical exam skills, Respondent demonstrated generally poor physical exam skills. Regarding professionalism, Respondent, at times, missed opportunities to express some support and empathy. Regarding clinical judgment, Respondent misdiagnosed one patient. Regarding

organization and efficiency, Respondent was hasty and brief with a patient. Overall regarding clinical competency, Respondent's primary deficiency was poor physical exam skills. Regarding chart note review, generally, his documented histories and physical examination notes were too brief and lacked adequate detail.

E. Respondent also took the Generalist 1 version of PRIMUM, a computerized test developed by the National Board of Medical Examiners (NBME) designed to assess his knowledge of clinical decision-making and patient-management skills. Respondent also underwent a transaction stimulated recall interview. Overall, while Respondent managed all of the cases in a satisfactory manner, there were deficiencies in his management, which reflected knowledge and judgment deficits.

F. Respondent also underwent a professionalism evaluation and "was very scatterbrained during his entire assessment and had a hard time focusing." He finished his assessment at 2 p.m. and then took the next 2.5 hours to complete his SPE write-up. He was given time to write up his SPE notes during his assessment as well. He was provided with several time warnings and his time limitation was extended on multiple occasions until finally he was cut off.

G. Overall, Respondent failed PACE. Respondent demonstrated poor physical examination skills - there were several areas of the physical examination that were either not done or in need of improvement. On the oral examination in family medicine, Respondent demonstrated unsatisfactory medical knowledge and clinical judgment - he consistently had difficulty answering direct questions regarding common symptoms, work-up, and treatment requiring the same question to be asked to him numerous times without providing a concrete answer. Additionally, he mentioned multiple times that some of his current diagnostic treatment choices are influenced by what he has seen on the news or seen on TV. In addition, on the PRIMUM and subsequent TSR interview, Respondent evinced deficiencies in his knowledge and judgment. The results of Respondent's neuropsychological testing also demonstrated weaknesses in attention, processing speed, and executive functioning. Finally, Respondent is unsafe to practice medicine due to his

deficient medical knowledge, his performance on neuropsychological testing, and his behavior observed by PACE faculty and staff (such as his hyperverbal and tangential behavior requiring redirection by the examiner and apparent inability to focus).

H. Respondent's evaluators at PACE found that Respondent's poor performance during the PACE program was "not compatible with overall physician competency and safe practice." In addition, the evaluators concluded that his poor performance could be due to a physical or mental health problem that prevented him from practicing safely. Based on the observed performance in the PACE assessment, the evaluators at PACE found that Respondent represented a potential danger to patients. The PACE evaluators found that Respondent's overall performance at PACE reflected major, significant deficiencies in clinical competence.

34. Respondent's failure to successfully complete PACE is a violation of the terms and conditions of his probation.

SECOND CAUSE TO REVOKE PROBATION

(Failure to Obey All Laws)

35. Respondent's probation is subject to revocation because he failed to comply with Condition 12 of the 2019 Decision's Disciplinary Order (Condition 12) in that he violated Code sections 2266 (by failing to maintain adequate and accurate medical records) and 2234, subdivision (c)(by being incompetent) and 2234, generally. The circumstances are as follows:

36. At all times after the effective date of the Decision, Condition 12 stated, in pertinent part:

> "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."

37. The allegations in the First Cause to Revoke Probation and First, Second, Third and Fourth Causes for Discipline below above are incorporated herein by reference as if fully set forth.

38. Respondent committed unprofessional conduct, displayed a lack of medical knowledge and skill during his participation in PACE, and failed to maintain adequate and

accurate medical records with respect to his medical documentation.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

39. Respondent is subject to disciplinary action under Code sections 2227 and 2234, subdivision (d), in that Respondent has demonstrated incompetence. The circumstances are as follows:

40. The allegations in the First and Second Causes to Revoke Probation above are incorporated herein by reference as if fully set forth.

41. Respondent evinced a lack of skill and knowledge through his acts and/or omissions during his participation in PACE pursuant to the 2019 Decision.

SECOND CAUSE FOR DISCIPLINE

(Mental Illness and/or Physical Illness)

42. Respondent is subject to disciplinary action under Code section 822, in that Respondent is suffering from a mental and/or physical illness. The circumstances are as follows:

43. The allegations in the First Cause for Discipline above is incorporated herein by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence in the Care and Treatment of Patients 1 and 2)

44. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in his care and treatment of Patients 1 and 2.[1] The circumstances are as follows:

Patient 1

45. Patient 1 began receiving medical care and treatment at Kaiser Permanente Riverside in 2006. Respondent, a family practitioner, became Patient 1's primary care physician in 2009, and he continued to treat her as her doctor until she died on or about June 28, 2018. Patient 1 had a history of chronic pain and Respondent continuously treated her with potent drugs throughout his care for her. On or about June 16, 2009, Respondent performed an initial examination at

[1] The patients herein are referred to as Patients 1 and 2 in order to protect their privacy.

which time he noted that Patient 1 (a 50-year-old woman) complained about a history of frequent low back pain. With respect to associated symptoms, she was noted to have no numbness or tingling. She had weakness without gait difficulty and no incontinence. Aggravating factors included bending, twisting and lifting without radiation to the legs. She denied any previous low back injury. She had previously been treated with anti-inflammatory medications, pain medications, and physical therapy. Respondent also noted that Patient 1 complained of tension headache, insomnia, allergic rhinitis, history of hysterectomy on hormone replacement and she requested a refill of her medications. Respondent failed to document any review of systems or physical examination for the patient. Respondent ordered laboratory tests and prescribed medications, including controlled substances, Norco, Ambien, Prozac, and Phentermine. Respondent noted that the risks of Phentermine were discussed in detail. No other medication risks were noted to have been discussed.

46. Respondent continued to serve as Patient 1's primary care physician managing her pain medications. On or about May 5, 2012, Respondent documented that Patient 1 was "seen today for medication refills for chronic low pain. She has been taking a lot of Robaxin (a muscle relaxer) and Norco." Respondent's examination was unchanged from prior visits. Using a template, Respondent noted that the risks and benefits of narcotics and benzodiazepines were discussed with the patient in detail and verbal consent was obtained. The template further noted that the option for no prescription was also discussed and the patient elected prescription despite the risks and benefits.[2] Respondent also noted that the patient's pain management option goals included cutting down her Tylenol dosages and short-term narcotic use. He also noted that the patient would start a trial of morphine with the goal less than 300 Norco (hydrocodone-acetaminophen) per month.

47. In spite of the limit noted on or about May 5, 2012, Respondent continued to prescribe Norco, 300 tablets at a time, which he continued through August 19, 2012, at intervals as short as 23 days (e.g., June 5, 2012 through June 28, 2012). As of May 5, 2012, Respondent

[2] Patient 1 was not offered an alternative or an explanation of how withdrawal could be done without suffering and improvement in pain.

added an additional opiate, MS Contin, 15 mg, 90 tablets per month. He increased the dosage strength of the MS Contin to 30 mg on or about August 1, 2012 and added a new prescription for fentanyl patches. Respondent failed to document an explanation or any medical decision making for the increase in morphine dose or addition of fentanyl subsequent to the May 5, 2012 office note, including Respondent's next office visit on or about August 5, 2012, or anytime thereafter.

48. On or about August 23, 2012, Respondent sent Patient 1 an email message that her last fentanyl prescription was last picked up on or about August 1, 2012, and that it would not be refillable until September 1, 2012. Thereafter, Respondent filled the fentanyl prescription prior to September 1, 2012 without any documented explanation for the early refill.

49. On or about November 15, 2012, Patient 1 was seen by Respondent for nausea, vomiting and diarrhea. Respondent concluded that Patient 1 had viral gastroenteritis. Respondent continued Patient 1's pain medications. Her chronic pain and analgesic prescriptions were not evaluated despite a greater than 3-month interval since last being seen.

50. On or about December 26, 2012, Patient 1 was seen by Respondent for her chronic low back pain. With respect to health problems reviewed, Respondent noted that Patient 1 had intermittent asthma, migraine, chronic low back pain, essential tremor, major depressive disorder and lumbar radiculopathy. He noted that she had history of a worker's compensation case and as a result was disabled. The patient's opiate analgesic was refilled. Respondent also noted that Patient 1 had a chronic opioid treatment agreement in place. However, there was no signed written agreement in Patient 1's chart.

51. In 2013, Patient 1 developed health issues secondary to the prescribed analgesics, including markedly elevated enzymes and an emergency room visit for nausea and vomiting. On or about February 15, 2013, Patient 1 presented to Respondent for low back pain and a medication review. Respondent noted that Patient 1 had a recent emergency room visit due to nausea and elevated liver enzymes due to possibly taking too much Norco. He noted that Patient 1 was "angry with nature of visit." Respondent changed Patient 1's pain medications to non-acetaminophen opioid analgesic medications. He ordered Dilaudid 2 mg tablets and noted that they would stop the patch and taper morphine equivalents. There was no documentation of

Respondent's reason for stopping hydrocodone-acetaminophen and no instructions for the patient to avoid acetaminophen.

52. On or about March 13, 2013, Patient 1 presented to Respondent with complaints of low back pain. At that time, Responded noted that Patient 1 denied diversion of medications. On or about March 29, 2013, Patient 1 sent Respondent an email notifying him that she was almost out of her Dilaudid, which was for 30-days, and that her husband takes her medication leaving her without any medication. Respondent responded the next day with another prescription for morphine without documentation of the reported diversion or management alteration.

53. On or about September 23, 2013, Patient 1 was seen by Respondent for complaints of low back pain. Respondent noted that he discussed pain management with Patient 1 and her husband and that she denied diversion.

54. On or about January 8, 2014, Respondent saw Patient 1 for lower back pain and a medication review. With respect to health problems reviewed, he noted that Patient 1 had intermittent asthma, major depressive disorder, an upper respiratory tract infection, restless leg syndrome, insomnia, anxiety disorder, cough, malaise, and fatigue. He documented a physical examination of the patient. He further documented that he had a long conversation on medication options and will continue to reduce narcotic and other controlled substances as medically tolerated or indicated. Respondent next saw the patient on or about March 31, 2014, following an emergency department visit for a fall and knee injury for which he referred Patient 1 to orthopedics for treatment of the knee injury. No pain medication evaluation took place at that time.

55. Patient 1's Controlled Substance Utilization Review and Evaluation System ("CURES") report[3] and medical records reflects that from January 2014 through early October 2014, Patient 1 filled the following prescriptions issued by Respondent for controlled substances:

[3] The Controlled Substance Utilization Review and Evaluation System (CURES) stores Schedule II, III, IV, and V controlled substance prescription information reported as dispensed in California. The following information is typically set forth in a CURES Report: patient first name, patient last name, patient date of birth, patient address, number of prescriptions, prescriber name, prescriber DEA number, prescriber address, pharmacy name, pharmacy license number, pharmacy address, date prescription was filled, prescription number, drug name, drug form, quantity, drug strength, refill number, number of authorized refills, number of days' supply, and prescription form serial number.

a. On or about January 13, 2014, Patient 1 filled prescriptions for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets) and a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

b. On or about February 13, 2014, Patient 1 filled prescriptions for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets) and a 50-day supply of Hydromorphone HCL 4 mg (200 tablets).

c. On or about March 10, 2014, Patient 1 filled a prescription for a 90-day supply of Temazepam 30 mg (90 capsules).

d. On or about March 14, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

e. On or about March 28, 2014, Patient 1 filled a prescription for a 30-day supply of Hydromorphone HCL 4 mg (120 tablets).

f. On or about April 11, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

g. On or about April 25, 2014, Patient 1 filled a prescription for a 12-day supply of Hydromorphone HCL 2 mg (200 tablets).

h. On or about May 12, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

i. On or about May 23, 2014, Patient 1 filled prescriptions for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

j. On or about June 16, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

k. On or about July 4, 2014, Patient 1 filled a prescription for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

l. On or about July 16, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

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m. On or about August 6, 2014, Patient 1 filled prescriptions for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

n. On or about August 13, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

o. On or about August 31, 2014, Patient 1 filled a prescription for a 12-day supply of Hydromorphone HCL 2 mg (200 tablets).

p. On or about September 8, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

q. On or about October 3, 2014, Patient 1 filled a prescription for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

r. On or about October 9, 2014, Patient 1 filled a prescription for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

56. On or about October 24, 2014, Patient 1 was seen by Dr. S.R. in the family practice department. Patient 1 requested prescription refills. Dr. S.R. assessed Patient 1 as having opioid dependence. He noted that Patient 1 should follow up with pain management due to excessive narcotic dosages. Dr. S.R. further recommended that Patient 1 begin physical therapy as well as undergo a chemical dependency recovery program or pain management in order to reduce risk of opiate death. Medications were not filled as it was too early and it was noted that Patient 1 needed to follow up with Respondent. Patient 1 was referred to Integrated Pain Management Program but she declined to enter the program.

57. On or about October 31, 2014, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

58. Respondent next saw Patient 1 on December 2, 2014 for a medication review and her lower back pain. Though he noted that her opioid treatment agreement was updated, there was no discussion of opioid dependence or excessive narcotic dosage. That same day, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

59. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about December 12, 2014, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

b. On or about December 26, 2014, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules).

c. On or about December 29, 2014, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

d. On or about January 15, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

e. On or about February 6, 2015, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

f. On or about February 20, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

60. On or about March 2, 2015, Respondent saw Patient 1 for complaints of a cough and breathing problems. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, chronic low back pain, intermittent asthma, major depressive disorder, history of total hysterectomy, bilateral sciatica, thoracic disc herniation, upper respiratory tract infection, and cough. He diagnosed her with an upper respiratory infection and instructed her to return as needed.

61. Respondent next saw Patient 1 on March 13, 2015 following a hospitalization for a viral upper respiratory infection. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, chronic low back pain, intermittent asthma, major depressive disorder, bilateral sciatica, systemic inflammatory response syndrome from infection and thoracic disc herniation. At the time of the visit, Respondent ordered drug screening and urine drug testing. He noted that he discussed the opioid refill policy and "polypharmacy." He also noted that he would continue to reduce narcotic and other controlled substances as medically tolerated or indicated. The patient was instructed to return as needed. That same day, Patient 1 filled a

prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

62. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about March 20, 2015, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules).

b. On or about March 21, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

c. On or about April 14, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

d. On or about April 24, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

e. On or about May 14, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

63. On or about June 13, 2015, Respondent saw Patient 1 for medication review for her low back pain. With respect to health problems reviewed, Respondent noted that Patient 1 had chronic low back pain, lumbar disc herniation, lumbosacral disc degeneration, major depressive disorder, thoracic disc herniation and thoracic spine pain. Respondent noted that the patient's last pain assessment was on June 13, 2015 and that her pain agreement was also dated June 13, 2015. He noted that her pain diagnosis was chronic thoracic and low back pain. He noted that her CURES result was compliant. While Respondent notes that a urine drug screen needed to be performed, he also noted that the last urine drug screen was performed on June 13, 2015. Respondent noted that the patient's primary diagnosis was chronic back pain. He noted that the pain agreement was reviewed and the patient verbalized an understanding of the terms of the agreement. It was documented that risks and benefits of the current pain medication regimen were discussed and that the patient will follow up in three months. That same day, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

64. On or about July 8, 2015, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules).

65. Respondent next saw Patient 1 on July 10, 2015 with complaints of a rash that was itchy but resolving. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, chronic low back pain, gastro-esophageal reflux disease, intermittent asthma, irritable bowel syndrome, major depressive disorder, migraine, rash, pruritus and pain. The rest of the template note was essentially copied from the June 13, 2015 visit for medication review, including vital signs. The patient was instructed to follow up in 2-3 months. That same day, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

66. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about August 11, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (200 tablets).

b. On or about August 19, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

c. On or about September 18, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

d. On or about October 6, 2015, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

e. On or about October 19, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

f. On or about November 10, 2015, Patient 1 filled prescriptions issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

g. On or about November 19, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

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h. On or about December 11, 2015, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

i. On or about December 18, 2015, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

j. On or about January 13, 2016, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets).

k. On or about February 12, 2016, Patient 1 filled prescriptions issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

l. On or about February 19, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

67. Patient 1 was next seen by Respondent on February 22, 2016 for a medication review and complaints of low back pain. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, essential tremor, chronic low back pain, major depressive disorder, migraine, obesity and allergic rhinitis. Respondent's primary diagnosis for Patient 1 was chronic low back pain for greater than three months. He noted that the current pain management regimen was discussed with the patient and she agreed to decrease opioid medications by watching for early refills. He noted that the risk and benefits of opioid use were discussed with the patient and that she was screened for potential abuse. The patient was instructed to follow up in 6 months.

68. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about March 8, 2016, Patient 1 filled a prescription issued by Respondent for a 25-day supply of Hydromorphone HCL 2 mg (200 tablets). It was noted to be an early refill authorized by Respondent and that her next refill will be on or after April 13, 2016.

b. On or about March 18, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

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c. On or about April 8, 2016, Patient 1 filled prescriptions issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

d. On or about April 18, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

e. On or about May 9, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg 9180 tablets)

69. On or about May 16, 2016, Patient 1 sent Respondent an email message requesting a Morphine refill and that she understands that she is being watched.

70. On or about May 17, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets). At that time, Respondent noted that the patient was "still over 100 mg equivalents of opioids and being tracked and monitored. Interval visits and urine drug testing is required."

71. On or about June 9, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

72. On or about June 17, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

73. On or about July 8, 2016, Respondent instructed nursing to advise the patient that he has authorized a medication refill of Hydromorphone HCL but that "after this refill, I am unable to prescribe the current amount of opiate prescriptions she is taking and that I recommend her to see pain management for her prescriptions rather than primary care." Respondent's clinical assistant noted that she spoke to the patient and made her aware of Respondent's message.

74. On or about July 9, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

75. On or about July 17, 2016, Patient 1 sent Respondent an email message that her brother is in a medically induced coma and on life support in Las Vegas and she returned home because she needs prescription refills. The message further set forth the following: "You are my Doctor. I do not have the time now to find another one. If you don't want patients using your personal phone, that's fine, just ask. But stop giving out your number then as if it's alright to use.

If needed I will contact member services or go beyond that to get this resolved." The next day, Patient 1 filled prescriptions issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets) and a 90-day supply Temazepam mg (90 capsules).

76. On or about August 2, 2016, Patient 1 sent two angry emails to Respondent. In the first email, Patient 1 stated that she was not lying about her brother's medical condition and subsequent death and that she had many stories to tell about Respondent. Thereafter, Patient 1 sent Respondent a second email, "I don't want a response from some Nurse who has no clue what you have done. I want you to act like a man and face us. And try to be sober."

77. On or about August 17, 2016, Patient 1 emailed Respondent requesting that her Morphine prescription be filled. There is a further note in the patient's chart that the message was handled and the patient picked up her medication on August 18, 2016.

78. On or about September 30, 2016, Patient 1 emailed respondent requesting that her Morphine prescription be filled as she had been out of state. The patient was informed to contact the pharmacy.

79. On or about October 5, 2016, Patient 1 filled a prescription issued by Respondent for a 20-day supply of Morphine Sulfate 30 mg (40 extended release tablets).

80. Patient 1 presented to Respondent on October 17, 2016 for a medication review and chronic thoracic and low back pain. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, chronic low back pain, irritable bowel syndrome, lumbosacral disc degeneration, major depressive disorder, migraine, chronic pain, bereavement and right hip joint pain. Patient 1 was noted to be in grief secondary to recently losing her brother and her best friend. She was noted to have no aberrant behaviors, had a urine drug screen on February 9, 2016 and her CURES result reflected that she was compliant. Her primary diagnosis was noted to be chronic low back pain. Respondent noted that her current pain management regimen was discussed and the patient agreed to continue the current regimen without change and planned to taper both narcotics and benzodiazepines. The patient was instructed to follow up in 3 months and contact Respondent immediately with any adverse effects. She was also referred to psychiatry, to be seen in one and a half weeks.

81. On or about October 17, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

82. On or about November 1, 2016, Patient 1 emailed Respondent requesting a refill of Dilaudid.

83. On or about November 10, 2016, Patient 1 emailed Respondent requesting that he fill her prescriptions.

84. On or about November 11, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets)

85. On or about November 21, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

86. On or about November 22, 2016, Patient 1 emailed Respondent to report that she had been seen in the emergency department for blacking out and had just blacked out again. Patient 1 declined to be seen in urgent care and an appointment to see Respondent was scheduled for November 28, 2016. There is no record of an appointment with Respondent on November 28, 2016.

87. On or about December 9, 2016, Patient 1 sent Respondent an email requesting early refill of her Dilaudid and other prescriptions.

88. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about December 12, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

b. On or about December 21, 2016, Patient 1 filled a prescription issued by Respondent for a 30-day supply Morphine Sulfate 30 mg (60 extended release tablets).

c. On or about January 8, 2017, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules).

89. On or about January 9, 2017, Patient 1 emailed Respondent asking whether she needed to have a urine drug screen before her next prescription could be filled and when her six-month appointment was due. Respondent replied to Patient 1 on January 11, 2017 stating that he

ordered a drug test on October 17, 2016 and Dr. H. had ordered one on November 26, 2016, neither of which had been done and needed to be done prior to picking up her Dilaudid. Patient 1 then contacted member services at Kaiser on or about January 11, 2017, requesting a medication refill. She was instructed that a urine drug screen was due and that she should follow up with Respondent regarding the refill.

90. On or about the evening of January 11, 2017, Patient 1 emailed Respondent asking that he fill her Dilaudid prescription and that he had promised Patient 1 long ago that he would never let her run out of her prescription and now he has broken her promise. Respondent replied to Patient 1 the following day and stated she is required to have face-to-face visits at least every six months and undergo urine drug screens on a random basis or at a minimum of every six months and that she can always enter the pain management program which would also require the visits and urine tests most likely much more frequently.

91. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about January 12, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

b. On or about February 12, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

c. On or about March 13, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

92. On or about March 15, 2017, Patient 1 emailed Respondent requesting her morphine prescription for travel. She would be traveling to Texas for a couple of weeks and stated "If I could pick up this RX Saturday that would be awesome, however if that's an issue with my points, I can get it after midnight Sunday morning (day 30) to appease the Feds." Respondent replied to Patient 1's email stating that he filled it that day. He further stated, "Its actually the Department of Justice/Drug Enforcement Agency who is monitoring prescriptions and refill activities. So PACE yourself and monitor your refill dates so you are safe from overdose."

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93. On or about March 17, 2017, Patient 1's chart had a note that the patient was told through staff that medications must last 30-days and that her refill interval was being tracked.

94. Patient 1 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about March 17, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

b. On or about April 3, 2017, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg, (90 caplets).

c. On or about April 13, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

d. On or about April 20, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

e. On or about May 13, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

95. On or about May 18, 2017, Patient 1 emailed Respondent requesting that her Morphine prescription be filled.

96. On or about May 20, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

97. On or about June 9, 2017, Patient 1 emailed Respondent requesting that he have her medications refilled. Patient 1 was instructed to contact the pharmacy staff to assist her.

98. On or about June 13, 2017, Patient 1 presented to Kaiser requesting a medication refill. The two doctors on duty declined the refill and informed the patient to check back the following day when Respondent returned.

99. On or about June 14, 2017, Respondent saw Patient 1 for chronic thoracic and low back pain and pain medication refills. With respect to health problems reviewed, Respondent noted that Patient 1 had chronic low back pain and lumbar disc herniation. He noted that her last pain assessment was February 22, 2016, her last pain agreement was dated February 22, 2016, and her last urine drug screen was February 9, 2016. He also noted that she had no aberrant

behavior and that her CURES results were compliant. Respondent noted that Patient 1 was alert and in mild discomfort and alert and oriented as to time person and place. She was noted to be crying and appears sad and depressed. The assessment was left blank and the plan noted "no orders of the defined types were placed in this encounter."

100. On or about June 14, 2017, Patient 1 filled prescriptions issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

101. On or about June 23, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

102. On or about June 28, 2017, Patient 1 presented to Respondent with complaints of dizziness since last Wednesday and memory problems. With respect to health problems reviewed, Respondent noted that Patient 1 had essential tremor, chronic low back pain, migraine, confusion and blurred vision. A CT was performed with no acute intracranial hemorrhage or mass effect noted. Respondent's primary diagnosis was confusion. He recommended that the patient avoid rapid change of position and avoid driving if she has severe vertigo. He requested a specialty evaluation.

103. On or about July 14, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

104. On or about July 21, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

105. On or about August 14, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply Hydromorphone HCL 2 mg (180 tablets).

106. On or about September 12, 2017, Patient 1 emailed Respondent requesting that her prescriptions be filled. Respondent instructed his staff to remind Patient 1 of the regulations that require urine drug testing and interval visits every 6 months.

107. On or about September 14, 2017, Patient 1 filled a prescription issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules).

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108. On or about September 14, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

109. On or about September 22, 2017, Patient 1 requested a refill on her Morphine ER 30 mg. Respondent instructed the pharmacy to fill and advise the patient that regulations require urine drug testing and interval visits every 6 months.

110. On or about September 24, 2017, Patient 1 filled prescriptions issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (30 extended release tablets) and a 90-day supply of Temazepam 30 mg (90 capsules).

111. On or about October 16, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

112. On or about October 17, 2017, Patient 1 was seen by Respondent for a follow up visit after she was hospitalized for a gastrointestinal bleed. He noted that at the time of her visit, the GI symptoms had resolved. With respect to health problems reviewed, Respondent noted that Patient 1 had anxiety disorder, gastroesophageal reflux disease, hematemesis, insomnia, intermittent asthma, irritable bowel syndrome, sinus tachycardia, and thoracic disc herniation. His assessment was a follow up exam after non-cancer treatment completion and ordered a flu vaccination. He did not document any consideration that the gastrointestinal bleed could be due to her opioid medications.

113. On or about October 23, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

114. On or about October 28, 2017, Patient 1 emailed Respondent requesting information as to when she was due for her urine drug screen and six-month visit. Respondent instructed his staff to assist Patient 1 in scheduling a visit in December.

115. On or about November 8, 2017, Respondent requested that her medications be refilled before she leaves on vacation. On or about November 10, 2017, Patient 1 had a five-minute telephone appointment visit with Respondent to address her prescription refill. It was noted that she needed her mediation refilled before going to Washington. The assessment section of the note was left blank and no orders were placed in the plan section.

116. On or about November 10, 2017, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (30 tablets).

117. On or about November 28, 2017, Patient 1 emailed Respondent that she lost her prescription in Washington.

118. On or about December 5, 2017, Patient 1 was seen by Respondent for an interval visit for pain medications for chronic back pain. Respondent's primary diagnosis was chronic low back pain. He ordered a drug abuse screening and noted that the patient would continue with the current medication regimen without change. Patient 1 was instructed to follow up in six months.

119. In March 2018, Patient 1 filled prescriptions for Hydromorphone HCL 2 mg, Morphine Sulfate 30 mg, and Temazepam 30 mg.

120. Patient 1 was last seen by Respondent for an office visit on December 5, 2017 for pain medications for chronic low back pain. Patient 1 was to follow up with Respondent in six months. He continued to refill her opioid and benzodiazepine medications through May 25, 2018.

121. On or about December 15, 2017, Patient 1 filled prescriptions issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets) and 90-day supply of Temazepam 30 mg (90 capsules).

122. On or about December 23, 2017, Patient 1 emailed Respondent that she was overdue on her medications and that he had promised her that he would not ever let her run out. That same day, Patient 1 filled a prescription issued by Respondent, for a 30-day supply of Morphine Sulfate 30 mg (30 extended release tablets).

123. On or about January 15, 2018, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

124. On or about February 21, 2018, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

125. On or about February 27, 2018, Respondent noted that Patient 1 did not keep an appointment scheduled for that day and that a medication reconciliation and review was not done.

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126. On or about March 16, 2018, Patient 1 filled prescriptions issued by Respondent for a 90-day supply of Temazepam 30 mg (90 capsules) and 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

127. On or about March 24, 2018, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Morphine Sulfate 30 mg (60 extended release tablets).

128. On or about April 11, 2018, Respondent ordered an opioid screen and pain management for Patient 1.

129. On or about April 16, 2018, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL 2 mg (180 tablets).

130. On or about May 18, 2018, Patient 1 filled a prescription issued by Respondent for a 30-day supply of Hydromorphone HCL, 2 mg (180 tablets).

131. On or about July 27, 2018 and August 27, 21018, Patient 1's prescriptions issued by Respondent for Morphine Sulfate 60 mg (60 tablets) and Hydromorphone HCL 2 mg (180 tablets) were filled through the Kaiser Hospital Pharmacy.

132. On or about June 28, 2018, Patient 1 died of a mixed drug intoxication secondary to a self-administered combination of prescription medications.

Medical History and Physical of Patient 1

133. When prescribing controlled substances for pain, the standard of care requires that the practitioner perform an initial history and physical examination and periodically re-assess and re-evaluate the patient in order to establish the correct diagnosis and therapy. With respect to Patient 1, Respondent failed to adequately conduct a thorough and clinically focused, history, specific physical examination, assessment, and evaluation identifying a likely diagnosis to justify prescribing controlled medications, and he failed to adequately re-assess and re-evaluate the patient periodically, including annually and/or bi-annually.

134. Respondent committed gross negligence when he failed to perform an adequate initial history and physical examination of Patient 1 and when he failed to adequately re-assess and re-evaluate Patient 1 periodically to establish a correct diagnosis and therapy for the patient.

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Treatment Plan and Objectives for Patient 1

135. The standard of care requires that when prescribing controlled substances for pain, the practitioner must discuss with the patient and document the rationale and reasoning that supports the current treatment plan and goals of therapy. Respondent failed to adequately document his rationale for his treatment plan and therapeutic objectives, including in the management of Patient 1's chronic pain with opioid medications. He failed to adequately document Patient 1's chronic pain and failed to adequately identify the generators or sources of her pain. During Respondent's care and treatment of Patient 1, he progressively increased Patient 1 opioid therapy without a coherent treatment plan and/or clear objectives. Respondent failed to adequately document the efficacy of any increases in opioid therapy or whether such therapy met any objectives of pain relief, physical, psychological and emotional function or improvement in activities of daily living.

136. Respondent committed gross negligence when he failed to develop and/or document an adequate, acceptable, rational and/or reasonable treatment plan and objectives.

Informed Consent for Patient 1

137. The standard of care requires that when prescribing controlled substances that the practitioner adequately discuss the treatment risks and benefits with the patient as well as the goals of treatment, including the advantages and disadvantages of therapy, risk of substance use disorder, addiction, potential risks of drug interactions, side effects and risks for accidental overdose. The practitioner should also discuss safe storage practices, approaches to refill requests, refill frequency, and warnings about mixing sedatives and sleep medications with opioid drugs. Respondent committed gross negligence when he failed to adequately obtain and/or document Patient 1's informed consent for his treatment of the patient, including his utilization of potent pain medications. The written unsigned medication contract from 2012 and the use of templates listing dangers of opioid therapy inserted in progress notes without active discussion and education with the patient, were inadequate. Respondent's use of templates pre-formulated to warn about the risk of addiction and overdose were non-specific additions to the patient chart.

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They failed to indicate that Patient 1 was specifically warned about drug toxicity and the risk of overdose.

138. Respondent committed gross negligence when he failed to adequately obtain and/or document the informed consent of Patient 1 during his care and treatment of her. Respondent failed to discuss specific treatment risks and benefits with Patient 1. He failed educate Patient 1 regarding the controlled substances that he prescribed. He failed to warn Patient 1 of the risk of acetaminophen liver toxicity when consuming large quantities of acetaminophen (Norco). As a result, Patient 1 was hospitalized for acute toxic hepatitis because Respondent failed to warn her of the potential risk of acetaminophen liver toxicity. Patient harm occurred when Patient 1 developed acetaminophen liver toxicity secondary to her Norco consumption. Respondent also failed to warn Patient 1 of the risk of accidental overdose when mixing opioid medications and benzodiazepines. Patient harm occurred when Patient 1 died of a mixed drug intoxication secondary to a self-administered combination of prescription medications.

Written Controlled Substance Agreement for Patient 1

139. Respondent committed gross negligence by failing to provide an initial and follow-up written informed consent or updated informed consent throughout the progress of Patient 1's care and treatment. The only written controlled substance agreement in the medical record was unsigned and there were no follow-up discussions or agreements as Patient 1's medication management changed between 2012 and 2018. As such, it was inadequate.

Pain Management Evaluation, Assessment, and Treatment for Patient 1

140. When treating routine medical problems, such as headaches and low back pain, the standard of care requires a thorough history and physical examination, an analysis of all prior and current medical problems, and diagnostic laboratory studies to evaluate the presenting complaints based on the patient's medical history, recent traumatic events, current medical problems. These findings should be correlated with the provider's physical exam findings in order to form a differential diagnosis of possible causes and conditions of pain and a plan of management.

141. Respondent committed gross negligence in the medical management of Patient 1's chronic pain condition. Respondent inappropriately relied on high dose opioid therapy to treat

headaches and chronic low back pain, failed to recognize dependence and failed to establish any other plan of medical pain management.

Excessive Prescribing to Patient 1

142. When prescribing opioids, the standard of care requires justification for the quantities prescribed, including the correlation of clinical findings, diagnostic test results, consultant diagnoses and opinions demonstrating a significant disease process. A treatment plan with clear objectives must be established to support the prescribing of controlled substances.

143. Respondent committed gross negligence when he escalated the prescribing of controlled substances to Patient 1 despite grossly normal objective clinical findings, minimally positive diagnostic tests, and inconstant consultant diagnoses and opinions which did not demonstrate significant disease processes that did not correlate with or justify the quantities of excessive doses of medications that Respondent prescribed to Patient 1. He failed to create a treatment plan with clear objectives. Respondent's excessive prescribing caused patient harm to Patient 1. Respondent's excessive prescribing of opioids and other controlled drugs led to Patient 1's opioid dependence followed by opioid addiction and benzodiazepine dependence. The patient developed behavioral changes when she misused drugs by request for early refills consistently.

Prescribing Opioid Medications and Benzodiazepines Without a Legitimate Medical Purpose to Patient 1

144. The standard of care requires that there must be a legitimate medical purpose for prescribing controlled and addictive substances to a patient.

145. Respondent committed gross negligence when he continued to prescribe opioid and benzodiazepine drugs to Patient 1 without a legitimate medical purpose and indication. Patient 1 complained of recurrent headaches and low back pain. The objective diagnostic evaluation of her pain complaints was based on musculoskeletal strain of a non-specific nature from co-existing prior occupational injuries. An objective diagnostic evaluation of the patient was limited to minor anatomically located observations. Respondent failed to treat Patient 1 with focused titration of routine non-addictive drugs specifically recommended for recurrent headaches and low back pain. Instead, both conditions were primarily treated by Respondent with opioid drugs. As a result,

Patient 1 developed opioid dependence and tolerance which progressed to opioid induced hyperalgesia and opioid addiction.

Prescribing Opioid Drugs to a Known Addict

146. A patient becomes opioid addicted when the patient's behavior indicates that he/she is unable to adhere to the prescribed regimen and requests early refills regularly by 2-4 days.

147. Respondent committed gross negligence when he continued to prescribe opioid medications to Patient 1 and failed to recognize that Patient 1 transitioned from being an opioid dependent patient to an opioid addict.

Failure to Recognize Opioid and Benzodiazepine Addiction in Patient 1

148. Respondent failed to educate or warn Patient 1 about the risks and benefits regarding prescriptions for opioid and benzodiazepine therapy. As Patient 1's primary care physician, Respondent failed to assist Patient 1 in preventing the consequences of addiction from progressing. Patient 1's repeated early refills of medications was a sign of addictive behavior that should have been recognized by Respondent for immediate treatment. Respondent committed gross negligence when he failed to recognize and treat Patient 1's opioid and benzodiazepine addictive disorder. Respondent caused patient harm by failing to recognize and treat Patient 1's opioid and benzodiazepine addictive disorder and continuing to excessively prescribe opioid and benzodiazepine medications to Patient 1.

Prescribing Controlled Substances to Patient 1 After Patient 1's Death

149. When prescribing controlled substances, the standard of care requires that the practitioner document the assessment of the indications, benefits, risks, alternatives (and offer of alternatives), adverse effects, effectiveness, and/or precautions regarding the safe prescribing of controlled substances.

150. Respondent committed gross negligence when he failed to attempt to safeguard outstanding prescriptions to Patient 1 that he issued and which remained available to be filled under Patient 1's name after her death.

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Patient 2

151. In or around 2007, Patient 2, who was then 45-years old and the spouse of Patient 1, began receiving medical care and treatment at Kaiser Permanente Riverside. On or about November 9, 2009, Respondent became Patient 2's primary care physician and treated Patient 2 for chronic low back pain and other problems until August 16, 2019, at which time other providers ultimately recognized and diagnosed Patient 2 as having a substance use disorder.

152. On or about November 9, 2009, Patient 2 was initially seen by Respondent for an annual screening and prevention physical as well as a reassessment of hyperlipidemia. A past history of low back pain was noted. The examination of Patient 2 was limited to vital signs, general appearance, and the cardiovascular system. Respondent's assessment noted the past history of low back pain. There was no documentation of the patient's current history of back pain, an examination of the back, or any specific intervention. Laboratory studies revealed high cholesterol and Respondent instructed Patient 2 to have his cholesterol values rechecked on March 8, 2010.

153. On or about December 3, 2010, Respondent initiated treatment of Patient 2 with opioid medications following a telephone call from Patient 2 to Respondent. At that time, Respondent prescribed 60 tablets of Norco 325-10 mg, with three refills, to be taken every four hours as needed for pain and 50 tablets of Methocarbamol 750 mg to be taken every eight hours for muscle spasms. There was no documentation of the content of the conversation or any diagnostic assessment to warrant treatment with opioid medications. Between December 3, 2010 and December 27, 2010, Patient 2 filled all three refills of the Norco as well as the initial prescription. Patient 2 continued to call in for Norco refills and by May 29, 2011, the Norco quantity dispensed went from 60 tablets at a time to 300 tablets. Respondent did not document the reason for the refills or the significant increase in dosage.

154. On or about June 21, 2011, Patient 2 was seen by Respondent for a medication review. Respondent noted that Patient 2 had bilateral intermittent low back pain that was worse when he was overly active. Patient 2 reported tingling on the lateral leg as well as the dorsal and lateral foot on the right side. Aggravating factors included bending, twisting and lifting. With

respect to prior injury, Respondent noted that it was "cumulative per verbal history." Respondent noted that Patient 2's prior treatment was with pain medications and that he was taking Norco, but exceeding 12 tablets on active days. Respondent documented a problem focused template examination (similar to that used in Patient 1's records) with the only positive finding of "tenderness" documented as pain in several localities with motion. Respondent failed to note whether the tenderness was subjective or in response to palpation. Respondent noted that the risks and benefits of narcotics were discussed and that he would add morphine in an attempt to reduce Tylenol (acetaminophen) consumption.

155. On or about July 14, 2011, Respondent prescribed Hydromorphone for Patient 2 without any documentation of the reason for the prescription. Respondent continued to prescribe Norco to Patient 2 on August 7, 2011, August 15, 2011[4] and August 31, 2011.

156. On or about January 11, 2012, the Kaiser pharmacy documented concern for the quantities of Norco being prescribed and requested verification as well as a six tablet per day limit. Respondent did not address the pharmacy's concern.

157. Patient 2's medical records documented a telephone message from a non-Kaiser pharmacy requesting a 300-tablet Norco refill on January 27, 2012 after one had already been filled at that non-Kaiser pharmacy on January 12, 2012. Respondent told the non-Kaiser pharmacy that Patient 2 gets his Norco at Kaiser now and he last filled it at the Kaiser pharmacy on January 19, 2012.

158. Patient 2's medical records also documented a call from Costco pharmacy, another non-Kaiser pharmacy, on April 5, 2012, at which time Patient 2 presented a hard copy prescription to be filled, after the pharmacy had previously filled Norco prescriptions on January 5, 2012, February 2, 2012, February 27, 2012 and March 21, 2012. The Kaiser pharmacy reported to the Costco pharmacist that the prescription had been filled at Kaiser on March 3, 2012 and March 25, 2012. When the Costco pharmacist told Patient 2 that it was too soon for a refill,

[4] On August 15, 2011, Respondent documented a telephone call from Patient 2 who reported dropping his Norco bottle into the toilet with the remaining pills getting ruined. Respondent gave a "one time oops (sic) refill."

Patient 2 told the pharmacist that she did not need to call Kaiser and that she could call Respondent for whom Patient 2 had a private number. Patient 2's medical records do not have any documentation of interactions with Respondent on his private phone number.[5] Respondent did not document any response to the Costco pharmacy issue nor did he start running CURES reports for Patient 2.

159. On or about September 14, 2012, Respondent documented that he advised Patient 2 that he would be reducing the amount of narcotics he writes for patients "due to safety policy." Patient 2's Norco prescriptions were thereafter reduced to 240 tablets. There was no documentation of any medical decision making or reason why 240 pills was determined to be a safe amount for Patient 2 to take.

160. Patient 2 began receiving 240 Norco tablets a month from October 10, 2012 through September 19, 2014, at which time the quantity was decreased to 180 Norco tablets a month until August 10, 2015. Though Patient 2's CURES report reflects that he was also receiving concurrent prescriptions from providers outside of Kaiser, Patient 2's medical records do not reflect that Respondent checked Patient 2's CURES reports at any time.

161. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about October 9, 2012, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

b. On or about October 24, 2012, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

c. On or about November 20, 2012, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

d. On or about December 18, 2012, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

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[5] As set forth in Patient 1's medical records, Patient 1 left a message for Respondent on July 17, 2016 indicating that Respondent should not have given Patient 1 his private phone number if he did not want her to use it.

162. On or about January 16, 2013, Patient 2 was seen by Respondent for low back pain and a medication review. Respondent referenced an opioid treatment agreement in Patient 2's medical records; however, no agreement was in the chart. Respondent noted that the patient had a prior work related back injury and an August 2002 history of disc herniation, lumbar radiculopathy, and neuropathic pain. Respondent ordered a lumbar spine x-ray but noted that the patient did not have time to have it performed. Respondent ordered a urine drug test and continued to prescribe Norco. Respondent noted that the risks and benefits of narcotics was discussed with the patient in detail and consent was obtained verbally prior to dispensing it. That same day, Respondent issued a 20-day supply of Norco 325-10 mg (240 tablets) to Patient 2.

163. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about January 22, 2013, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

b. On or about February 11, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

c. On or about March 7, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

d. On or about March 25, 2013, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

e. On or about April 25, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

f. On or about May 21, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

g. On or about June 18, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

h. On or about July 1, 2013, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

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i. On or about July 15, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

164. On or about August 15, 2013, Respondent documented that Patient 2 was seen in the clinic on August 13, 2013, because he had not been seen in six months and required a face-to-face visit before having his Norco refilled. In a note dated August 13, 2013, Respondent documented that he reviewed Patient 2's health problems consisting of hyperlipidemia and low back pain. Respondent noted that Patient 2 had a herniated disc in 2000, that he continued to work, and that it had ruptured in 2002. Respondent documented that Patient 2 had a history of physical therapy and a laminectomy on August 22, 2002. Respondent documented that Patient 2's pain was at a 7 out of 10 for the last few days and was taking about 8 to 9 Norco tablets a day.[6] Patient 2 also took Ambien at night as needed for sleep. That same day, Respondent refilled Patient 2's Norco prescription, consisting of a 20-day supply (240 tablets), and noted that the risks and benefits of narcotics were discussed in detail with the patient.

165. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about September 10, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

b. On or about September 19, 2013, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

c. On or about October 7, 2013, Patient 2 filled a 20-day supply of Norco 325-10 mg (240 tablets) prescribed by Respondent.

d. On or about November 5, 2013, Patient 2 filled a 16-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

e. On or about January 26, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

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[6] There was no reference to Patient 2's CURES Report that reflects that Patient 2 was also obtaining Norco from other providers.

f. On or about February 26, 2014, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) and a 16-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

g. On or about March 24, 2014, Patient 2 filled a 30-day supply of Norco 325-10 mg (120 tablets) prescribed by Respondent.

h. On or about April 3, 2014, Patient 2 filled a 16-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

i. On or about May 4, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

j. On or about June 1, 2014, Patient 2 filled a 16-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

k. On or about June 14, 2014, Patient 2 filled a 90-day supply of Ambien 10 mg (90 tablets) prescribed by Respondent.

l. On or about June 30, 2014, Patient 2 filled a 17-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

m. On or about July 29, 2014, Patient 2 filled a 17-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

n. On or about August 20, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

o. On or about August 21, 2014, Patient 2 filled a 10-day supply of Ambien 5 mg (100 tablets) prescribed by Respondent.

p. On or about September 16, 2014, Patient 2 filled a 16-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

q. On or about October 16, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

r. On or about November 13, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

s. On or about December 1, 2014, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

166. Patient 2 was next seen by Respondent on December 2, 2014. Respondent noted that the visit was for low back pain. A majority of the note was copied and pasted from the August 13, 2013 note, including the same exact vital signs that were documented on August 13, 2013 and that "the patient had called for a medication refill but had not been seen since January 16th." Respondent noted that the patient reported that his pain is only controlled by Norco. Respondent noted a similar examination as with past visits and assessed that the patient was having chronic lower back pain, muscle spasms of the back and lumbar radiculopathy. Respondent referenced an opioid medication agreement letter that was signed on that date and a copy given to the patient. However, there is no copy of the agreement in the electronic medical record. Respondent further documented that he advised the patient about chronic pain prescribing rules and regulations and that he will be seen on a minimum at six-month intervals.

167. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about December 12, 2014, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

b. On or about January 8, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

c. On or about February 11, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

d. On or about March 9, 2015, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

e. On or about March 10, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

168. Patient 2 was next seen by Respondent on April 2, 2015, and Respondent again documented that "Patient had called for a refill but had not been seen since January 16th, so I added him to today's schedule." At this visit, Respondent prescribed phentermine for weight management but failed to document any history, supporting examination findings or supporting diagnosis for the prescription other than a body mass index in the obese category. Respondent

continued the patient's Norco prescription and noted that the patient's opioid treatment agreement was discussed in detail. There was no opioid treatment agreement in Patient 2's chart. That same day, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets)

169. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about May 8, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

b. On or about June 1, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

c. On or about July 30, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

d. On or about August 3, 2015, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

e. On or about September 28, 2015, Patient 2 filled a 7-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

f. On or about October 30, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

g. On or about November 29, 2015, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

h. On or about January 26, 2016, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

i. On or about February 25, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

j. On or about March 11, 2016, Patient 2 filled a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

k. On or about March 25, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

l. On or about April 26, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

m. On or about May 25, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

170. On or about June 5, 2016, Patient 2 was taken to the emergency room after he fell at home. He was admitted to the hospital overnight and was diagnosed with an altered mental status, transient loss of consciousness and syncope due to an accidental psychotropic overdose. It was noted that the patient had consumed Ambien with Norco and alcohol before falling and hitting his head. At the time of discharge from the hospital, Patient 2 was advised not to combine pain medications and sedatives with alcohol. The discharging physician also sent a note to Respondent for follow up. Patient 2 was also discharged on Atenolol for an elevated blood pressure.

171. Patient 2 was seen by Respondent on June 9, 2016 for a follow up of his head injury. It was noted that the patient fell in the kitchen at home losing his balance and that he may have lost consciousness. Respondent refilled phentermine and noted that he discussed the risks associated with the use of phentermine. There was no discussion regarding the newly diagnosed hypertension and anti-hypertensive prescription by the hospital physician nor was there any discussion regarding the inpatient physician's concerns regarding Patient 2's concurrent overuse of opiates, sleeping pills, and alcohol.

172. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about June 9, 2016, Patient 2 filled a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

b. On or about July 26, 2016, Patient 2 filled a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

c. On or about July 28, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

d. On or about October 24, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

173. On or about November 8, 2016, Patient 2 was seen by Respondent with a chief complaint of flu like symptoms. Respondent's impression was an upper respiratory infection. At this visit, Respondent prescribed morphine sulfate without any history or medical decision making to support adding this new opioid medication to Patient 2's medication regimen.

174. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about November 8, 2016, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

b. On or about November 8, 2016, Patient 2 filled a 15-day supply of Morphine Sulfate 15 mg (30 extended release tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

c. On or about November 25, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

d. On or about December 7, 2016, Patient 2 filled a 15-day supply of Morphine Sulfate 15 mg (30 extended release tablets) prescribed by Respondent.

e. On or about December 21, 2016, Patient 2 filled 6 a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

f. On or about December 28, 2016, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

g. On or about January 6, 2017, Patient 2 filled a 15-day supply of Morphine Sulfate 15 mg (30 extended release tablets) prescribed by Respondent.

175. On or about January 9, 2017, Patient 2 is seen by Respondent in his office for a medication review. Respondent noted that the patient had low back pain. Respondent offered a referral to the chronic pain management department and advised the patient about non-

pharmacological treatments. There is no documentation of Patient 2's response to the offers of treatment alternatives.

176. Patient 2's medical records has a template January 9, 2017 Opioid Treatment Agreement in a letter format. However, there was no signature line for Patient 2 in the agreement, nor any signature of Patient 2.

177. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about January 27, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

b. On or about February 6, 2017, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) and a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

c. On or about March 6, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent. There is no documentation as to why the amount of Morphine Sulfate was doubled from previous prescription.

d. On or about March 27, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

e. On or about April 6, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

f. On or about April 25, 2017, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

178. On or about April 26, 2017, Respondent documented a 5-minute telephone appointment visit with Patient 2 at which time Patient 2 requested an off work order as he was told that he was abusing sick leave. Patient 2 also requested a Norco refill.

179. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

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a. On or about April 26, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

b. On or about May 5, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

c. On or about June 5, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

d. On or about June 26, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

e. On or about July 5, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

f. On or about July 12, 2017, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

g. On or about July 26, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

h. On or about August 5, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

i. On or about August 28, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

180. On or about October 6, 2017, Patient 2 presented to Respondent with complaints of chronic pain and anxiety. Patient 1 reported a decreased interest in activities, feelings of worthlessness, low energy, and poor concentration. In addition, he had been gaining weight. Respondent's assessment was anxiety and he referred Respondent to mental health. However, Respondent failed to document any discussions regarding the possible effect of opioid medication as exacerbating his symptoms.

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181. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about October 6, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

b. On or about October 16, 2017, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

c. On or about October 31, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

d. On or about November 7, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

e. On or about November 30, 2017, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

f. On or about December 5, 2017, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

g. On or about December 12, 2017, Patient 2 filled a 90-day supply of Ambien 5 mg (180 tablets) prescribed by Respondent.

h. On or about January 7, 2018, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

i. On or about January 31, 2018, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

j. On or about February 6, 2018, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

k. On or about March 6, 2018, Patient 2 filled a 12-day supply of Norco 325-10 mg (100 tablets) prescribed by Respondent.

l. On or about March 9, 2018, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

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182. On or about March 15, 2018, Patient 2 registered for Naloxone and Opioid Training per Respondent's authorization. However, Respondent failed to document any explanation as to why authorization for this training was requested.

183. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about April 4, 2018, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

b. On or about April 11, 2018, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) and a 60-day supply of Phentermine HCL 37.5 mg (60 tablets) prescribed by Respondent.

c. On or about May 4, 2018, Patient 2 filled a 25-day supply of Norco 325-10 mg (200 tablets) prescribed by Respondent.

184. On or about October 8, 2018, Patient 2 was seen by Respondent for symptoms of chronic pain. Patient 2 was noted to be in for an interval refill of medications. It was further noted that Patient 2's wife (Patient 1) passed away from an accidental overdose of prescription drugs.

185. Patient 2 was not assessed or evaluated by Respondent before the following prescriptions were filled:

a. On or about October 8, 2018, Patient 2 filled a 22-day supply of Norco 325-10 mg (180 tablets) prescribed by Respondent.

b. On or about October 13, 2018, Patient 2 filled a 30-day supply of Morphine Sulfate 15 mg (60 extended release tablets) prescribed by Respondent.

c. On or about November 8, 2018, Patient 2 filled a 22-day supply of Norco 325-10 mg (180 tablets) prescribed by Respondent.

186. Starting November 19, 2018, Patient 2 was seen by other physicians in the family medicine department and was subsequently assigned to a new primary care physician on January 30, 2019. At that time, Patient 2 was noted to be on high dose opioid medications and multiple other medications that could increase the risk to his safety. Rather than prescribing Phentermine,

Patient 2's new primary care physician referred Patient 2 to preventative medicine to help with weight. In addition, plans were made to taper Patient 2's opioid intake. By March 7, 2019, Patient 2 initiated treatment for opiate dependence at Kaiser's Addiction Medicine Department. As of April 25, 2019, Patient 2 was reported to have been off opioid medication for two months and was feeling much better.

Medical History and Physical of Patient 2

187. Respondent committed gross negligence when he failed to perform an adequate initial history and physical examination of Patient 2 to identify the likely diagnosis that would justify prescribing high-dose opioid therapy and when he failed to adequately re-assess and re-evaluate Patient 2's chronic pain periodically to justify the use of controlled substances in the management and treatment of Patient 2's pain.

Treatment Plan and Objectives of Patient 2

188. Respondent committed gross negligence when he progressively increased Patient 2's opioid therapy without a coherent treatment plan and clear objectives. Respondent failed to adequately develop and/or document his rationale for his treatment plan and therapeutic objectives in the management of Patient 2's chronic complaints of pain and discomfort. Respondent failed to establish or identify the specific diagnosis of likely pain generators or sources of pain pathophysiologically. Respondent failed to document and show that the increase in opioid therapy met any objective of pain relief, physical, psychological and emotional function or improvement in activities of daily living.

Informed Consent for Patient 2

189. Respondent committed gross negligence when he failed to adequately obtain and/or document Patient 2's informed consent for his treatment of the patient, including his utilization of potent pain medications, Respondent failed to discuss specific treatment risks and benefits with Patient 2. He failed to educate Patient 2 regarding the controlled substances that he prescribed. Respondent failed to warn Patient 2 of the risk of acetaminophen liver toxicity when consuming large quantities of acetaminophen. Respondent failed to warn Patient 2 about the risk of accidental overdose when mixing opioid medications and benzodiazepines. As a result, Patient 2

was hospitalized after falling and losing consciousness secondary to mixing opioids, benzodiazepines and alcohol. This patient harm was a result of Respondent's failure to adequately educate and warn Patient 2 about the risks of mixing opioids, benzodiazepines, and alcohol. Respondent's use of templates pre-formulated to warn about the risk of addiction and overdose were non-specific additions to the patient chart. They failed to indicate that Patient 2 was specifically warned about drug toxicity and the risk of overdose. As such, they were inadequate.

Written Controlled Substance Agreement for Patient 2

190. Respondent committed gross negligence by failing to provide initial and follow up written informed consent or updated informed consent throughout the progress of Patient 2's care and treatment. The only written controlled substance agreement in the medical record was unsigned and there were no follow-up discussions or agreements as Patient 2's medication management changed between 2012 and 2018. As such, it was inadequate.

Pain Management Evaluation, Assessment, and Treatment of Patient 2

191. Respondent committed gross negligence in the medical management of Patient 2's chronic complaints of pain. Respondent inappropriately escalated Patient 2's opioid therapy without reasonable clinical rationale and without justification that supported the increases in medication doses. Despite dose increases of controlled medications, there was no observed reduction of pain, improvement in function or evidence of improved quality of life. Respondent failed to document any evaluation, assessment, and treatment to support increases in controlled medications to support high dose opioid therapy to treat chronic pain.

Excessive Prescribing to Patient 2

192. Respondent committed gross negligence when he excessively prescribed medications to Patient 2, including when he escalated the prescribing of controlled substances to Patient 2 and failed to adequately monitor Patient 2's overuse of opioid medications, including opioid medications sought from other providers. Respondent failed to recognize and act upon Patient 2's behavioral changes when the patient sought drugs from other providers and utilized outside pharmacies. Instead, Respondent continued to prescribe excessive doses of opioid drugs to the

patient despite grossly normal objective clinical findings, minimally positive diagnostic tests, and inconstant consultant diagnoses and opinions which did not demonstrate significant disease processes that did not correlate with or justify the quantities of excessive doses of medications that Respondent prescribed to Patient 2. Respondent's excessive prescribing caused patient harm to Patient 2. Respondent's excessive prescribing of opioid and other controlled drugs led to Patient 2's opioid dependence followed by opioid addiction and benzodiazepine dependence.

Prescribing Opioid Medications and Phentermine Without a Legitimate Medical Purpose to Patient 2

193. Respondent committed gross negligence when he continued to prescribe opioid and phentermine without a legitimate medical purpose and indication. Patient 2 complained of recurrent low back pain. The objective diagnostic evaluation and physical examination was limited to non-specific observations. Patient 2 developed opioid dependence and tolerance which progressed to opioid induced hyperalgesia and opioid addiction. In addition, Respondent treated Patient 2 with phentermine, an addictive stimulant, for weight loss without formulating a weight loss program and plan, including education on exercise, diet, calorie counting, and cognitive behavioral therapy. Phentermine should not be used on a long-term basis for weight loss. Further, phentermine can contribute to cardiovascular side effects. Respondent continued to prescribe phentermine to Patient 2 despite the diagnosis of hypertension and prescription for anti-hypertensive medications while hospitalized on June 5, 2016.

Prescribing Opioid Drugs to a Known Addict

194. Respondent failed to monitor Patient 2's opioid use and check Patient 2's CURES report when it was brought to his attention that Patient 2 sought Norco prescriptions from pharmacies outside of Kaiser while concurrently obtaining the same medications at Kaiser pharmacies. Respondent committed gross negligence when he failed to recognize that Patient 2 exhibited aberrant behavior identifying him as a probable opioid addict or possible drug dealer. Further, Respondent prescribed phentermine to Patient 2 for multiple years, which indicates misuse when phentermine should only be used short-term in a well-defined weight loss program.

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Failure to Recognize Opioid Addiction in Patient 2

195. Respondent failed to adequately educate or warn Patient 2 of the risks and benefits regarding prescriptions for opioid therapy. As Patient 2's primary care physician, Respondent failed to assist Patient 2 in preventing the consequences of addiction from progressing. Respondent failed to recognize that Patient 2 exhibited signs of addictive behavior that should have been recognized by Respondent for immediate treatment. Respondent's failure to recognize and treat Patient 1's opioid addictive disorder represents gross negligence.

Failure to Manage and Treat Patient 2's Pain and Obesity

196. When a patient presents with routine medical problems such as low back pain and obesity, the standard of care requires that the physician take a thorough history and perform a complete physical examination as well as analyze the patient's prior and current medical problems, laboratory and diagnostic test results and review the patient's recent clinical events, current medical problems in order to formulate a working diagnosis for beginning specific treatment.

197. Respondent committed gross negligence in connection with the management and treatment of Patient 2's pain and obesity. The documented neurologic and musculoskeletal examination findings and subjective complaints for Patient 2 did not warrant or justify prescriptions of high dose opioid therapy. Further Phentermine was used inappropriately for weight loss because of the absence of a standardized weight loss program with dietary management.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

198. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patients 1 and 2. The circumstances are as follows:

199. The allegations of the Third Cause for Discipline are incorporated herein by reference as if fully set forth.

200. Each of the alleged acts of gross negligence set forth above in the Third Cause for

Discipline is also a negligent act.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

201. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients 1 and 2 without an appropriate prior examination and/or medical indication. The circumstances are as follows:

202. The allegations of the Third and Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth. During the time Respondent treated Patients 1 and 2, he failed to perform an appropriate corresponding prior examination and determine a medical indication for each dangerous drug that he prescribed to each patient.

SIXTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

203. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patients 1 and 2. The circumstances are as follows:

204. The allegations of the Third, Fourth, and Fifth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth. During the time Respondent treated Patients 1 and 2, he excessively prescribed dangerous drugs to each patient.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing to an Addict)

205. Respondent is subject to disciplinary action under Code section 2241, in that he prescribed controlled substances to Patients 1 and 2, both of whom developed an opioid dependency and subsequent addiction. The circumstances are as follows:

206. The allegations of the Third, Fourth, Fifth, and Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

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EIGHTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

207. Respondent is subject to disciplinary action under Code sections 2234 and 2228.1, in that his action and/or actions represent unprofessional conduct and patient harm occurred as a result. The circumstances are as follows:

208. The allegations of the Third, Fourth, Fifth, Sixth, Seventh, and Eighth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

209. In addition, patient harm occurred from Respondent's unprofessional conduct, including, when he inappropriate prescribed medications to Patients 1 and 2.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

210. Respondent is subject to disciplinary action under Code sections 2227 and 2266 in that he failed to maintain adequate and accurate records. The circumstances are as follows:

211. The allegations in the First and Second Causes for Discipline above are incorporated herein by reference as if fully set forth.

212. On or about or about April 9, 2021, a physician practice monitor prepared a report on Respondent's practice. He found several deficiencies in Respondent's record keeping, including: data in patient charts which was not located in the proper place (data- (HPI, ROS, PMHx) that should be in one place, is actually placed in another), e.g., patient instructions found in HPI. In addition, EHR templates were not appropriately edited; allergies were not consistently documented within a note; medication lists were incomplete; and blood pressures were inconsistently noted. The practice monitor found that Respondent required, "significant changes to his documentation to be complete" and compliant with the standard of care.

213. The allegations in the Third Cause for Discipline above is incorporated herein by reference as if fully set forth.

214. Respondent failed to maintain adequate and accurate medical records for Patient 1. Respondent's progress notes set forth a copy and paste template form that failed to set forth adequate histories and physical examinations as well as assessments and specific diagnoses

concerning the conditions being addressed with dangerous drugs, including opioid medications. Further, Respondent failed to document treatment outcomes and his clinical management for Patient 1.

215. Respondent failed to maintain adequate and accurate medical records for Patient 2. Respondent's progress notes set forth a copy and paste template form that failed to set forth adequate history and physical examinations as well as assessments and specific diagnoses concerning the conditions being addressed with dangerous drugs, including opioid medications. Further, Respondent failed to document treatment outcomes and his clinical management for Patient 2.

DISCIPLINARY CONSIDERATIONS

216. To determine the degree of discipline, if any, to be imposed on Respondent Michael Anthony Simental, M.D., Complainant alleges that Respondent has a history of discipline with the Board. The circumstances are set forth in paragraphs 3, 4, and 5, above, which are incorporated herein by reference as if fully set forth.

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 86750, issued to Respondent Michael Anthony Simental, M.D.;

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

3. Ordering Respondent Michael Anthony Simental, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent Michael Anthony Simental, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: JAN 0 5 2022

Reji Varghese
Deputy Director

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

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Exhibit A

2016 Decision, Case No. 18-2012-226103

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

In the Matter of the Accusation Against:	)	
	)	
MICHAEL ANTHONY SIMENTAL, M.D.	)	Case No. 18-2012-226103
	)	
Physician's and Surgeon's Certificate No. A 86750	)	
	)	
Respondent.	)	
	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on December 22, 2016.

IT IS SO ORDERED November 22, 2016.

MEDICAL BOARD OF CALIFORNIA

By: Michelle Anne Bholat MD
Michelle Bholat, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
CHRISTINA L. SEIN
Deputy Attorney General
State Bar No. 229094
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-9444
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation Against: **MICHAEL A. SIMENTAL, M.D.** **10800 Magnolia Avenue #2A** **Riverside, CA 92505** **Physician's and Surgeon's Certificate No. A 86750,** Respondent.	Case No. 18-2012-226103 OAH No. 2014100158 **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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Christina L. Sein, Deputy Attorney General.

2. Respondent Michael A. Simental, M.D. (Respondent) is represented in this proceeding by attorney Paul Spackman, Esq., whose address is: 28441 Highridge Road, Suite 201, Rolling Hills Estates, CA 90274.

3. On or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate No. A 86750 to Respondent. The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on February 28, 2016, unless renewed.

JURISDICTION

4. Accusation No. 18-2012-226103 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 29, 2014. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 18-2012-226103 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. 18-2012-226103. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 18-2012-226103, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. A 86750.

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

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 86750 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 Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and 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. 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.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 86750 issued to Respondent Michael A. Simental, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for two (2) years on the following terms and conditions.

///

1. 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 the following: 1) the name and address of 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.

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

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

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

3. 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.

4. 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.

5. 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.

6. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

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(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.

7. 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.

8. 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 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; and General Probation Requirements.

9. 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.

10. 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.

11. 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.

12. 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Paul Spackman, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A 86750. 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: 4/14/2016

MICHAEL A. SIMENTAL, M.D.
Respondent

I have read and fully discussed with Respondent Michael A. Simental, 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: 4/14/2016

PAUL SPACKMAN, ESQ.
Attorney for Respondent

[Endorsement on following page]

ENDORSEMENT

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

Dated: 4/14/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

CHRISTINA L. SEIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 18-2012-226103

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
JOHN E. RITTMAYER
Deputy Attorney General
State Bar No. 67291
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-7485
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Michael A. Simental, M.D.** **10800 Magnolia Avenue, #2A** **Riverside, California 92505** **Physician's and Surgeon's Certificate Number A 86750,** Respondent.	Case No. 18-2012-226103 ACCUSATION

Complainant alleges:

PARTIES

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

2. On or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate Number A 86750 to Michael A. Simental, M.D. (respondent). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on February 29, 2016, 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 unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

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

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"..."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"..."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to

disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action under Section 2234, subdivision (b), in that he committed gross negligence in the care and treatment of S.P. and J.B. The circumstances are as follows:

11. Respondent is a board-certified family practice physician who graduated from the Loma Linda University, completed a residency in family medicine at Kaiser Permanente and began working there in 2005.

S.P.

12. S.P. had addiction problems ever since he was a young boy. He reported to a Board investigator that he was initially addicted to sports and later to substances. His addiction to illicit substances began long before he actually encountered respondent, who continued care for the patient and continued prescriptions for various controlled substances. On or about October 12, 2009, respondent saw S.P. for a complaint of ongoing low back pain. However, the imaging studies ordered by respondent and respondent's own physical examinations on S.P. revealed minimal findings at worst, negating the need for large amounts of opioid analgesics. Respondent's own records lack any evidence that could justify a diagnosis of the moderate-to-severe low back pain that would require a number of long and short-acting opioid analgesics to treat his pain. Furthermore, the patient was quite young and more conservative management with physical therapy and rehabilitation may have been much better options for the patient. Respondent tried to offer conservative management to the patient. However, S.P. refused to go. Respondent claimed concern about the patient's opioid analgesic usage and offered pain management and chemical-dependency programs to the patient on other occasions but he refused; respondent continued to fill the patient's strong and high quantity pain medications on an irregular basis, with early refills for "lost" and "stolen" medications for S.P. At no time did he try to at

least taper the patient's medications on a regimented basis or refuse to write the patient's medications indefinitely until he actually presented to the Pain Management Clinic or the Addiction Clinic, for an evaluation. Although respondent obtained imaging studies that were virtually negative followed by a negative physical examination, he did not alter his treatment plan of prescribing large amounts of opioid analgesics. To further complicate the issue, there does not appear to be a pain management agreement with S.P. regarding his medications. There is some indication that one year had passed without having any in-person contact or conducting an evaluation with S.P.

13. Aside from all opioid analgesics prescribed for the patient, respondent also prescribed anxiety medicines such as benzodiazepines. No psychological evaluation of the patient or a psychiatric consultation was ever completed to clinically validate the need for strong, ongoing benzodiazepines for this patient. Again despite normal imaging studies, medications were escalated and the patient at one point was given every three-month visits, despite his aberrant drug behavior and known early refills. To further complicate the issue, urine toxicology examinations were done on the patient, which were completely, consistently negative. A negative urine toxicology exam could potentially suggest diversion or overtaking of the medication, and respondent never addressed either of these issues with S.P. Finally, there was documentation that the patient's low back pain may have actually been muscular spasms.

14. The standard of care is to care for patients for chronic pain after the diagnosis has been established by various medical diagnostic tools and physical examinations. Respondent has the obligation to investigate this chronic low back pain issue and determine the correct treatment plan for the patient outside of large amounts of opioid analgesics. A physician has the obligation to treat a patient's pain to the best of his ability. Low and moderate doses of opioid analgesics are appropriate for the treatment of chronic pain if the diagnosis has been well established with the studies and the physical examination at hand. Medications can only be continued for a patient as long as there is no aberrant drug behavior, there is no concern for diversion, and there is documented improvement of the patient's condition - either improvement in function or pain control as evidenced by a patient's statement or a family member's confirmation.

15. It is also the standard of care in the community to obtain an opioid agreement on any patient who suffers from chronic pain and requires opioid analgesics as part of their treatment regimen. This standard of care in the United States dictates random urine toxicology exams to verify that the patient is at least taking some of the medication on a regular basis. A negative urine toxicology exam should be addressed for possible diversion, overtaking or lack of consumption of medicines for any particular reason.

16. The standard of care is to refrain, if at all possible, from prescribing benzodiazepines to any patient who takes opioid analgesics on a regular basis. Evidence suggests augmented altered mental status may occur in patients with a combination of benzodiazepines and an opioid on board. Although benzodiazepines are prescribed on occasion for very anxious patients, it is the standard of care in the United States to monitor the utilization of these medications very carefully and possibly obtain a psychological or a psychiatric consultation to justify the utilization of these medicines. Utilization of antidepressants, which have antianxiety properties, is significantly more common than the utilization of benzodiazepines. This is particularly true when the patients are being prescribed opioid analgesics for pain. In the case of S.P., there is no indication that the patient was offered any type of antidepressant medications prior to the utilization of benzodiazepines.

17. Respondent committed an extreme departure from the standard of care in the treatment of S.P., singularly and collectively due to:

a. Lack of opioid agreement with the patient.

b.. Lack of an appropriate response to negative urine toxicology examinations.

c.. Frequent early refills for medications for various reasons without accountability.

d. High doses of long and short-acting opioid analgesics for the patient without medical evidence of necessity.

e. Lack of substantial evidence of chronic low back pain on physical examination and imaging studies.

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///

J.B.

18. J.B. also had a history of abuse and addiction. During his ongoing care by respondent, the patient had multiple issues. One of the most significant problems was the fact that he had an elevated liver enzyme on a laboratory study performed on the patient which was not addressed by respondent. Respondent failed to at least determine whether the medications prescribed for the patient could have contributed to this issue. The patient had a chronic pain issue and respondent did refer him to pain management. However, J.B. never complied. A urine toxicology exam was completely negative for everything including the medications prescribed for the patient. Respondent never addressed this. An MRI was ordered on the patient; however, the medical records on J.B. do not show that it was ever completed. Therefore, there was never an established diagnosis to treat the patient with opioid analgesics for chronic pain. The patient's Norco quantity was doubled with early refills between July 28, 2011, and August 9, 2011. The patient had multiple presentations during the pursuing few months. He also had a completely negative urine toxicology examination on October 25, 2011. The medical records contain no discussion whatsoever of the reason for the negative test results. Respondent simply failed to address any issue regarding the patient's general health by not addressing the elevated liver enzymes.

19. The standard of care is to address any abnormal laboratory evaluation performed on any patient. Respondent, the patient's family physician, never addressed an elevated liver enzyme result. The standard of care dictates that any concern regarding noncompliance with instructions for taking controlled substances, such as a negative urine test, should prompt a treating physician to obtain a pain management consultation or simply refer the patient to a specialist who can better manage and treat the patient's condition. Although there was some discussion about the pain management referral, this was never completed. Furthermore, in order to establish a chronic pain diagnosis, the standard of care requires an evaluation, including imaging studies and a physical examination, which could establish the diagnosis for the patient, followed by appropriate treatment. Although respondent attempted to do this evaluation, the patient never completed it. Therefore, the need for ongoing opioid analgesics for the patient was never established with an

appropriate clinical diagnosis, contrary to the standard of care.

20. Respondent committed an extreme departure from the standard of care with regard to J.B. singularly and collectively due to:

a. No opioid agreement.

b. Frequent early refills of scheduled medications.

c. Lack of clear diagnosis and indication for opioid analgesic prescriptions.

d. Neglecting to evaluate patient for elevated liver enzymes.

e. Neglecting to address at least one negative urine toxicology exam.

f. No action taken with a high-risk patient to change his regimen after he failed to comply with a pain management referral.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is subject to disciplinary action under Section 2234, subdivision (c), in that he negligently treated patients S.P., J.B., and T.A. The circumstances are as follows:

22. Complainant repeats the allegations of the First Cause for Discipline as if set forth in full, as repeated negligent acts.

T.A.

23. T.A. had multiple pain conditions including mild narrowing of the subarticular recess in her lumbar spine, knee surgery and "diffuse joint and muscle pain." However, none of them required large amounts of opioid analgesics. She also had a history of alcoholism and drug abuse.

24. Medical records on T.A. indicate that respondent prescribed significant amounts of medications and gave early refills. However, the medical records also clearly indicate that respondent was uncomfortable prescribing any medication for T.A. He refused to increase medications on various occasions and warned her about the medication several times. Respondent was fully aware of the fact that the patient had an abuse history. He suggested tapering medications and pain management referrals on several occasions to the patient. He knew that T.A. had a history of alcoholism but continued to prescribe Norco tablets for her despite the fact that Norco contains acetaminophen. It is well known that chronic acetaminophen use along

with alcoholism may compromise a patient's hepatic function. Safer medications were indeed available to the doctor and T.A. In addition, respondent prescribed benzodiazepines to T.A. on a regular basis despite the fact that there was no psychiatric diagnosis established for the need for such a sedative-hypnotic.

25. The standard of care requires physicians to treat patients for their chronic pain with the best and safest medications available and with the lowest dose possible. Respondent simply ignored the fact that the patient had a history of alcoholism, drug abuse and aberrant drug behavior, despite his concern regarding this patient. He prescribed Norco for the patient at high quantities of 10 to 12 tablets per day while having full knowledge of the fact that the patient had a history of alcohol abuse and could potentially put her liver at risk. The standard of care requires sending a complicated patient such as T.A., at the very least, for a pain management consultation to obtain a concrete and established regimen on how to treat the patient on a short and long-term basis.

26. Respondent's lack of comprehensive care of T.A. and his failure to take her various abuse histories and prescriptions into consideration, prior to prescribing any medicine whatsoever to her, constituted a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Prior Examination and Medical Indication)

27. Respondent is subject to disciplinary action under Section 2242, subdivision (a), in that he prescribed controlled substances to S.P. and J.B. without an appropriate prior examination and medical indication. The circumstances are as follows:

28. Complainant repeats the allegations of paragraphs 12, 13 and 18 of the First Cause for Discipline as if set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

29. Respondent is subject to disciplinary action under Section 725 in that he repeatedly prescribed clearly excessive amounts of medications to S.P. and J.B. The circumstances are as follows:

30. Complainant repeats the allegations of paragraphs 12, 13 and 18 of the First Cause for Discipline as if set forth in full.

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 86750, issued to Michael A. Simental, M.D.;

2. Revoking, suspending or denying approval of Michael A. Simental, M.D.'s authority to supervise physician assistants, pursuant to Section 3527 of the Code;

3. Ordering Michael A. Simental, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: July 29, 2014

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

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Exhibit B

2019 Decision, Case No. 800-2018-049419

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

In the Matter of the Accusation and Petition to Revoke Probation Against:	)	
Michael A. Simental, M.D.	)	Case No. 800-2018-049419
Physician's and Surgeon's Certificate No. A 86750	)	
Respondent	)	

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 August 9, 2019.

IT IS SO ORDERED: July 10, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina D. Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
State Bar No. 195729
California Department of Justice
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6000
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **MICHAEL ANTHONY SIMENTAL, M.D.** **10800 Magnolia Avenue #2A** **Riverside, CA 92505** **Physician's and Surgeon's Certificate No. A 86750,** Respondent.	Case No. 800-2018-049419 OAH No. 2019020557 **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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Edward K. Kim, Deputy Attorney General.

2. Michael Anthony Simental, M.D. (Respondent) is represented in this proceeding by attorney Paul Joseph Spackman, whose address is: 28441 Highridge Road, Suite 201, Rolling Hills Estates, CA 90274.

3. On or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate

No. A 86750 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation and Petition to Revoke Probation No. 800-2018-049419, and will expire on February 29, 2020, unless renewed.

JURISDICTION

4. Accusation and Petition to Revoke Probation No. 800-2018-049419 was filed before the Board, and is currently pending against Respondent. The Accusation and Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on December 18, 2018. Respondent timely filed his Notice of Defense contesting the Accusation and Petition to Revoke Probation.

5. A copy of Accusation and Petition to Revoke Probation No. 800-2018-049419 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 and Petition to Revoke Probation No. 800-2018-049419. Respondent has also carefully read, fully discussed with 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 and Petition to Revoke Probation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation and Petition to Revoke Probation No. 800-2018-049419, if proven at a hearing, constitute cause

for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation and Petition to Revoke Probation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie basis for the charges in the Accusation and Petition to Revoke Probation, 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.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2018-049419 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

CONTINGENCY

13. 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.

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 formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 86750 issued to Respondent MICHAEL ANTHONY SIMENTAL, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - ABSTAIN FROM USE. Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to Respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, Respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If Respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the Respondent with a hearing within 30 days of the request, unless the Respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed

decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

2. ALCOHOL - ABSTAIN FROM USE. Respondent shall abstain completely from the use of products or beverages containing alcohol.

If Respondent has a confirmed positive biological fluid test for alcohol, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the Respondent with a hearing within 30 days of the request, unless the Respondent stipulates to a later hearing. the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issues its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 30 days of the

issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

3. BIOLOGICAL FLUID TESTING. Respondent shall immediately submit to biological fluid testing, at Respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, Respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and Respondent.

If Respondent fails to cooperate in a random biological fluid testing program within the specified time frame, Respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The Respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within 30 days of the notification to cease practice. If the Respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the Respondent with a hearing within 30 days of the request, unless the Respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, requests for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of

practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 days of the issuance of the notification to cease practice or does not provide Respondent with a hearing within 30 days of such a request, the notification of cease practice shall be dissolved.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

5. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and

mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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 the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

6. PSYCHIATRIC EVALUATION. Within 30 calendar days of the effective date of

this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, Respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that Respondent is mentally fit to practice medicine safely. The period of time that Respondent is not practicing medicine shall not be counted toward completion of the term of probation.

7. PSYCHOTHERAPY. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed psychiatrist or licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, Respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist with any information and documents that the psychotherapist may deem pertinent. Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require Respondent to undergo and continue psychotherapy treatment and/or undergo psychiatric evaluations by a Board approved

and appointed board certified psychiatrist. If, prior to the completion of probation, Respondent is found to be mentally unfit to resume 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 mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

8. 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 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 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.

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that Respondent is medically fit to practice safely.

9. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor 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. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, 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. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

This Condition 9 of probation (practice monitoring) shall remain in effect only during the three-year period following the effective date of this Stipulated Settlement and Disciplinary Order, provided that Respondent has been in compliance with all terms and conditions of probation hereunder during the probationary term and provided further that this paragraph is subject to any recommendations by a Board evaluator pursuant to Conditions 6 and 8.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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(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.

15. 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.

16. 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..

17. 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.

18. 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.

19. 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.

20. 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Paul Joseph Spackman. 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: 6/5/2019

MICHAEL ANTHONY SIMENTAL, M.D.
Respondent

I have read and fully discussed with Respondent MICHAEL ANTHONY SIMENTAL, 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: 6/6/2019

PAUL JOSEPH SPACKMAN
Attorney for Respondent

ENDORSEMENT

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

DATED: 6/7/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation and Petition to Revoke Probation No. 800-2018-049419

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
EDWARD KIM
Deputy Attorney General
State Bar No. 195729
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6000
Facsimile: (213) 897-9395
Attorneys for Complainant

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **Michael A. Simental, M.D.** **10800 Magnolia Avenue, #2A** **Riverside, California 92505** **Physician's and Surgeon's Certificate Number A 86750,** Respondent.	Case No. 800-2018-049419 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation and Petition to Revoke Probation (hereinafter, "Accusation") solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about April 14, 2004, the Board issued Physician's and Surgeon's Certificate Number A 86750 to Michael A. Simental, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on February 29, 2020, 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 unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

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

6. Section 2234 of the Code, states:

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

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

". . ."

7. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"..."

8. Section 822 of the Code states:

"If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

"(a) Revoking the licentiate's certificate or license.

"(b) Suspending the licentiate's right to practice.

"(c) Placing the licentiate on probation.

"(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

"The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated."

FIRST CAUSE FOR DISCIPLINE

(Impaired Ability to Practice Medicine)

9. Respondent is subject to disciplinary action under section 822 of the Code in that his ability to practice medicine is impaired due to mental and/or physical illness. The circumstances are as follows:

10. On or about November 24, 2018, the Corona Police Department dispatched police officers to Respondent's home in the City of Corona. The police officers responded to an incident call indicating that Respondent threw things around his home, claimed that police were watching him, and ran outside in front of his house naked and that his house was on fire. Upon arriving on scene, a police officer saw Respondent lying naked on the street one house south from his residence. Respondent had blood on both of his arms and was bleeding from several areas of his body. His knees appeared to be injured as well. The police officer told Respondent to stay on the ground and roll onto his stomach. He initially complied with the instructions, but then rolled onto his back. The officer did not want Respondent to return to the inside of his home because there

was smoke coming out of his front door. While he was grabbing his penis, Respondent stated that he wanted the officer to shoot and kill Respondent. Respondent was later handcuffed. Based upon the observations of the officers, he was placed on a safety hold pursuant to Welfare and Institutions Code section 5150 and transported to a hospital. Respondent also told an officer at the hospital that he was a sniper and that he was going to shoot people with weapons he had already hidden at a tower.

11. The fire department also arrived on scene to extinguish the fire at Respondent's residence and observed several items thrown about the house and several firearms. Once it was safe, police officers entered Respondent's home, and noticed that it appeared that paper work was placed on a stove top and that the burners were ignited. The entire house appeared to be ransacked as well. It appeared that items were thrown against the walls. In addition, the police officers located several firearms located in the upstairs bedroom in plain view, including semi-automatic rifles, bolt action rifles, semi-automatic handguns and revolvers. These firearms were in different calibers including .338, .308, .22, 45, 9 mm, and 5.56 mm. Several of these firearms appeared to be new and were still wrapped in plastic and there were two that had attached scopes. There was also a bullet press (to make ammunition), both pistol and rifle powder and several thousand rounds of boxed ammunition, and a tactical style vest that could carry several gun magazines. There was also one Safariland ballistic vest and a few handgun holsters. Throughout the residence there were medical kits and books/magazines about shooting, guns and snipers. In addition, a record check found that Respondent had other unaccounted firearms.

SECOND CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

12. Respondent is subject to disciplinary action under Code section 2234, in that his actions and/or omissions represent unprofessional conduct, generally. The circumstances are as follows:

13. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

///

CAUSE TO REVOKE PROBATION

(Violation of Order; Failure to Obey All Laws)

14. Respondent is subject to revocation of his probationary order in that he violated paragraph 4 of his disciplinary order effective on or about December 22, 2016, in the disciplinary action entitled, "In the Matter of the Accusation Against Michael Anthony Simental, M.D." before the Medical Board of California, in Case No. 18-2012-226103, wherein Respondent's license was revoked, the revocation was stayed and Respondent was placed on probation, in that he committed unprofessional conduct by failing to obey all applicable laws. The circumstances are as follows:

15. At all times after the effective date of Respondent's probation, Condition Number 4, of his disciplinary order stated in relevant part:

"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."

16. Respondent violated the Medical Practice Act as alleged above in paragraphs 9 through 13.

DISCIPLINE CONSIDERATIONS

17. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that effective on or about December 22, 2016, in a prior disciplinary action entitled, "In the Matter of the Accusation Against Michael Anthony Simental, M.D." before the Medical Board of California, in Case No. 18-2012-226103, Respondent's license was revoked, the revocation was stayed and Respondent was placed on probation for two years in connection with gross negligence, repeated negligent acts and excessive presribing in the care and treatment of patients. That decision is now final and is incorporated by reference as if fully set forth.

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 86750;

issued to Michael A. Simental, M.D.;

2. Revoking, suspending or denying approval of Michael A. Simental, M.D.'s authority to supervise physician assistants and advanced practice nurses, pursuant to Section 3527 of the Code;

3. Ordering Michael A. Simental, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: December 18, 2018

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

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Exhibit C

Cease Practice Order

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

In the Matter of the Decision and Order against: **Michael Anthony Simental, M.D.** Physician's and Surgeon's Certificate No. A 86750 Respondent	Case No. 800-2018-049419

CEASE PRACTICE ORDER

In the Medical Board of California (Board) Case No. 800-2018-049419, the Board issued a Decision adopting a Stipulated Settlement and Disciplinary Order, which became effective August 9, 2019. In the Board's Order, Physician's and Surgeon's License No. A 86750, issued to Michael Anthony Simental, M.D., was revoked, with the revocation stayed, and placed on 5 years' probation, with terms and conditions.

Probationary Condition No. 5 - Clinical Competence Assessment Program.

The Respondent has failed to obey Probationary Condition No. 5 as ordered in the above Decision, by failing to successfully complete the Clinical Competence Assessment Program. Accordingly, Respondent, Michael Anthony Simental, M.D., is prohibited from engaging in the practice of medicine. Respondent shall not resume the practice of medicine until a final Decision has been issued on an Accusation and/or a Petition to Revoke Probation filed pursuant to this matter.

IT IS SO ORDERED **May 20, 2021** at 5:00 p.m.

William Prasifka
Executive Director