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

In the Matter of the Accusation Against:	)	
	)	
	)	
NAGA RAJA THOTA, M.D.	)	**Case No. 10-2012-224091**
	)	
Physician's and Surgeon's Certificate No. A 53526	)	
	)	
	)	
Respondent	)	
	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on March 2, 2016.

IT IS SO ORDERED: February 1, 2016.

MEDICAL BOARD OF CALIFORNIA

By: _____
Howard Krauss, M.D., Chair
Panel B

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
MATTHEW M. DAVIS
Deputy Attorney General
State Bar No. 202766
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2093
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **NAGA RAJA THOTA, M.D.** **2732 Navajo Road** **El Cajon, CA 92020** **Physician's and Surgeon's Certificate No. A 53526** Respondent.	Case No. 10-2012-224091 OAH No. 2015030268 **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 and is represented herein by Kamala D. Harris, Attorney General of the State of California, by Matthew M. Davis, Deputy Attorney General.

2. Respondent Naga Raja Thota, M.D. (respondent), is represented herein by Robert W. Frank, Esq., whose address is 1010 Second Ave., Ste. 2500 San Diego, CA 92101-4959.

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JURISDICTION

3. On or about September 14, 1994, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 53526 to respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations in Accusation No. 10-2012-224091 and will expire on August 31, 2016, unless renewed.

4. On September 4, 2014, complainant Kimberly Kirchmeyer, in her official capacity as the Executive Director of the Board, filed Accusation No. 10-2012-224091 against respondent. On September 4, 2014, respondent was served with a true and correct copy of Accusation No. 10-2012-224091, together with true and correct copies of all other statutorily required documents, at his address of record on file with the Board which was: 2732 Navajo Road, El Cajon, CA 92020. A true and correct copy of Accusation No. 10-2012-224091 is attached hereto as Attachment "A" and incorporated by reference as if fully set forth herein. On September 12, 2014, respondent filed a Notice of Defense and requested a hearing on the charges and allegations contained in Accusation No. 10-2012-224091.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 10-2012-224091. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary 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 Accusation No. 10-2012-224091; 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, the California Code of Civil Procedure and other applicable laws, having been fully advised of same by his attorney of record, Robert W. Frank, Esq.

7. Respondent, having the benefit of counsel, hereby voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 10-2012-224091, a true and correct copy of which is attached hereto as Attachment "A," and that he has thereby subjected his Physician's and Surgeon's Certificate No. A 53526 to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

9. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 10-2012-224091 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California.

CONTINGENCY

10. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Board for its consideration in the above-entitled matter and, further, that the Board shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Board considers and acts upon it.

11. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's office. Communications pursuant to this paragraph shall

not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Board reject this Stipulated Settlement and Disciplinary Order for any reason, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

12. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

13. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies and signatures shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 53526 issued to respondent Naga Raja Thota, M.D., (respondent) is revoked. However, the revocation is stayed and respondent is placed on probation for seven (7) years from the effective date of this decision on the following terms and conditions:

1. **Actual Suspension**

As part of probation, respondent is suspended from the practice of medicine for thirty (30) days beginning the sixteenth (16th) day after the effective date of this decision.

2. **Controlled Substances - Partial Restriction**

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act. Respondent shall be subject to this restriction until he submits, to the Board or its designee, proof of completion of 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.

3. **Education Course**

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

4. **Prescribing Practices Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices 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.

5. **Medical Record Keeping Course**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by 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 medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

15 calendar days after the effective date of the Decision, whichever is later.

6. **Clinical Training Program**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). 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 program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, 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, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. Determination as to whether respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical training 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 training program have been completed. If the respondent did not successfully complete the clinical training 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.

7. **Monitoring-Practice**

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professional enhancement program (PEP) equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart and prescribing practice 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.

The PEP 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. 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 respondent fails to enroll in a professional enhancement program (PEP) equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine 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 he enrolls in a professional enhancement program (PEP) equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine.

8. **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 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.

9. **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.

10. **Supervision of Physician Assistants**

During probation, respondent is prohibited from supervising physician assistants.

11. **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.

12. **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.

13. **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.

14. **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.

15. **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.

16. **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.

17. **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.

18. **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.

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19. **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, Naga Raja Thota, M.D., have carefully read this Stipulated Settlement and Disciplinary Order and, having the benefit of counsel, enter into it freely, voluntarily, intelligently, and with full knowledge of its force and effect on my Physician's and Surgeon's Certificate No. A 53526. I fully understand that, after signing this stipulation, I may not withdraw from it, that it shall be submitted to the Medical Board of California for its consideration, and that the Board shall have a reasonable period of time to consider and act on this stipulation after receiving it. By entering into this stipulation, I fully understand that, upon acceptance by the Board, my Physician's and Surgeon's Certificate No. A 53526 will be revoked, with the revocation stayed, and I shall be placed on probation and required to comply with all of the terms and conditions of the Disciplinary Order set forth above. I also fully understand that any failure to comply with the terms and conditions of the Disciplinary Order set for above shall constitute unprofessional conduct and a violation or violations of probation, will subject to my Physician's and Surgeon's Certificate No. A 53526 to further disciplinary action and, in addition, that the Board, after giving me notice and opportunity to be heard, may carry out the disciplinary order that was stayed, i.e., revocation of my Physician's and Surgeon's Certificate No. A 53526.

DATED: 11/6/15

NAGA RAJA THOTA, M.D.
Respondent

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I have read and fully discussed with respondent Naga Raja Thota, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11-11-15

ROBERT W. FRANK, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/13/15

Respectfully Submitted,

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

MATTHEW M. DAVIS
Deputy Attorney General
Attorneys for Complainant

Attachment "A"

Accusation No. 10-2012-224091

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General
ALEXANDRA M. ALVAREZ
Deputy Attorney General
State Bar No. 187442
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3141
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against: **NAGA RAJA THOTA, M.D.** 2732 Navajo Road El Cajon, CA 92020 **Physician's and Surgeon's Certificate No. A 53526** Respondent.	Case No. 10-2012-224091 **A C C U S A T I O N**

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.

2. On or about September 14, 1994, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 53526 to Naga Raja Thota, M.D., (Respondent). The Physician's and Surgeon's Certificate No. A 53526 was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2016, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded and ordered to complete relevant educational courses, or have such other action taken in relation to discipline as the Board or an administrative law judge deems proper.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

". . . ."

6. Section 2266 of the Code states:

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

7. Section 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.

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"(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)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. A 53526 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of patients F.S., L.A., T.S., L.S. and Ch.S., as more particularly alleged hereinafter:

Patient F.S.

9. In or about 1999, patient F.S., a then 46 year old man, began seeing respondent for low back pain and right greater than left lower extremity pain that was secondary to post laminectomy syndrome[1] and radiculopathy.[2] At that time, patient F.S. was on Prozac[3] 20 mg b.i.d., Ultram[4] 8 tablets per day, and Vicodin ES[5] 6 tablets per day. Respondent discontinued the Ultram and prescribed patient F.S. with oxycodone[6] 80 mg per day.

10. From on or about 1999 through 2007, patient F.S. continued to see respondent for pain management. During this time period, the amount of morphine equivalent daily dose

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[1] Post-laminectomy syndrome is a condition where the patient suffers from persistent pain in the back following surgery to the back.

[2] Radiculopathy is caused by compression or irritation of a nerve as it exits the spinal column. Symptoms of radiculopathy include pain, numbness, tingling, or weakness in the arms or legs.

[3] Prozac is a brand name of fluoxetine and is used to treat depression, panic attacks, obsessive compulsive disorder, and a certain eating disorder (bulimia).

[4] Ultram is a brand name of tramadol and is a narcotic-like pain reliever and a dangerous drug within the meaning of California Business and Professions Code section 4022.

[5] Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

(MEDD) of medications prescribed by respondent to patient F.S. increased from a MEDD of 165 mg in 1999 to approximately a MEDD of 3800 mg in 2007.

11. From on or about January 8, 2007, through December 5, 2007, patient F.S. saw respondent approximately twelve times for pain management. At each visit, patient F.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient F.S. noted that his pain level was either at 9 or 10 level out of a 10 point scale, repeatedly noted that the pain medications did not always work or did not work at all, and that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient F.S.' forms. During this time period, respondent documented in patient F.S.' chart an analgesia percentage (pain relief) range from 40% pain relief to 60% pain relief despite the fact that at each visit patient F.S. would indicate a 9 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient F.S.

12. From on or about January 8, 2007, through December 5, 2007, respondent wrote patient F.S. 16 prescriptions for Methadone HCL[7] 10 mg for a total of 11000 tablets, 18 prescriptions for Kadian[8] 100 mg for a total of 835 tablets, and 3 prescriptions for Percocet[9] 5 mg for a total of 360 tablets.

13. From on or about January 8, 2007, through December 5, 2007, respondent continued to prescribe patient F.S. high doses of opioids without any clear positive response, such as a

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[7] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Kadian (morphine sulfate) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

decrease in pain level. The progress notes for these visits do not contain any assessment of patient F.S.' pain level. Throughout the progress notes, the medications prescribed to patient F.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

14. From on or about January 8, 2007, through December 5, 2007, respondent did not refer patient F.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or require patient F.S. to have a toxicology screen.

15. From on or about January 8, 2007, through December 5, 2007, respondent did not review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

16. From on or about January 2, 2008, through December 31, 2008, patient F.S. saw respondent approximately eleven times for pain management. At each visit, patient F.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient F.S. noted that his pain level was either at 9 or 10 level out of a 10 point scale, repeatedly noted that the pain medications did not always work or did not work at all, and that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient F.S.' forms. During this time period, respondent documented in patient F.S.' chart an analgesia percentage range from 40% pain relief to 60% pain relief despite the fact that at each visit patient F.S. would indicate a 9 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient F.S.

17. From on or about January 2, 2008, through December 31, 2008, respondent wrote patient F.S. 11 prescriptions for Methadone HCL 10 mg for a total of 11000 tablets, 1 prescription

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for Kadian 100 mg 60 tablets, and 12 prescriptions for Oxycontin[10] 80 mg for a total of 1410 tablets.

18. From on or about January 2, 2008, through December 31, 2008, respondent continued to prescribe high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient F.S.' pain level. Throughout the progress notes, the medications prescribed to patient F.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

19. From on or about January 2, 2008, through December 31, 2008, respondent did not refer patient F.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or require patient F.S. to have a toxicology screen.

20. From on or about January 2, 2008, through December 31, 2008, respondent did not review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

21. From on or about January 28, 2009, through December 9, 2009, patient F.S. saw respondent approximately twelve times for pain management. At each visit, patient F.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient F.S. noted that his pain level was either at 9 or 10 level out of a 10 point scale, repeatedly noted that the pain medications did not always work or did not work at all, and that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient F.S.' forms. During this time period, respondent documented in patient F.S.' chart an analgesia percentage range from 40% pain relief to 60% pain relief despite the fact that at each visit patient F.S. would indicate a 9 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress

[10] Oxycontin is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient F.S.

22. From on or about January 28, 2009, through December 9, 2009, respondent wrote patient F.S. 11 prescriptions for Methadone HCL 10 mg for a total of 11000 tablets, 11 prescriptions for Kadian 100 mg for a total of 780 tablets, and 5 prescriptions for Oxycontin 80 mg for a total of 600 tablets. In addition, respondent wrote patient F.S. 11 prescriptions for Diazepam[11] 10 mg for a total of 1050 tablets.

23. From on or about January 28, 2009, through December 9, 2009, respondent continued to prescribe high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient F.S.' pain level. Throughout the progress notes, the medications prescribed to patient F.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

24. From on or about January 28, 2009, through December 9, 2009, respondent did not refer patient F.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or require patient F.S. to have a toxicology screen.

25. From on or about January 28, 2009, through December 9, 2009, respondent did not review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

26. From on or about January 5, 2010, through December 16, 2010, patient F.S. saw respondent approximately twelve times for pain management. At each visit from on or about January through June 2010, patient F.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient F.S. noted that his pain level was either at 9 or 10 level out of a 10 point scale, repeatedly noted that the pain medications did not always work or did not work at all, and

[11] Diazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient F.S.' forms. During this time period, respondent documented in patient F.S.' chart an analgesia percentage (pain relief) range from 40% pain relief to no greater than 60% pain relief despite the fact that at each visit patient F.S. would indicate a 9 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient F.S.

27. On or about July 29, 2010, respondent began maintaining electronic medical records for patient F.S. From or about July 29, 2010, through December 16, 2010, respondent's electronic medical records for patient F.S. were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores.

28. From on or about January 5, 2010, through December 16, 2010, respondent wrote patient F.S. 13 prescriptions for Methadone HCL 10 mg for a total of 13000 tablets, 18 prescriptions for Kadian 100 mg for a total of 1260 tablets, and 5 prescriptions for APAP/Oxycodone 325/5 mg for a total of 1590 tablets. In addition, respondent wrote patient F.S. 13 prescriptions for Diazepam 10 mg for a total of 1050 tablets.

29. From on or about January 5, 2010, through December 16, 2010, respondent continued to prescribe high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient F.S.' pain level. Throughout the progress notes, the medications prescribed to patient F.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

30. From on or about January 5, 2010, through December 16, 2010, respondent did not refer patient F.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or require patient F.S. to have a toxicology screen.

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31. From on or about January 5, 2010, through December 16, 2010, respondent did not review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

32. From on or about January 17, 2011, through June 7, 2011, patient F.S. saw respondent approximately six times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. In each progress note, respondent noted that patient F.S. was sad and depressed. Respondent did not refer patient F.S. for treatment of his depression.

33. From on or about January 17, 2011, through June 7, 2011, respondent wrote patient F.S. 6 prescriptions for Methadone HCL 10 mg for a total of 5500 tablets, 5 prescriptions for Kadian 100 mg for a total of 300 tablets, and 6 prescriptions for APAP/Oxycodone 325/5 mg for a total of 990 tablets. In addition, respondent wrote patient F.S. 6 prescriptions for Diazepam 10 mg for a total of 540 tablets.

34. From on or about January 17, 2011, through June 7, 2011, respondent did not refer patient F.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or require patient F.S. to have a toxicology screen.

35. From on or about January 17, 2011, through June 7, 2011, respondent did not review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

36. On or about June 17, 2011, patient F.S. was found unresponsive in the street and admitted into the hospital for four days. He was discharged on June 21, 2011, with a diagnosis of opioid dependence with prescription medication. The attending physician was able to reduce the amount of pain medication for patient F.S. to 20 mg of Methadone daily and 60 mg of MS Contin[12] twice daily, which was dramatically less than the amount of medication he had been

[12] MS Contin is a brand name for morphine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

prescribed by respondent in June 2011 of 200 mg of Kadian daily, 330 mg of Methadone daily, and 30 mg of Percocet daily.

37. Respondent committed gross negligence in his care and treatment of patient F.S. which included, but was not limited to the following:

A. Paragraphs 9 to 36 above, are hereby incorporated by reference as if fully set forth herein; and

B. Excessively prescribing extremely high doses of opioids that resulted in MEDD of greater than 4000 mg from the period of January 2007 through June 2011.

Patient L.A.

38. On or about August 30, 2005, patient L.A., a then 46 year old woman, was referred by her primary care physician to respondent for chronic pain management with a diagnosis of lumbar facet joint disease, radiculopathy, and myofascial pain. Patient L.A. had complaint of pain in her lower back, elbows and back of neck. At that time, patient L.A. was on Soma 350 mg[13] 6 tablets daily and Norco[14] 325/5 mg 6 tablets daily with a MEDD of 60 mg. From on or about 2005 through 2012, patient L.A. continued to see respondent for pain management.

39. From on or about January 4, 2007, through December 11, 2007, patient L.A. saw respondent approximately thirteen times for pain management. At each visit, patient L.A. would fill out a form indicating her pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient L.A. usually noted that her pain level was either at 6 or 7 out of a 10 point scale. She repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient L.A.'s forms. During this time period, respondent documented in patient L.A.'s chart an analgesia percentage range from 60% pain relief to 75%

[13] Soma, a brand name for carisoprodol, is a muscle relaxant with a known potentiating effect on narcotics. It is a muscle relaxer that works by blocking pain sensations between the nerves and the brain. In December 2011, the Federal Drug Administration listed carisoprodol as a Schedule IV controlled substance. (76 Fed.Reg. 77330 (Dec. 12, 2011).)

[14] Norco is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

pain relief despite the fact that at each visit patient L.A. would indicate a 6 or 7 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient L.A.

40. From on or about January 4, 2007, through December 11, 2007, respondent wrote patient L.A. 12 prescriptions for MS Contin 100 mg for a total of 1480 tablets, 10 prescriptions for Norco 10/325 mg for a total of 1800 tablets, and 6 prescriptions for Soma 350 mg for a total of 1080 tablets.

41. From on or about January 4, 2007, through December 11, 2007, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient L.A. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

42. From on or about January 4, 2007, through December 11, 2007, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

43. From on or about January 4, 2007, through December 11, 2007, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

44. From on or about January 8, 2008, through December 10, 2008, patient L.A. saw respondent approximately eight times for pain management. At each visit, patient L.A. would fill out a form indicating her pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient L.A. usually noted that her pain level was either at 6 or 7 out of a 10 point scale. She repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient L.A.'s forms. During this time period, respondent documented in patient L.A.'s chart an analgesia percentage range from 60% pain relief to 70% pain relief despite the fact

that at each visit patient L.A. would indicate a 6 or 7 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient L.A. Throughout the progress notes, the medications prescribed to patient L.A. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

45. From on or about January 8, 2008, through December 10, 2008, respondent wrote patient L.A. 7 prescriptions for MS Contin 100 mg for a total of 630 tablets, 7 prescriptions for Norco 10/325 mg for a total of 1080 tablets, 7 prescriptions for Soma 350 mg for a total of 600 tablets, and 2 prescriptions for oxycodone 5/325 mg for a total of 180 tablets.

46. From on or about January 8, 2008, through December 10, 2008, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient LA. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

47. From on or about January 8, 2008, through December 10, 2008, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

48. From on or about January 8, 2008, through December 10, 2008, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

49. From on or about January 7, 2009, through December 9, 2009, patient L.A. saw respondent approximately seven times for pain management. At each visit, patient L.A. would fill out a form indicating her pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient L.A. usually noted that her pain level was either at 7 or 8 out of a 10 point scale. She repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were

inconsistent with patient L.A.'s forms. During this time period, respondent documented in patient L.A.'s chart an analgesia percentage of 40% pain relief despite the fact that at each visit patient L.A. would indicate a 6 or 7 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient L.A.

50. From on or about January 7, 2009, through December 9, 2009, respondent wrote patient L.A. 7 prescriptions for MS Contin 100 mg for a total of 570 tablets, 5 prescriptions for Norco 10/325 mg for a total of 720 tablets, 7 prescriptions for Soma 350 mg for a total of 840 tablets, and 5 oxycodone 5/325 mg for a total of 450 tablets.

51. From on or about January 7, 2009, through December 9, 2009, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient L.A. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

52. From on or about January 7, 2009, through December 9, 2009, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

53. From on or about January 7, 2009, through December 9, 2009, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

54. From on or about February 5, 2010, through June 23, 2010, respondent wrote patient L.A. 5 prescriptions for MS Contin 100 mg for a total of 300 tablets and 9 prescriptions for Norco 10/325 mg for a total of 1590 tablets. There are no progress notes from February 2010 through June 2010 in patient L.A.'s medical record.

55. On or about July 6, 2010, respondent began maintaining electronic medical records for patient L.A. From on or about July 6, 2010, through December 14, 2010, respondent's

electronic medical records for patient L.A. were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the history of present illness (HPI) and what was noted in the vital signs sections. In each progress note, respondent noted that patient L.A. was sad and depressed. Respondent did not refer patient L.A. for treatment of her depression or prescribe her any antidepressants. On or about September 29, 2010, respondent saw patient L.A. for pain management; however, there is no progress note for this visit.

56. From on or about July 6, 2010, through December 14, 2010, respondent wrote patient L.A. 6 prescriptions for MS Contin 100 mg for a total of 360 tablets, 15 prescriptions for Norco 10/325 mg for a total of 2310 tablets, and 9 prescriptions of Soma 350 mg for a total of 900 tablets.

57. From on or about January 2010, through December 14, 2010, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient LA. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

58. From on or about January 2010, through December 14, 2010, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

59. From on or about January 2010, through December 14, 2010, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

60. From on or about January 11, 2011, through December 19, 2011, patient L.A. saw respondent approximately twelve times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections. In each progress note, respondent noted that patient L.A.

was sad and depressed. Respondent did not refer patient L.A. for treatment of her depression or prescribe her any antidepressants.

61. On or about December 19, 2011, respondent prescribed patient L.A. Methadone HCL with no explanation as to why it was being prescribed in the medical record. Respondent continued patient L.A. on Methadone HCL and MS Contin, two long-acting opioids, without documenting an explanation in the medical record.

62. From on or about January 11, 2011, through December 19, 2011, respondent wrote patient L.A. 12 prescriptions for MS Contin 100 mg for a total of 750 tablets, 31 prescriptions for Norco 10/325 mg for a total of 3720 tablets, 9 prescriptions for Soma 350 mg for a total of 1620 tablets, 1 prescription for oxycodone 10/325 mg for a total of 120 tablets, and 1 prescription for Methadone HCL 10 mg for a total of 90 tablets.

63. From on or about January 11, 2011, through December 19, 2011, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient L.A. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

64. From on or about January 11, 2011, through December 19, 2011, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

65. From on or about January 11, 2011, through December 19, 2011, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

66. From on or about January 16, 2012, through August 30, 2012, patient L.A. saw respondent approximately nine times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections. In each progress note, respondent noted that patient L.A.

was sad and depressed. Respondent did not refer patient L.A. for treatment of her depression or prescribe her any antidepressants.

67. From on or about January 16, 2012, through August 30, 2012, respondent wrote patient L.A. 8 prescriptions for MS Contin 100 mg for a total of 480 tablets, 9 prescriptions for Norco 10/325 mg for a total of 1620 tablets, 17 prescriptions for Soma 350 mg for a total of 1460 tablets, 6 prescriptions for Methadone HCL 10 mg for a total of 540 tablets, and 3 prescriptions for temazepam[15] 15 mg for a total of 90 capsules.

68. From on or about January 16, 2012, through August 30, 2012, respondent continued to prescribe patient L.A. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.A.'s pain level. Throughout the progress notes, the medications prescribed to patient L.A. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

69. From on or about January 11, 2011, through December 19, 2011, respondent did not refer patient L.A. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.A. to have a toxicology screen.

70. From on or about January 11, 2011, through December 19, 2011, respondent did not review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

71. Respondent committed gross negligence in his care and treatment of patient L.A. which included, but was not limited to the following:

A. Paragraphs 38 to 70 above, are hereby incorporated by reference as if fully set forth herein; and

B. Failing to maintain adequate and accurate medical records for patient L.A. from February 2010 through June 2010, and September 29, 2010.

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[15] Temazepam is a generic brand for restoril and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

Patient T.S.

72. On or about October 3, 2003, patient T.S., a then 63 year old man, was referred by his primary care physician to respondent for pain management with a diagnosis of post laminectomy syndrome, radiculopathy, back pain, and myofascial pain. Patient T.S. had complaints of back and leg pain. From on or about 2003 through 2012, patient T.S. continued to see respondent for pain management.

73. From on or about January 24, 2007, through December 5, 2007, patient T.S. saw respondent approximately fourteen times for pain management. At each visit, patient T.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient T.S. usually noted that his pain level was either at 8 to 10 out of a 10 point scale. He repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient T.S.' forms. During this time period, respondent documented in patient T.S.' chart an analgesia percentage range from 50% pain relief to 80% pain relief despite the fact that at each visit patient T.S. would indicate a 8 to 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient T.S.

74. From on or about January 24, 2007, through December 5, 2007, respondent wrote patient T.S. 10 prescriptions for Kadian 80 mg for a total of 480 tablets, 3 prescriptions for Kadian 50 mg for a total of 90 tablets, 10 prescriptions for Methadone HCL 10 mg for a total of 1164 tablets, 4 prescriptions for diazepam 10 mg for a total of 480 tablets, 4 prescriptions of Ambien CR 12.5 mg for a total of 120 tablets, 3 prescriptions of Vicodin 7.7/750 mg for a total of 540 tablets, and 1 prescription for Norco 10/325 mg for a total of 180 tablets.

75. From on or about January 24, 2007, through December 5, 2007, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S.

were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

76. From on or about January 24, 2007, through December 5, 2007, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain. There were no toxicology reports documented for this time period.

77. From on or about January 24, 2007, through December 5, 2007, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

78. From on or about January 28, 2008, through December 31, 2008, patient T.S. saw respondent approximately twelve times for pain management. At each visit, patient T.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient T.S. usually noted that his pain level was either at 8 to 9 out of a 10 point scale. He repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient T.S.' forms. During this time period, respondent documented in patient T.S.' chart an analgesia percentage range from 40% pain relief to 60% pain relief despite the fact that at each visit patient T.S. would indicate a 8 to 9 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient T.S.

79. From on or January 28, 2008, through December 31, 2008, respondent wrote patient T.S. 11 prescriptions for Kadian 80 mg for a total of 660 tablets, 11 prescriptions for Methadone HCL 10 mg for a total of 1440 tablets, 3 prescriptions for diazepam 10 mg for a total of 360 tablets, 6 prescriptions of Ambien CR 12.5 mg for a total of 180 tablets, and 6 prescriptions for Norco 10/325 mg for a total of 1080 tablets.

80. From on or about January 28, 2008, through December 31, 2008, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such

as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

81. From on or about January 28, 2008, through December 31, 2008, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain. There were no toxicology reports documented for this time period.

82. From on or about January 28, 2008, through December 31, 2008, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

83. From on or about January 8, 2009, through December 9, 2009, patient T.S. saw respondent approximately twelve times for pain management. At each visit, patient T.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient T.S. usually noted that his pain level was either at 8 to 9 out of a 10 point scale. He repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient T.S.' forms. During this time period, respondent documented in patient T.S.' chart an analgesia percentage range from 40% pain relief to 60% pain relief despite the fact that at each visit patient T.S. would indicate a 8 to 9 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient T.S.

84. From on or about January 8, 2009, through December 9, 2009, respondent wrote patient T.S. 3 prescriptions for Kadian 80 mg for a total of 180 tablets, 13 prescriptions for Methadone HCL 10 mg for a total of 2880 tablets, 9 prescriptions for Oxycontin 20 mg for a total of 1020 tablets, 3 prescriptions for diazepam 10 mg for a total of 360 tablets, 2 prescriptions of

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Ambien CR 12.5 mg for a total of 60 tablets, and 4 prescriptions for Norco 10/325 mg for a total of 720 tablets.

85. From on or about January 8, 2009, through December 9, 2009, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

86. On or about May 12, 2009, respondent substituted Oxycontin 20 mg 3 tablets daily for Kadian without explanation. On or about June 22, 2009, respondent increased the amount of Oxycontin to 40 mg 2 tablets daily without explanation. Respondent continued to prescribe Methadone to patient T.S. along with the Oxycontin with documenting the continuation of two long-acting opioids.

87. From on or about January 8, 2009, through December 9, 2009, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain. There were no toxicology reports documented for this time period.

88. From on or about January 8, 2009, through December 9, 2009, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

89. From on or about January 7, 2010, through December 9, 2010, patient T.S. saw respondent approximately thirteen times for pain management. At each visit from on or about January through June 2010, patient T.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient T.S. noted that his pain level was either at 9 or 10 level out of a 10 point scale. He repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient T.S.' forms. During this time period, respondent documented in patient T.S.' chart an analgesia percentage range from

40% pain relief to no greater than 60% pain relief despite the fact that at each visit patient T.S. would indicate a 9 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient T.S.

90. On or about June 23, 2010, respondent began maintaining electronic medical records for patient T.S. From on or about June 23, 2010, through December 9, 2010, respondent's electronic medical records for patient T.S. were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

91. From on or about January 7, 2010, through December 9, 2010, respondent wrote patient T.S. 1 prescription for Kadian 80 mg for a total of 60 tablets, 13 prescriptions for Methadone HCL 10 mg for a total of 3120 tablets, 1 prescription for Oxycontin 20 mg for a total of 120 tablets, 11 prescriptions for Oxycontin 40 mg for a total of 1260 tablets, 13 prescriptions for diazepam 10 mg for a total of 1560 tablets, 6 prescriptions of Ambien CR 12.5 mg for a total of 180 tablets, 12 prescriptions for Norco 10/325 mg for a total of 2160 tablets, and 1 prescription for Soma 350 mg for a total of 90 tablets.

92. On or about February 4, 2010, respondent increased patient T.S.' prescription for Oxycontin to 120 mg daily without any documentation. On or about April 1, 2010, respondent increased patient T.S.' prescription for Oxycontin to 160 mg daily with any documentation.

93. From on or about January 7, 2010, through December 9, 2010, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

94. From on or about January 7, 2010, through December 9, 2010, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain

symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain.

95. On or about July 10, 2010, patient T.S. submitted to a urine drug screen which showed an inconsistency in that there was no detection of Methadone and Oxycodone which had been prescribed to patient T.S. There were no other toxicology reports documented for this time period. Respondent did not address these inconsistencies in patient T.S.' medical record. He did not run a CURES report to determine if patient T.S. was receiving prescriptions for controlled substances from other providers.

96. From on or about January 7, 2010, through December 9, 2010, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

97. From on or about January 6, 2011, through December 8, 2011, patient T.S. saw respondent approximately ten times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

98. From on or about January 6, 2011, through December 8, 2011, respondent wrote patient T.S. 1 prescription for MS Contin 80 mg for a total of 120 tablets, 7 prescriptions for Diazepam 10 mg for a total of 840 tablets, 11 prescriptions for Kadian 80 mg for a total of 660 tablets, 10 prescriptions for Norco 10/325 mg for a total of 1800 tablets, 3 prescriptions for oxycodone 15 mg for a total of 420 tablets, and 12 prescriptions for Methadone HCL 10 mg for a total of 2880 tablets.

99. From on or about January 6, 2011, through December 8, 2011, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

100. From on or about January 6, 2011, through December 8, 2011, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain. There were no toxicology reports documented for this time period.

101. From on or about January 6, 2011, through December 8, 2011, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

102. From on or about January 5, 2012, through July 19, 2012, patient T.S. saw respondent approximately eight times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

103. From on or about January 5, 2012, through July 19, 2012, respondent wrote patient T.S. 7 prescriptions for MS Contin 80 mg for a total of 420 tablets, 6 prescriptions for diazepam 10 mg for a total of 720 tablets, 8 prescriptions for oxycodone 15 mg for a total of 1200 tablets, 6 prescriptions for Methadone HCL 10 mg for a total of 1440 tablets, and 5 prescriptions for Soma 350 mg for a total of 450 tablets.

104. On or about February 2, 2012, patient T.S. submitted to a urine drug screen which showed an inconsistency in that there was no detection of Methadone and oxycodone which had been prescribed to patient T.S. There were no other toxicology reports documented for this time period. Respondent did not address these inconsistencies in patient T.S.' medical record. He did not run a CURES report to determine if patient T.S. was receiving prescriptions for controlled substances from other providers.

105. From on or about January 5, 2012, through July 19, 2012, respondent continued to prescribe patient T.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient T.S.' pain level. Throughout the progress notes, the medications prescribed to patient T.S.

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were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

106. From on or about January 5, 2012, through July 19, 2012, respondent did not refer patient T.S. for any diagnostic studies to determine if other pathology existed for his pain symptoms, refer him to physical therapy, or provide him any type of treatment for neuropathic pain.

107. From on or about January 5, 2012, through July 19, 2012, respondent did not review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

108. Respondent committed gross negligence in his care and treatment of patient T.S. which included, but was not limited to the following:

A. Paragraphs 72 to 107 above, are hereby incorporated by reference as if fully set forth herein; and

B. Excessively prescribing extremely high doses of opioids that resulted in MEDD of 1232 mg from the period of January 2011 through July 2012.

Patient L.S.

109. On or about December 3, 2008, patient L.S., a then 65 year-old woman, was admitted to the hospital for persistent abdominal pain. Respondent conducted a pain management consultation and started patient L.S. on MS Contin. On or about December 9, 2008, patient L.S. was discharged and instructed to follow up with respondent for pain management.

110. On or about January 26, 2009, patient L.S. saw respondent for pain management with a diagnosis of abdominal pain, dumping syndrome, and post lumbar laminectomy. Patient L.S. had a pain level of 10 out of 10 point scale. Respondent prescribed patient L.S. MS Contin 240 mg daily and MSIR[16] 120 mg daily for an initial MEDD of 300. From on or about 2009 through 2012, patient L.S. continued to see respondent for pain management.

[16] MSIR (morphine) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

111. From on or about January 26, 2009, through December 7, 2009, patient L.S. saw respondent approximately thirteen times for pain management. At each visit, patient L.S. would fill out a form indicating her pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient L.S. noted that her pain level was a 10 out of a 10 point scale and repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient L.S.' forms. During this time period, respondent documented in patient L.S.' chart an analgesia percentage range from 40% pain relief to 60% pain relief despite the fact that at each visit patient L.S. would indicate a 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient L.S.

112. From on or about January 26, 2009, through December 7, 2009, respondent wrote patient L.S. 12 prescriptions for MSIR 30 mg for a total of 3060, 10 prescriptions for MS Contin 100 mg for a total of 900 tablets, 2 prescriptions for MS Contin 30 mg for a total of 180, 1 prescription for MS Contin 60 mg for a total of 90 tablets, 2 prescriptions for temazepam 30 mg for a total of 120 capsules, 1 prescription for Ambien 10 mg for a total of 30 tablets, 1 prescription for Methadone HCL 10 mg for a total of 90 tablets, 1 prescription for Oxycontin 15 mg for at total of 180 tablets, 1 prescription for Oxycontin 20 mg for a total of 90 tablets, and 1 prescription for Xanax[17] .5 mg for a total of 90 tablets.

113. From on or about January 26, 2009, through December 7, 2009, respondent continued to prescribe high doses of opioids to patient L.S. without any clear positive response, such as a decrease in pain level. Throughout the progress notes, the medications prescribed to patient L.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

[17] Xanax (alprazolam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

114. From on or about January 26, 2009, through December 7, 2009, respondent did not refer patient L.S. for any diagnostic studies to determine if other pathology existed for her pain symptoms or refer her to physical therapy.

115. From on or about January 26, 2009, through December 7, 2009, respondent did not review the course of pain treatment of patient L.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

116. On or about August 17, 2009, patient L.S. submitted to a urine drug screen which was positive for codeine. This was inconsistent with the medications that respondent prescribed to patient L.S. Respondent did not document that he discussed the inconsistent urine drug screen with patient L.S.

117. From on or about January 4, 2010, through December 7, 2010, patient L.S. saw respondent approximately thirteen times for pain management. At each visit from on or about January through May 2010, patient L.S. would fill out a form indicating her pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient L.S. noted that her pain level was either at 8 or 10 level out of a 10 point scale and repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient L.S.' forms. During this time period, respondent documented in patient L.S.' chart an analgesia percentage range from 30% pain relief to no greater than 60% pain relief despite the fact that at each visit patient L.S. would indicate a 8 or 10 pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient L.S.

118. On or about May 24, 2010, respondent began maintaining electronic medical records for patient L.S. From on or about May 24, 2010, through December 7, 2010, respondent's electronic medical records for patient L.S. were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

119. From on or about January 4, 2010, through December 7, 2010, respondent wrote patient L.S. 12 prescriptions for MS Contin 100 mg for a total of 1080 tablets, 13 prescriptions for MS Contin 30 mg for a total of 3330 tablets, 12 prescriptions for Methadone HCL 10 mg for a total of 3150 tablets, 1 prescription for oxycodone 30 mg for a total of 180 tablets, 5 prescriptions for temazepam 30 mg for a total of 150 capsules, 9 prescriptions for diazepam 10 mg for a total of 810 tablets, 2 prescriptions for diazepam 5 mg for a total of 240 tablets, 13 prescriptions of Ambien 10 mg for a total of 390 tablets, and 1 prescription for hydromorphone HCL[18] 4 mg for a total of 120 tablets.

120. From on or about January 4, 2010, through December 7, 2010, respondent continued to prescribe patient L.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of the patient L.S.' pain level indicated on the patient form. Throughout the progress notes, the medications prescribed to patient L.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

121. From on or about January 4, 2010, through December 7, 2010, respondent did not refer patient L.S. for any diagnostic studies to determine if other pathology existed for her pain symptoms or refer her to physical therapy, or require patient L.S. to have a toxicology screen.

122. From on or about January 4, 2010, through December 7, 2010, respondent did not review the course of pain treatment of patient L.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

123. From on or about January 4, 2011, through December 23, 2011, patient L.S. saw respondent approximately thirteen times for pain management office visits. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

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[18] Hydromorphone HCL is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

124. On or about December 9, 16, and 23, 2011, patient L.S. underwent corticosteroid injections in her right knee. Respondent diagnosed patient L.S. with osteoarthritis at these visits. Respondent did not document the rationale for these injections. He did not refer patient L.S. for orthopedic care.

125. From on or about January 4, 2011, through December 23, 2011, respondent wrote patient L.S. 13 prescriptions for MS Contin 100 mg for a total of 1170 tablets, 13 prescriptions for Methadone HCL 10 mg for a total of 4680 tablets, 8 prescriptions for temazepam 30 mg for a total of 240 capsules, 4 prescriptions for diazepam 10 mg for a total of 360 tablets, 4 prescriptions for Ambien 10 mg for a total of 120 tablets, 13 prescriptions for hydromorphone HCL 4 mg for a total of 1560 tablets, and 6 prescriptions for clonazepam[19] .5 mg for a total of 360 tablets.

126. From on or about January 4, 2011, through December 23, 2011, respondent continued to prescribe patient L.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.S.' pain level. Throughout the progress notes, the medications prescribed to patient L.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

127. From on or about January 4, 2011, through December 23, 2011, respondent did not refer patient L.S. for any diagnostic studies to determine if other pathology existed for her pain symptoms, refer her to physical therapy, or require patient L.S. to have a toxicology screen.

128. From on or about January 4, 2011, through December 23, 2011, respondent did not review the course of pain treatment of patient L.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

129. From on or about January 6, 2012, through September 25, 2012, patient L.S. saw respondent approximately fourteen times for office visits, which included six office visits for joint injections. The progress notes for these office visits were essentially an exact copy of the

[19] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections. In each progress note, respondent noted that patient L.S. was sad and depressed. Respondent did not refer patient L.S. for treatment of her depression.

130. On or about March 30, April 6, April 13, and September 25, 2012, patient L.S. underwent corticosteroid injections in her left knee. Respondent diagnosed patient L.S. with osteoarthritis at these visits. Respondent did not document the rationale for these injections. He did not refer patient L.S. for orthopedic care.

131. On or about July 3, 2012, and September 4, 2012, patient L.S. underwent corticosteroid injections in her right knee. Respondent diagnosed patient L.S. with osteoarthritis at these visits. Respondent did not document the rationale for these injections. He did not refer patient L.S. for orthopedic care.

132. From on or about January 6, 2012, through September 25, 2012, respondent wrote patient L.S. 11 prescriptions for MS Contin 100 mg for a total of 990 tablets, 11 prescriptions for Methadone HCL 10 mg for a total of 3960 tablets, 11 prescriptions of Ambien 10 mg for a total of 330 tablets, 11 prescriptions for hydromorphone HCL 4 mg for a total of 1320 tablets, 10 prescriptions for clonazepam .5 mg for a total of 600 tablets, and 1 prescription for Nucynta[20] 50 mg for a total of 10 tablets.

133. On or about March 29, 2012, patient L.S. submitted to a urine drug screen which was positive for methamphetamine[21] (an illicit street drug) and meprobamate. This was inconsistent with the medications that respondent prescribed to patient L.S. Respondent did not document that he discussed the inconsistent urine drug screen with patient L.S.

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[20] Nucynta (tapentadol) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[21] Methamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d).

134. On or about September 13, 2012, patient L.S. submitted to a urine drug screen which was positive for codeine, Soma, and meprobamate. This was inconsistent with the medications that respondent prescribed to patient L.S. The urine drug screen also noted a low level of Methadone which was inconsistent with the amount prescribed. Respondent did not document that he discussed the inconsistent urine drug screen with patient L.S.

135. On or about November 8, 2012, patient L.S. submitted to a urine drug screen which was positive for methamphetamine and amphetamines. This was inconsistent with the medications that respondent prescribed to patient L.S. The urine drug screen also noted a low level of Methadone which was inconsistent with the amount prescribed. Respondent did not document that he discussed the inconsistent urine drug screen with patient L.S.

136. From on or about January 6, 2012, through September 25, 2012, respondent continued to prescribe patient L.S. controlled substances without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient L.S.' pain level indicated on the patient form. Throughout the progress notes, the medications prescribed to patient L.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

137. From on or about January 6, 2012, through September 25, 2012, respondent did not refer patient L.S. for any diagnostic studies to determine if other pathology existed for her pain symptoms or refer her to physical therapy.

138. From on or about January 6, 2012, through September 25, 2012, respondent did not review the course of pain treatment of patient L.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

139. Respondent committed gross negligence in his care and treatment of patient L.S. which included, but was not limited to the following:

A. Paragraphs 109 to 138 above, are hereby incorporated by reference as if fully set forth herein; and

B. Failing to maintain adequate and accurate medical records for patient L.S.;

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C. Excessively prescribing high doses of opioids, benzodiazepines, Soma, and Ambien in the presence of inconsistent urine drug screens and without any documented benefit; and

D. Continuing to prescribe controlled substances to patient L.S. when she tested positive for illicit drugs and possibly diverted Methadone.

Patient Ch.S.

140. On or about September 14, 2005, patient Ch.S., a then 52-year old man, was referred by his primary care physician to respondent for chronic pain syndrome and abdominal pain. Patient Ch.S. had been stabbed in the abdomen in 2002 and had adhesions resulting from his surgery to repair the stab wound. From 2005 through 2012, patient Ch.S. continued to see respondent for pain management.

141. From on or about January 17, 2007, through December 19, 2007, patient Ch.S. saw respondent approximately thirteen times for pain management. At each visit, patient Ch.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient Ch.S. noted that his pain level was either at 3 or 4 level out of a 10 point scale and repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient Ch.S.' forms. During this time period, respondent documented in patient Ch.S.' chart an analgesia percentage range from 60% pain relief to 75% pain relief despite the fact that at each visit patient Ch.S. would indicate that there was no improvement of his pain level. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient Ch.S.

142. From on or about January 17, 2007, through December 19, 2007, respondent wrote patient Ch.S. 13 prescriptions for Duragesic[22] patches 100 mcg for a total of 195 patches, 11

[22] Duragesic patches contain a high concentration of fentanyl, which is delivered into the body slowly through the skin. Fentanyl is a Schedule II controlled substance under Health and Safety Code section 11055(c)(8) and a dangerous drug within the meaning of California Business and Professions Code section 4022. Schedule II opioid substances have the highest potential for (continued...)

Methadone HCL 10 mg for a total of 1680 tablets, 12 prescriptions for Norco 10/325 mg for a total of 2202 tablets, 1 prescription of OxyIR 15 mg for a total of 120 tablets, 1 prescription for MSIR 15 mg for a total of 120 tablets, and 1 prescription for hydrocodone 50 mg for a total of 240 tablets.

143. From on or about January 17, 2007, through December 19, 2007, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

144. From on or about January 17, 2007, through December 19, 2007, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

145. From on or about January 15, 2008, through December 15, 2008, patient Ch.S. saw respondent approximately twelve times for pain management. At each visit, patient Ch.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient Ch.S. noted that his pain level was either at 3 or 4 level out of a 10 point scale and repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient Ch.S.' forms. During this time period, respondent documented in patient Ch.S.' chart an analgesia percentage range from 50% pain relief to 65% pain relief despite the fact that at each visit patient Ch.S. would indicate that there was no improvement of his pain level.

(...continued)
abuse and associated risk of fatal overdose due to respiratory depression. The prescribing information for Duragesic contains a black box warning that indicates, "DURAGESIC should ONLY be used in patients who are already receiving opioid therapy, who have demonstrated opioid tolerance, and who require a total daily dose at least equivalent to DURAGESIC 25 mcg/h. Patients who are considered opioid-tolerant are those who have been taking, for a week or longer, at least 60 mg of morphine daily, or at least 30 mg of oral oxycodone daily, or at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid." It also states Duragesic is contraindicated in patients who are not opioid-tolerant, "because serious or life-threatening hypoventilation could occur."

The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient Ch.S.

146. From on or about January 15, 2008, through December 15, 2008, respondent wrote patient Ch.S. 13 prescriptions for Duragesic patches 100 mcg for a total of 195 patches, 13 Methadone HCL 10 mg for a total of 2700 tablets, 7 prescriptions for Norco 10/325 mg for a total of 1680 tablets, 1 prescription for Soma 350 mg for a total of 390 tablets, and 4 prescriptions of OxyIR 15 mg for a total of 480 tablets.

147. From on or about January 15, 2008, through December 15, 2008, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

148. From on or about January 15, 2008, through December 15, 2008, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities.

149. From on or about January 12, 2009, through December 14, 2009, patient Ch.S. saw respondent approximately twelve times for pain management. At each visit, patient Ch.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient Ch.S. noted that his pain level was either at 3 or 4 level out of a 10 point scale and repeatedly noted that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient Ch.S.' forms. During this time period, respondent documented in patient Ch.S.' chart an analgesia percentage range from 60% pain relief to 75% pain relief despite the fact that at each visit patient Ch.S. would indicate that there was no improvement of his pain level. The progress notes for each of these visits were difficult to read and had various items checked or

circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the controlled substances prescribed to patient Ch.S.

150. From on or about January 12, 2009, through December 14, 2009, respondent wrote patient Ch.S. 13 prescriptions for Duragesic patches 100 mcg for a total of 195 patches, 13 Methadone HCL 10 mg for a total of 3360 tablets, 5 prescriptions for Norco 10/325 mg for a total of 1200 tablets, and 5 prescriptions for Soma 350 mg for a total of 480 tablets.

151. From on or about January 12, 2009, through December 14, 2009, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of the patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

152. From on or about January 12, 2009, through December 14, 2009, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

153. From on or about January 4, 2010, through December 16, 2010, patient Ch.S. saw respondent thirteen times for pain management. At each of the thirteen visits, patient Ch.S. would fill out a form indicating his pain level out of a 10 point scale and whether there was improvement from the last visit. For each of the visits during this time period, patient Ch.S. noted that his pain level was either at 4 or 5 level out of a 10 point scale and that there had been no improvement since the last office visit. Respondent's progress notes for these visits were inconsistent with patient Ch.S.' forms. During this time period, respondent documented in patient Ch.S.' chart an analgesia percentage range from 50% pain relief to no greater than 80% pain relief despite the fact that at each visit patient Ch.S. would indicate there had been no improvement. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not

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contain the number of tablets and dosages for the controlled substances prescribed to patient Ch.S.

154. On or about June 2, 2010, respondent began maintaining electronic medical records for patient Ch.S. From on or about June 2, 2010, through December 16, 2010, respondent's electronic medical records for patient Ch.S. were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

155. From on or about January 4, 2010, through December 16, 2010, respondent wrote patient Ch.S. 12 prescriptions for Duragesic patches 100 mcg for a total of 180 patches, 11 Duragesic patches 25 mcg for a total of 165 patches, 12 Methadone HCL 10 mg for a total of 2830 tablets, 7 prescriptions for Vicodin 10/325 mg for a total of 4080 tablets, 6 prescriptions for hydromorphone HCL 4 mg for a total of 750 tablets, and 1 prescription for Kadian 30 mg for a total of 30 tablets. In addition, patient Ch.S. was receiving diazepam prescriptions from his primary care physician. Respondent did not document the diazepam prescriptions in patient Ch.S.' medical record.

156. From on or about January 4, 2010, through December 16, 2010, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

157. From on or about January 4, 2010, through December 16, 2010, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

158. From on or about January 13, 2011, through December 15, 2011, patient Ch.S. saw respondent approximately thirteen times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates,

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vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

159. From on or about January 13, 2011, through December 15, 2011, respondent wrote patient Ch.S. 1 prescription for lorazepam .5 mg for a total of 2 tablets, 3 prescriptions for MS Contin 100 mg for a total of 270 tablets, 2 prescriptions for MS Contin 30 mg for a total of 120 tablets, 4 prescriptions for MS Contin 60 mg for a total of 240 tablets, 1 prescription for Percocet 10/325 mg for a total of 90 tablets, 9 prescriptions for Vicodin 10/325 mg for a total of 1630 tablets, 9 prescriptions for Methadone 10 mg for a total of 2160 tablets, and 1 prescription for codiene/promethazine syrup 10 mg/5 ml-6.25 mg/5 ml for a total of 240 ml. In addition, patient Ch.S. was receiving diazepam prescriptions from his primary care physician. Respondent did not document the diazepam prescriptions in patient Ch.S.' medical record.

160. On or about July 16, 2011, patient Ch.S. was hospitalized after a drug overdose. Patient Ch.S. required intubation as a result of opiate induced respiratory depression. On or about July 17, 2011, respondent evaluated patient Ch.S. during his hospitalization and noted in the hospital consultation report that "in the last two months [patient Ch.S.] was admitted to the hospital 2 times with overdose. This is the second time." At the time of his admission, patient Ch.S. was on MS Contin 300 mg daily, Soma 350 three times daily, oxycodone 15 mg four times daily as well as Methadone 20 mg daily. Respondent planned on discontinuing patient Ch.S.' use of all opioids and starting him on Suboxone[23] therapy. Respondent did not document the two overdose incidents in patient Ch.S.' office medical chart. He did not document his rationale for starting and stopping medications in patient Ch.S. office medical chart. Respondent did not refer patient Ch.S. to an addiction specialist.

161. From on or about January 13, 2011, through December 15, 2011, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any

[23] Suboxone is a brand name for buprenorphine and naloxone and is used to treat opiate addiction. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

assessment of patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

162. From on or about January 13, 2011, through December 15, 2011, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

163. From on or about January 12, 2012, through October 18, 2012, patient Ch.S. saw respondent approximately eight times for pain management. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections. In each progress note, respondent noted that patient Ch.S. was sad and depressed. Respondent did not refer patient Ch.S. for treatment of his depression.

164. From on or about January 12, 2012, through October 18, 2012, respondent wrote patient Ch.S. 1 prescription for Lunesta 3 mg for a total of 30 tablets, 3 prescriptions for MS Contin 100 mg for a total of 270 tablets, 6 prescriptions for MS Contin 100 mg for a total of 360 tablets, 4 prescriptions for MS Contin 60 mg for a total of 240 tablets, 9 prescriptions for Soma 350 mg for a total of 1620 tablets, 6 prescriptions for oxycodone HCL 15 mg for a total of 1080 tablets, 5 prescriptions for Vicodin 10/325 mg for a total of 600 tablets, 8 prescriptions for Methadone 10 mg for a total of 1920 tablets, 3 prescriptions for Ambien 10 mg for a total of 90 tablets, 1 prescription for Nucynta 75 mg for a total of 120 tablets, 1 prescription for temazepam 30 mg for a total of 30 capsules, 1 prescription for Duragesic patches 50 mcg for a total of 10 patches, 1 prescription for hydromorphone HCL 4 mg for a total of 40 tablets, and 1 prescription for Lyrica 100 mg for a total of 30 tablets. In addition, patient Ch.S. was receiving diazepam prescriptions from his primary care physician. Respondent did not document the diazepam prescriptions in patient Ch.S.' medical record.

165. From on or about January 12, 2012, through October 18, 2012, respondent continued to prescribe patient Ch.S. high doses of opioids without any clear positive response, such as a decrease in pain level. The progress notes for these visits did not contain any assessment of

patient Ch.S.' pain level. Throughout the progress notes, the medications prescribed to patient Ch.S. were started and stopped and the dosages were routinely increased and decreased without any rationale or documentation.

166. From on or about January 12, 2012, through August 18, 2012, respondent did not review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

167. Respondent committed gross negligence in his care and treatment of patient Ch.S. which included, but was not limited to the following:

A. Paragraphs 140 to 166 above, are hereby incorporated by reference as if fully set forth herein;

B. Excessively prescribing extremely high doses of opioids that resulted in MEDD of 1600 mg during the course of treatment: and

C. Failure to maintain adequate and accurate records for patient Ch.S.

SECOND CAUSE OF ACTION

(Repeated Negligent Acts)

168. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 53526 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients F.S., L.A., T.S., L.S., Ch.S. and C.S., as more particularly alleged hereinafter:

Patient F.S.

169. Respondent has committed repeated negligent acts in his care and treatment of patient F.S., which included, but was not limited to, the following:

A. Paragraphs 9 to 37 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient F.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities;

C. Failing to refer patient F.S. for psychological treatment of his depression; and

D. Failing to maintain adequate and accurate medical records for patient F.S.

Patient L.A.

170. Respondent has committed repeated negligent acts in his care and treatment of patient L.A., which included, but was not limited to, the following:

A. Paragraphs 38 to 71 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient L.A., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities;

C. Failing to refer patient L.A. for psychological treatment or treat her depression;

D. From January 2012 through August 2012, overprescribing to patient L.A. an average of 6.5 Soma per day, 6 Norco per day, MS Contin 200 mg per day, and Methadone HCL 30 mg per day; and

E. Failing to maintain adequate and accurate medical records for patient L.A.

Patient T.S.

171. Respondent has committed repeated negligent acts in his care and treatment of patient T.S., which included, but was not limited to, the following:

A. Paragraphs 72 to 108 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient T.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities;

C. Failing to consider the possibility of drug diversion and continuing to prescribe Methadone HCL to patient T.S. despite multiple urine drug screens where Methadone HCL was not detected; and

D. Failing to maintain adequate and accurate medical records for patient T.S.

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Patient L.S.

172. Respondent has committed repeated negligent acts in his care and treatment of patient L.S., which included, but was not limited to, the following:

A. Paragraphs 109 to 139 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient L.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities;

C. Failing to maintain adequate and accurate medical records for patient L.S.;

D. Failing to refer patient L.S. for psychological treatment of her depression; and

E. Failing to refer patient L.S. for orthopedic care.

Patient Ch.S.

173. Respondent has committed repeated negligent acts in his care and treatment of patient Ch.S., which included, but was not limited to, the following:

A. Paragraphs 140 to 167 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient Ch.S., assess the appropriateness of continued use of the current treatment plan, and consider the use of other therapeutic modalities;

C. Failing to refer patient Ch.S. for psychological treatment; and

D. Failing to refer patient Ch.S. to an addiction specialist.

Patient C.S.

174. On or about August 20, 2007, patient C.S. was referred by her primary care physician to respondent for pain management for complaints of neck and mid upper back pain. Respondent diagnosed patient C.S. with cervical disc disease and cervical radiculopathy. At the time patient

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C.S. was referred to respondent, patient C.S. was being prescribed Naproxen,[24] Flexeril,[25] Ultram, and Motrin for her chronic pain.

175. From on or about August 20, 2007 until January 6, 2009, patient C.S. continued to see respondent for pain management. The progress notes for each of these visits were difficult to read and had various items checked or circled without any narrative explanation. The progress notes for each of these visits did not contain the number of tablets and dosages for the medications prescribed to patient C.S.

176. From on or about August 20, 2007 until January 6, 2009, respondent did not review the course of pain treatment of patient C.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

177. On or about July 24, 2010, patient C.S. was referred again to respondent for pain management for complaints of neck pain, left and right upper extremity pain, left and right shoulder pain, left elbow pain, and wrist pain. Respondent recommended that patient C.S. receive cervical epidural steroid injections to reduce her neck pain.

178. On or about September 7, 2010, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 8 out of a 10 point scale. Respondent prescribed to patient C.S. Soma 350 mg and Ultram 50 mg for her pain management.

179. On or about September 21, 2010, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 8 out of a 10 point scale. Respondent prescribed to patient C.S. Soma 350 mg and Ultram 50 mg for her pain management.

180. On or about October 12, 2010, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 8 out of a 10 point scale. On or about October 21, 2010, patient C.S. saw respondent for pain management. Respondent prescribed to patient C.S. Soma 350 mg and Ultram 50 mg. The progress note was essentially an exact copy of

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[24] Naproxen is a nonsteroidal anti-inflammatory drug (NSAID).

[25] Flexeril (cyclobenzaprine) is a muscle relaxant.

the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

181. From on or about March 7, 2011, through December 6, 2011, patient C.S. saw respondent approximately ten times for pain management office visits. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

182. On or about March 7, 2011, patient C.S. saw respondent for pain management. Respondent discontinued the Ultram 50 mg because patient C.S. "had head injury." Patient C.S. had been admitted to the hospital on or about February 28, 2011 for a head injury and a concussion. Respondent had seen patient C.S. in the hospital and noted in the hospital consultation note that patient C.S. had a history of depression and drug abuse with amphetamines. He also noted that patient C.S. was very disturbed, needed a psychiatric evaluation, and was addicted to diazepam. Respondent did not document these issues in patient C.S.' office progress notes.

183. On or about April 5, 2011, patient C.S. saw respondent for pain management. Respondent prescribed patient C.S. MS Contin 30 mg and Norco 10/325 mg without documenting a rationale for prescribing these controlled substances.

184. On or about April 5, 2011, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 9 out of a 10 point scale. On her next office visit on or about May 25, 2011, patient C.S.' pain level remained 9 out of a 10 point scale.

185. On or about May 25, 2011, patient C.S. saw respondent for pain management. Respondent prescribed patient C.S. Methadone HCL 10 mg without documenting a rationale for prescribing this controlled substance.

186. On or about July 11, 2011, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 8 out of a 10 point scale. On her next office visit on or about July 20, 2011, patient C.S.' pain level remained 8 out of a 10 point scale.

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187. On or about August 3, 2011, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 6 out of a 10 point scale. On her next office visit on or about August 17, 2011, patient C.S.' pain level remained 9 out of a 10 point scale.

188. On or about August 17, 2011; September 14, 2011; October 12, 2011; November 9, 2011; and December 6, 2011, patient C.S. saw respondent for pain management. At each of these office visits, it was noted that "pt does not take ms contin." On or about August 17, 2011; September 14, 2011; October 12, 2011; November 9, 2011; and December 6, 2011, respondent continued to prescribe patient C.S. MS Contin 80 mg.

189. On or about August 24, 2011, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 8 out of a 10 point scale. On her next office visit on or about September 26, 2011, patient C.S.' pain level remained 9 out of a 10 point scale. Respondent did not document the medical necessity for the continued epidural steroid injections or patient C.S.' response to the treatments.

190. From on or about March 7, 2011, through December 6, 2011, respondent did not review the course of pain treatment of patient C.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

191. From on or about January 4, 2012, through October 11, 2012, patient C.S. saw respondent approximately ten times for pain management office visits. The progress notes for these office visits were essentially an exact copy of the previous record with minor changes in the dates, vital signs, and pain scores. There were inconsistencies between what was noted in the HPI and what was noted in the vital signs sections.

192. On or about January 4, 2012; February 1, 2012; and March 2, 2012, patient C.S. saw respondent for pain management. At each of these office visits, it was noted that "pt does not take ms contin." On or about January 4, 2012; February 1, 2012; and March 2, 2012, respondent continued to prescribe patient C.S. MS Contin 80 mg.

193. On or about January 17, 2012, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 6 out of a 10 point scale. On or about

January 24, 2012, patient C.S. received a cervical epidural steroid injection. Patient C.S. indicated that her pain level was 7 out of a 10 point scale. On her next office visit on or about February 1, 2012, patient C.S.' pain level remained 8 out of a 10 point scale. Respondent did not document the medical necessity for the continued epidural steroid injections or patient C.S.' response to the treatments.

194. On or about July 19, 2012, patient C.S. saw respondent for pain management and indicated that her pain level was 3 out of a 10 point scale. Respondent noted that patient C.S. stated the "medications are effective." Respondent recommended that patient C.S. receive a cervical epidural steroid injection to reduce her neck pain. Respondent did not document the medical necessity for the epidural steroid injection.

195. On or about August 7, 2012, patient C.S. received a cervical epidural steroid injection. Respondent did not document patient C.S.' pain level. On her next office visit on or about August 16, 2012, patient C.S.' pain level was 8 out of a 10 point scale. Respondent did not document the medical necessity for the continued epidural steroid injections or patient C.S.' response to the treatments.

196. On or about August 21, 2012, patient C.S. received a cervical epidural steroid injection. Respondent did not document patient C.S.' pain level. On or about August 28, 2012, patient C.S. received a cervical epidural steroid injection. Respondent did not document patient C.S.' pain level. On her next office visit on or about October 11, 2012, patient C.S.' pain level remained 8 out of a 10 point scale. Respondent did not document the medical necessity for the continued epidural steroid injections or patient C.S.' response to the treatments.

197. From on or about January 4, 2012, through October 11, 2012, respondent did not review the course of pain treatment of patient C.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities.

198. Respondent has committed repeated negligent acts in his care and treatment of patient C.S., which included, but was not limited to, the following:

A. Paragraphs 174 to 197 above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Failing to periodically review the course of pain treatment of patient C.S., assess the appropriateness of continued use of the current treatment plan, or consider the use of other therapeutic modalities; and

C. Failing to maintain adequate and accurate medical records for patient C.S.

THIRD CAUSE FOR DISCIPLINE

(Excessive Prescribing)

199. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 53526 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that, respondent prescribed excessive amounts of controlled substances for patients F.S., T.S., and Ch.S. as more particularly alleged in paragraph 9 through 37, 72 through 108, and 140 through 167, above, which are incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

200. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 53526 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records in his care and treatment of patients F.S., L.A., T.S., L.S., Ch.S., and C.S., as more particularly alleged in paragraphs 9 through 198, above, which are incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 53526, issued to respondent Naga Raja Thota, M.D.;

2. Revoking, suspending or denying approval of respondent Naga Raja Thota, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Naga Raja Thota, M.D., to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and

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

DATED: September 4, 2014

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

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