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9 **BEFORE THE**
10 **MEDICAL BOARD OF CALIFORNIA**
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

12 **In the Matter of the Accusation Against:**

Case No. 800-2014-004873

13 **GREGORY SEAN PANICCIA, M.D.**
14 **1908 Sweetwater Road**
National City, CA 91950-7628

A C C U S A T I O N

15 **Physician's and Surgeon's Certificate**
16 **No. G76979,**

17 **Respondent.**

18
19 Complainant alleges:

20 **PARTIES**

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

24 2. On or about June 28, 1993, the Board issued Physician's and Surgeon's Certificate
25 No. G76979 to Gregory Sean Paniccia, M.D. (respondent). The Physician's and Surgeon's
26 Certificate was in full force and effect at all times relevant to the charges and allegations brought
27 herein and will expire on September 30, 2018, unless renewed.

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JURISDICTION

1
2 3. This Accusation is brought before the Board, under the authority of the following
3 laws. All section references are to the Business and Professions Code (Code) unless otherwise
4 indicated.

5 4. Section 2227 of the Code states:

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

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

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

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

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

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

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

27 ////

28 ////

1 5. Section 2234 of the Code, states:

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

5 “... .

6 “(b) Gross negligence.

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

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

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

17 “... .”

18 6. Section 2241 of the Code states:

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

23 “(b) A physician and surgeon may prescribe, dispense, or administer
24 prescription drugs or prescription controlled substances to an addict for purposes
25 of maintenance on, or detoxification from, prescription drugs or controlled
26 substances only as set forth in subdivision (c) or in Sections 11215, 11217,
27 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this
28 subdivision shall authorize a physician and surgeon to prescribe, dispense, or

1 administer dangerous drugs or controlled substances to a person he or she knows
2 or reasonably believes is using or will use the drugs or substances for a nonmedical
3 purpose.

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

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

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

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

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

18 “(A) Impaired control over drug use.

19 “(B) Compulsive use.

20 “(C) Continued use despite harm.

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

24 7. Section 2242 of the Code states:

25 “(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section
26 4022 without an appropriate prior examination and a medical indication, constitutes
27 unprofessional conduct.
28

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

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

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

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

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

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

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

22 8. Section 2266 of the Code states:

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

25 9. Section 725 of the Code states:

26 “(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or
27 administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic
28 procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as

1 determined by the standard of the community of licensees is unprofessional conduct for a
2 physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor,
3 optometrist, speech-language pathologist, or audiologist.

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

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

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

14 **FIRST CAUSE FOR DISCIPLINE**

15 **(Gross Negligence)**

16 10. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
17 by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care
18 and treatment of patients R.M, K.L.C., R.MA., R.R., and R.P., as more particularly alleged
19 hereinafter:

20 **Patient R.M.**

21 11. On or about January 29, 2013, respondent had his first visit with patient R.M., a then-
22 29 year old female referred to respondent after the patient’s previous psychiatrist retired. There is
23 no indication that respondent attempted to obtain medical records from prior treating physicians
24 and/or mental health professionals. Patient R.M. was previously diagnosed with bipolar disorder
25 and had a psychiatric history which included, but was not limited to, two prior inpatient
26 hospitalizations when she was 19 and 24 years old following suicide attempts. Patient R.M.’s
27 substance abuse history included abusing and/or being dependent on alcohol, methamphetamine
28 and heroin. Patient R.M. reported she was not currently using drugs or alcohol. There was no

1 documented inquiry as to the time frames and/or amounts for the patient's alcohol and drug abuse
2 set forth in her history; or whether there were any relapses, past treatment for the alcohol and
3 substance abuse and/or whether she was currently seeing any other treating physicians. Patient
4 R.M.'s social history included arrests for domestic violence, prostitution, and petty theft; and she
5 reported being paranoid about a man who had attacked her and further reported having suffered
6 head trauma from "fights." Respondent's assessment was Bipolar Disorder Type I, Post
7 Traumatic Stress Disorder (PTSD), Seasonal Affective Disorder and Social Phobia. The
8 treatment plan included increasing Neurontin (gabapentin) to 600 mg b.i.d. (twice a day); resume
9 Xanax (alprazolam)¹ 2 mg q.i.d. (four times a day); and return to clinic in 4 to 6 weeks. Neither
10 gabapentin nor alprazolam are standard treatments for Bipolar Disorder.

11 12. On or about March 5, 2013, patient R.M. had a follow up visit with respondent who
12 raised concerns about upcoming surgery to her arm and a seizure that she attributed to Lamictal.
13 According to the progress note for this visit, patient R.M. was requesting Soma (carisoprodol) or
14 Valium (diazepam)² for muscle spasms. Respondent further documented that patient R.M.'s
15 "mood was improving, but has swings," pain affected her sleep, her appetite had decreased with
16 the patient losing ten pounds; and she was feeling guilt, worthlessness and hopelessness over her
17 illness. The patient's current medications were listed as Neurontin (gabapentin) 600 mg b.i.d.,
18 Xanax (alprazolam) 2 mg q.i.d. and Lamictal 25 mg b.i.d. (with a notation of first pill today).

19 _____
20 ¹ Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a
21 Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision
22 (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When
23 properly prescribed and indicated, it is used for the management of anxiety disorders.
24 Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory
25 depression, coma, and death." The Drug Enforcement Administration (DEA) has identified
26 benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide
27 (2011 Edition), at p. 53.)

24 ² Valium® (diazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a
25 Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision
26 (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When
27 properly prescribed and indicated, it is used for the management of anxiety disorders or for the
28 short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound
sedation, respiratory depression, coma, and death." The Drug Enforcement Administration
(DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse,
DEA Resource Guide (2011 Edition), at p. 53.)

1 Respondent made no inquiry or mention that between the last visit and this visit patient R.M. had
2 received a total of 260 tablets of oxycodone/APAP 10/325 mg. Respondent's assessment was
3 Bipolar Disorder Type I, Seizure Disorder and Muscle Spasms; and his treatment plan was to add
4 Baclofen (muscle relaxant generally used to treat muscle spasms or spasticity) 10 mg b.i.d. to be
5 increased after seven days to 20 mg b.i.d., continue present medications and return to clinic in 4
6 to 6 weeks.

7 13. On or about April 25, 2013, patient R.M. had a follow up visit with respondent in
8 which she reported, among other things, that she recently had the flu, she was taking her
9 medications, that she wanted Ativan³ over the Xanax due to seizures, she was still taking the
10 Lamictal, she was sleeping on and off, her appetite was "ok," her mood was improving, she was
11 "becoming interested," there was no reported psychosis or suicidal ideation and she was
12 scheduled to see a neurologist on May 1, 2013, for her seizures. The patient's current
13 medications were listed as Neurontin 600 mg b.i.d., Xanax 2 mg q.i.d. and Lamictal 25 mg b.i.d.
14 Respondent made no inquiry or mention that between the last visit and this visit, that patient R.M.
15 had received a total of 290 tablets of oxyocodone/APAP 10/325 mg. Respondent's assessment
16 was Bipolar Disorder Type I, Seizure Disorder and Muscle Spasms; and his treatment plan was to
17 increase the Lamictal to 50 mg b.i.d. and the Neurontin to 600 mg t.i.d. (three times a day);
18 discontinue Xanax and replace with Ativan 2 mg q.i.d. and return to clinic in 4 to 6 weeks.

19 14. According to patient M.R.'s Controlled Substances Utilization and Evaluation System
20 (CURES) report, she filled prescriptions for Suboxone⁴ (#6) on May 1, 2013; and Suboxone (#90)

21 ³ Ativan® (lorazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a
22 Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision
23 (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When
24 properly prescribed and indicated, it is used for the management of anxiety disorders or for the
25 short term relief of anxiety or anxiety associated with depressive symptoms. Concomitant use of
26 Ativan® with opioids "may result in profound sedation, respiratory depression, coma, and death."
27 The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Ativan®,
28 as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

⁴ Suboxone® (buprenorphine and naloxone) is a Schedule III controlled substance
pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug
pursuant to Business and Professions Code section 4022. When properly prescribed and
indicated, it is used for the treatment of opioid dependence and should be used as part of a
complete treatment program to include counseling and psychosocial support.

1 on May 29, 2013, that were prescribed by another health care provider.

2 15. On or about May 30, 2013, patient R.M. had a follow up visit with respondent in
3 which he documented, among other things, that the Ativan helped patient R.M.'s seizures but not
4 her anxiety, she had pain in her back, arms and legs; less muscle spasms on the Baclofen; that she
5 was forgetful, felt like she couldn't work, had "bad visions in her head," and that her neurologist,
6 whose name was not documented in the progress note, wanted her on Lamictal at 20 mg and
7 Depakote, her neurologist had raised the Neurontin to 1200 mg b.i.d.; she "wants to die when she
8 has bad visions;" she sits in her room and locks the door because she feels people are out to get
9 her; and she had insomnia. The current medications were listed as Neurontin 600 mg b.i.d.
10 (increased to 1200 mg b.i.d.), Ativan 2 mg q.i.d. and Lamictal 50 mg b.i.d. There was no mention
11 or inquiry about patient R.M. recently starting on Suboxone, as indicated on her CURES report.
12 Respondent's assessment was Bipolar Disorder Type I; and his treatment plan was Neurontin and
13 Lamictal per directions of neurologist; discontinue Ativan due to lack of response; resume Xanax
14 2 mg q.i.d.; add Ambien⁵ 5-10 mg at bedtime (HS) as needed (PRN) for sleep; and return to clinic
15 in 4 to 6 weeks.

16 16. On or about July 16, 2013, patient R.M. had a follow up visit with respondent in
17 which he documented, among other things, that the patient had an argument with another person
18 in the waiting room, she was going to enter a dual diagnosis program, she had pain in her arms
19 and muscle spasms, and that she was now on Tegretol, a medication to treat seizures. There was
20 no inquiry about any comorbid substance abuse disorder that would require a dual diagnosis
21 program. The assessment was Bipolar Disorder Type I and seizure disorder with a documented
22 upcoming appointment with a neurologist and the treatment plan was "MSA's as per Neurology,"
23 continue Xanax, increase Baclofen 20 mg, "will sign ROI for Dr. [G]" and return to clinic in 4 to
24 6 weeks.

25 _____
26 ⁵ Ambien® (zolpidem tartrate), a centrally acting hypnotic-sedative, is a Schedule IV
27 controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a
28 dangerous drug pursuant to Business and Professions Code section 4022. When properly
prescribed and indicated, it is used for the short-term treatment of insomnia characterized by
difficulties with sleep initiation.

1 17. On or about August 6, 2013, patient R.M. had a follow up visit with respondent in
2 which he documented, among other things, that she “was inpatient for 4 days” and her Baclofen
3 was decreased to 10 mg t.i.d. The patient reported “her body went into shock from taking an
4 extra dose of Baclofen” and her pill bottles were taken at the hospital and not returned. The
5 assessment was Bipolar Disorder Type I and seizure disorder with a note of “sees Neurologist
6 today” and the treatment plan was refill the patient’s Xanax and Ambien, discontinue Ativan, and
7 return to clinic in 4 to 6 weeks.

8 18. On or about September 10, 2013, patient R.M. had a follow up visit with respondent
9 in which he documented, among other things, that the patient reported having a stressful month,
10 that she “ran out of Xanax today – script due 9/13/13,” she had mood swings, had been
11 impulsively calling other people, was on Lamictal 50 mg b.i.d. for less than one week, had been
12 in inpatient care where they did not want her on Xanax and Ambien, and that sometimes she took
13 more Ambien than prescribed. CURES indicates that respondent prescribed hydrocodone/APAP
14 5/500 mg (#15) which was not documented (that was filled on September 18, 2013). The
15 assessment was Bipolar Disorder Type I, rule out panic attacks; seizure disorder with a note that
16 she was seeing Dr. [G] tomorrow; and migraine headaches. Respondent’s treatment plan
17 included, but was not limited to, continuing present medications (Xanax, Baclofen, Ambien,
18 Ativan, Tegretol, Lamictol and Neurontin), add Saphris (asenapine) 5 mg b.i.d., consider
19 Seroquel and return to clinic in 4 to 6 weeks.

20 19. On or about October 22, 2013, patient R.M. had a follow up visit with respondent in
21 which he documented, among other things, that the patient had a recent second surgery on her
22 elbow, that she saw a pain specialist and got morphine and oxycodone, she had a panic attack the
23 day before, the narcotics made her tired in the day, and she had trouble sleeping at night. The
24 assessment was Bipolar Disorder Type I, panic attacks, seizure disorder and migraine headaches.
25 Respondent’s treatment plan was to continue present medications, start Saphris 5 mg b.i.d., labs,
26 and return to clinic in 4 to 6 weeks.

27 20. On or about January 7, 2014, patient R.M. had a follow up visit with respondent for
28 her bipolar disorder with no narrative history documented. As of this date, respondent had

1 switched from handwritten progress notes to electronic medical records. Her current medications
2 were listed as Ambien 10 mg p.r.n. sleep, Baclofen 10 mg t.i.d., Lamictal 100 mg q.a.m. (every
3 morning), Neurontin 600 mg t.i.d., Tegretol 200 mg b.i.d., and Xanax 2 mg q.i.d. The treatment
4 plan was listed as “Patient will call or come in if symptoms increase” and a box was checked for
5 “continue with current treatment.”

6 21. On or about February 18, 2014, patient R.M. had a follow up visit with respondent for
7 her bipolar disorder with no narrative history documented. The patient was listed as not being
8 stable on her present medications, she was depressed, noted as having “delusions” and her
9 prognosis was listed as fair. Respondent added a prescription for Latuda (generally indicated for
10 the treatment of patients with schizophrenia) 40 mg per day. Respondent’s assessment was
11 documented as Bipolar Disorder. Respondent’s treatment plan was to add Latuda, get labs, and
12 continue with current treatment.

13 22. On or about April 1, 2014, patient R.M. had a follow up visit with respondent with no
14 narrative history documented. The patient was documented as, among other things, being stable
15 on her medications, improved but still depressed, still having delusions, no suicidal or homicidal
16 ideation, and having a delusional and paranoid thought process. Respondent increased the
17 patient’s Latuda prescriptions from 40 mg per day to 80 mg per day. There was no assessment
18 indicated in the record for this visit.

19 23. On or about May 6, 2014, patient R.M. had a follow up visit with respondent with no
20 narrative history documented. The patient was documented as, among other things, being stable
21 on her medications, behavior and mood was within normal ranges, no longer having delusions, no
22 suicidal or homicidal ideation, with a fair prognosis. Respondent continued Xanax 2 mg q.i.d.
23 (#120); Latuda 80 mg per day (#30) and his plan was to continue with current treatment.

24 24. On or about July 8, 2014, patient R.M. had a follow up visit with respondent which is
25 documented as a “Medication check-up for Bipolar Depression.” The medical record for this
26 visit, which is in a different format, is cursory, missing a narrative history and missing
27 information in the “Family History” and “Introspective Awareness” sections of the medical
28 record. Respondent’s assessment was Bipolar Mood Disorder, Type 1, Depressed Type with

1 Psychotic Features. Respondent's documented treatment plan was to continue Xanax 2 mg q.i.d.
2 and increase the Latuda to 160 mg every p.m. with dinner.

3 25. On or about August 5, 2014, patient R.M. had a follow up visit with respondent in
4 which he documented that the "Patient presents for follow-up for Bipolar Disorder, Type 1,
5 Depressed Type with Psychotic Features." There is no narrative history provided and the "Family
6 History" section is blank. The current medications were listed as zolpidem tartrate (Ambien) 10
7 mg, Latuda 80 mg when, in fact, the Latuda had been increased to 160 mg at the last visit, and
8 Xanax 2 mg. The Axis 1 assessment was documented as Bipolar Disorder, Type 1, Depressed
9 Type with Psychotic Features. Respondent's treatment plan was to "stabilize mood" and address
10 the problem behavior which was listed as "Depression/Insomnia/Anxiety." Respondent's
11 treatment plan included increasing the prescription of Xanax 2 mg from four times a day to five
12 times a day; continue Latuda 160 mg every p.m. with dinner; and resume Baclofen 10 mg b.i.d. to
13 t.i.d.; resume Ambien 10 mg p.r.n. sleep and return to clinic in 4 to 6 weeks.

14 26. On or about September 16, 2014, patient R.M. had a follow up visit with respondent.
15 The current medications were documented as zolpidem tartrate (Ambien) 10 mg, Latuda 80 mg
16 when, in fact, the Latuda was continued at 160 mg, and Xanax 2 mg. There was no family history
17 listed, no narrative history, and the Axis I and III diagnoses were inconsistently listed on the
18 medical record documentation for this visit. The "Psychopharmacology" was listed as Xanax 2
19 mg five times a day, continue Latuda 160 mg every p.m. with dinner; discontinue Lamictal due to
20 seizures, continue Baclofen 10 mg b.i.d. to t.i.d.; increase Ambien to 20 mg every evening p.r.n.
21 sleep, and refill Keppra 500 mg b.i.d. The treatment plan included referral to neurologist, follow
22 up labs and return to clinic in 4 to 6 weeks.

23 27. On or about December 2, 2014, patient R.M. had a follow up visit with respondent for
24 her bipolar disorder. The current medications were documented as zolpidem tartrate (Ambien) 10
25 mg, Latuda 80 mg when, in fact, the Latuda was continued at 160 mg, and Xanax 2 mg. There
26 was no narrative history and the Axis I and III diagnoses were inconsistently listed on the medical
27 record documentation for this visit. The treatment plan for this visit was the same as for the prior
28 visit.

1 28. A review of patient R.M.'s CURES report for the period of November 1, 2011, to
2 November 12, 2014, contains indications of patient R.M.'s misuse, abuse and/or diversion of
3 controlled substances including, but not limited to, patient R.M. filling multiple prescriptions for
4 opioids⁶ being prescribed by other physicians and being filled at different pharmacies in 2013 and
5 2014 and patient R.M. filling multiple prescriptions for Suboxone (buprenorphine and naloxone)
6 in 2013 and 2014 that was being prescribed by another physician. During his interview before a
7 Department of Consumer Affairs, Health Quality Unit (HQIU) Investigator and Medical
8 Consultant, respondent admitted that he was not reviewing CURES while he was prescribing
9 controlled substances to patient R.M. and, thus, was not aware of the prescribing pattern set forth
10 in the CURES report.

11 29. Respondent committed gross negligence in his care and treatment of patient R.M.
12 including, but not limited to, the following:

- 13 (a) Respondent repeatedly prescribed excessive amounts of controlled
14 substances, including hypnotic-sedative medications and/or
15 benzodiazepines, to a known substance abuser, without any objective
16 and justifiable basis for prescribing such amounts of controlled
17 substances;
- 18 (b) Respondent failed to provide any legitimate treatment for patient
19 R.M.'s substance abuse and increased the risk of harm to her by
20 continuing to prescribe her excessive and unjustified amounts of
21 controlled substances;
- 22 (c) Respondent repeatedly prescribed benzodiazepines to patient R.M.
23 while she was pregnant without any informed consent regarding the
24 dangers associated with benzodiazepines or without reducing the
25

26 ⁶ As an example, during the period of January 29, 2013, to March 13, 2013 (43 days),
27 patient R.M. obtained 550 tabs of oxycodone/APAP 10/325 mg from four different physicians.
28 Shortly after this run, she began taking Suboxone® which is clinically indicated for the treatment
of opioid dependence.

1 dosage of benzodiazepines to the minimal amount necessary to avoid
2 incapacitating symptoms;

3 (d) Respondent repeatedly prescribed controlled substances to patient R.M.
4 despite objective indications of abuse, misuse and/or diversion of
5 controlled substances; and

6 (e) Respondent repeatedly prescribed controlled substances to patient R.M.
7 without reviewing CURES, without utilizing urine drug screens,
8 without consulting with and/or obtaining records from prior treating
9 physicians and/or without utilizing other risk screening tools.

10 **Patient K.L.C**

11 30. On or about May 12, 2009,⁷ patient K.L.C. had her initial visit with respondent in
12 which he documented that the patient was self-referred for major depression. She was
13 documented as being negative for suicidal ideation, homicidal ideation, mania and psychosis.
14 The patient's substances abuse history was listed as negative and the patient was positive for a
15 family history of psychiatric disorders. Current medications were listed as Soma (carisoprodol)⁸
16 one tablet q.i.d., Klonopin 2 mg t.i.d., Darvocet one tablet q.i.d. and Trazadone 100 q.h.s.
17 Respondent's Axis I diagnoses was Major Depressive Disorder (296.32) and his treatment plan
18 was to continue the Klonopin⁹ 2 mg, increase Trazadone 200 to 300 mg q.h.s. as needed for sleep,
19 add Pristiq 50 mg q.a.m. (morning) and return to clinic in one month.

20 ⁷ Conduct occurring more than seven (7) years from the filing date of this Accusation is
21 for informational purposes only and is not alleged as a basis for disciplinary action.

22 ⁸ Soma® (carisoprodol) is a Schedule IV controlled substance pursuant to Health and
23 Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
24 Professions Code section 4022. When properly prescribed and indicated, it is used for the
25 treatment of acute and painful musculoskeletal conditions.

26 ⁹ Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that
27 is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
28 subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.
When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.
Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory
depression, coma, and death." The Drug Enforcement Administration (DEA) has identified
benzodiazepines, such as Klonopin®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide
(2011 Edition), at p. 53.)

1 31. For the period of on or about May 13, 2009, through on or about April 20, 2010,
2 respondent continued to see patient K.L.C. on a near monthly basis for follow up on her Axis 1
3 diagnosis of Major Depressive Disorder (296.32) and for medication management of her
4 symptoms. During this time, patient K.L.C. reported continued marital strife with her husband,
5 that she had “served husband papers” on or around January 5, 2010, that her husband, who
6 initially had a brief period of sobriety, was “still drinking,” and on April 20, 2010, that
7 “[d]ivorced (sic) now finalized” and “[l]iving in mobile [home] now with ex-husband [with] less
8 conflict.”

9 32. On or about May 21, 2010, patient K.L.C. had a follow up visit with respondent who
10 documented, among other things, that the patient was feeling distressed about her brother being
11 arrested again for driving under the influence and her labs had been completed. Respondent’s
12 assessment was Major Depressive Disorder (296.32) with residual symptoms and Insomnia
13 (327.02) with some symptoms. Current medications were listed as Sercone 300 mg b.i.d., Soma
14 350 mg q.i.d., Valium 10 mg q.i.d., Restoril¹⁰ 30 mg q.h.s. p.r.n. sleep, and Abilify 10 mg h.s.
15 The treatment plan was to increase Abilify to 15 mg q.h.s. and return to clinic in 5 weeks.

16 33. On or about August 31, 2010, patient K.L.C. had a follow up visit with respondent
17 who documented, among other things, that the patient “appears emaciated” and “weight today =
18 86 lbs.” The patient reported problems with sleeping, no appetite, that she was very sad, and she
19 had guilt over giving her husband a second chance. Respondent’s assessment was Major
20 Depressive Disorder (296.32) with increased depression, Insomnia (327.02) symptoms still
21 present and migraine headaches with the patient asking for Depakote. Respondent’s treatment
22 plan was to continue with current medications (Serzone, Soma, Valium and Restoril),
23 discontinue Abilify due to complaints of akathisia (restlessness) and add Depakote (VPA) at 250

24 ¹⁰ Restoril® (temazepine), a benzodiazepine, is a centrally acting hypnotic-sedative that
25 is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057,
26 subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.
27 When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders.
28 Concomitant use of Restoril® with opioids “may result in profound sedation, respiratory
depression, coma, and death.” The Drug Enforcement Administration (DEA) has identified
benzodiazepines, such as Restoril®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide
(2011 Edition), at p. 53.)

1 mg b.i.d., and then increasing to 500 mg b.i.d., after 10 days.

2 34. On or about October 5, 2010, patient K.L.C. had a follow up visit with respondent
3 who documented, among other things, that the patient appeared better, she was tearful when
4 discussing her current life situation, she had stopped Serozone upon starting the Depakote (VPA),
5 and her weight had increased to 92.8 pounds. Respondent's assessment was Major Depressive
6 Disorder (296.32) improved, Insomnia (327.02), with migraine headaches noted as still present.
7 Respondent's treatment plan was to continue with current medications (Depakote (VPA),
8 Serzone, Soma, Valium and Restoril) with Darvocet p.r.n. pain., follow up on VPA level and
9 return to clinic in two months.

10 35. On or about November 30, 2010, patient K.L.C. had a follow up visit with respondent
11 who documented, among other things, that the patient was having migraines and depression, not
12 eating well, having trouble sleeping, was tired, and having feelings of worthlessness. The patient
13 denied suicidal and homicidal ideation. Labs were reviewed, including the VPA level. The
14 current medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg
15 q.i.d., Restoril 30 mg q.h.s. and Darvocet p.r.n. pain. The assessment was Major Depressive
16 Disorder (296.32) with an increase in depressive symptoms, Insomnia (327.02) and migraine
17 headaches. Respondent's treatment plan was to continue with current medications and to increase
18 the Depakote to 1000 mg b.i.d. and recheck VPA level in two weeks; Midrin was also added for
19 the patient's migraine headaches; and return to the clinic in four to six weeks.

20 36. On or about January 5, 2011, patient K.L.C. had a follow up visit with respondent
21 who documented, among other things, that the patient was "very anxious [and] tremulous today,
22 she had seen another doctor recently for a social security re-evaluation who indicated patient
23 K.L.C. had post-traumatic stress disorder. The patient indicated she was sad, had crying spells,
24 no joy, she was angry, irritable, very overwhelmed, and was having nightmares. The current
25 medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d.,
26 Restoril 30 mg q.h.s., Darvocet p.r.n. pain, and Trazadone 150 mg q.h.s. (which was not listed in
27 the last progress note). The assessment was Major Depressive Disorder (296.32) with an increase
28 in symptoms, Insomnia (327.02) with a note of "slept on Restoril/Trazadone," tremor in hands,

1 and migraine headaches. Respondent's treatment plan was to continue with current medications,
2 check VPA level, add Inderol 10 mg q.a.m. for the tremors, and "rechallenge" Paxil 10 mg q.a.m.
3 for seven days and then increase to 20 mg., and return to clinic in one month.

4 37. On or about February 1, 2011, patient K.L.C. had a follow up visit with respondent
5 who documented, among other things, that the patient was upset because her social security
6 request was denied after she was deemed to no longer be physically disabled, less tremors on
7 Inderal, and with the patient reporting the Paxil was working well at 20 mg. The current
8 medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d.,
9 Restoril 30 mg q.h.s., Darvocet p.r.n. pain, Trazadone 50 mg q.h.s. (listed as 150 mg in the prior
10 progress note), Inderal 10 mg q.a.m., and Paxil 20 mg q.a.m. The assessment was Major
11 Depressive Disorder (296.32), Insomnia (327.02), tremor in hands less with the Inderal, and
12 migraine headaches. Respondent's treatment plan was to continue with current medications,
13 increase Inderal to 80 mg, return to clinic in four to six weeks, and referral to an attorney for
14 social security appeal.

15 38. On or about March 22, 2011, patient K.L.C. had a follow up visit with respondent
16 who documented, among other things, that the patient complained of having no money and no
17 place to live, being "very angry," upset with her ex-husband, she had decreased Depakote (VPA)
18 "due to sedation," and she didn't like the Paxil because "it doesn't help me." The current
19 medications were listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d.,
20 Restoril 30 mg q.h.s., Darvocet p.r.n. pain, Trazadone 150-300 mg q.h.s., Inderal 80 mg q.a.m.,
21 Paxil 20-40 mg q.a.m. The assessment was Major Depressive Disorder (296.32) increase in
22 symptoms, Insomnia (327.02) "broken sleep," tremor improved, and migraine headaches.
23 Respondent's treatment plan was to continue with current medications, add Zoloft 50 mg q.a.m.,
24 discontinue Paxil, and return to clinic in four to six weeks.

25 39. On or about April 21, 2011, patient K.L.C. had a follow up visit with respondent who
26 documented, among other things, the patient's displeasure with her ex-husband's daughter taking
27 over her house and the patient having "no response to Zoloft." The current medications were
28 listed as Depakote 500 mg b.i.d., Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s.,

1 Trazadone 150-300 mg q.h.s., Inderal 80 mg q.a.m. and Zoloft 50 mg q.a.m. The assessment was
2 Major Depressive Disorder (296.32) depressive symptoms, Insomnia (327.02), tremor less on
3 Inderal, and migraine headaches. Respondent's treatment plan was to continue with current
4 medications, increase Zoloft to 100 mg q.a.m., referral to two other people for social security
5 appeal, and return to clinic in four to six weeks.

6 40. On or about June 16, 2011, patient K.L.C. had a follow up visit with respondent who
7 documented, among other things, conflict with her ex-husband due to his daughter being at her
8 house, the ex-husband and step-daughter both using alcohol, patient feeling no joy, pleasure, very
9 tired, and having low appetite. The current medications were listed as Depakote 500 mg b.i.d.,
10 Soma 350 mg b.i.d., Valium 10 mg q.i.d., Restoril 30 mg q.h.s., Trazadone 150-300 mg q.h.s.,
11 Inderal 80 mg q.a.m. and Zoloft 100 mg q.a.m. The assessment was Major Depressive Disorder
12 (296.32) depressive symptoms, Insomnia (327.02), tremor, migraine headaches, and back pain
13 with patient "asking for Tramadol 50 mg #120 [because she] cannot afford Dr. [N.M.] at this
14 time." Respondent's treatment plan was to continue with current medications, increase Zoloft to
15 200 mg q.a.m., refill the Valium for another 3 months, add Ultram 50 mg q.i.d. p.r.n. pain; and
16 follow up at Helping Hand Counseling in four to six weeks.

17 41. On or about September 6, 2011, patient K.L.C. had a follow up visit with respondent
18 who documented, among other things, continued problems with the patient's ex-husband and his
19 daughter, that the patient was "going nuts," "isolates in [her] room," was sleeping with
20 Trazadone and Restoril, and still "no appetite." The current medications were listed as
21 Trazadone, Restoril, Tramadol, Valium, Soma and Zoloft 50 mg q.a.m. (the last chart note
22 recorded Zoloft at 100 mg). The assessment was Major Depressive Disorder (296.32) "still
23 depressed." The treatment plan was to continue with current medications, increase Zoloft 100 mg
24 q.a.m. and return to clinic "6-8 weeks - 4 months."

25 42. On or about February 9, 2012, patient K.L.C. had a follow up visit with respondent
26 who documented, among other things, that the patient's ex-husband had been "belligerent [and]
27 drunk," the patient "isolates in [her] room," she was compliant with her medications, and her
28 weight was 90 pounds. The current medications were listed as Trazadone 150 mg q.h.s., Zoloft

1 100 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram
2 50 mg q.i.d. The assessment was Major Depressive Disorder (296.32) stable and Insomnia
3 (327.02) stable. Respondent's treatment plan was to continue with current medications and return
4 to clinic in 3 months.

5 43. On or about May 8, 2012, patient K.L.C. had a follow up visit with respondent who
6 documented, among other things, that the patient was feeling sad, had increased crying spells,
7 somewhat low appetite, she was tired and sleeping during the day, overwhelmed, and reading one
8 bible chapter a day. The current medications were listed as Trazadone 150 mg q.h.s., Zoloft 100
9 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram 50
10 mg q.i.d. The assessment was Major Depressive Disorder (296.32) increase in symptoms,
11 Insomnia (327.02) "broken sleep-sleeps in day," and back pain from scrubbing linoleum floor, in
12 bed for 2 days, with patient indicating Ultram was "too weak." Respondent's treatment plan was
13 to continue with current medications, increase Ultram 100 mg q.i.d. p.r.n. pain, and return to
14 clinic in 4 to 6 weeks.

15 44. On or about January 22, 2013, patient K.L.C. had a follow up visit with respondent
16 who documented, among other things, that the patient, who had been out-of-state, gained some
17 weight, her appetite was doing better, she was staying with her ex-husband, who was still
18 drinking, and she was "relatively compliant with meds." Weight was recorded as 127 pounds.
19 The current medications were listed as Trazadone 150-300 mg q.h.s., Zoloft 200 mg q.a.m.
20 (which was 100 mg more than the last recorded Zoloft level), Tramadol 50 mg q.i.d. (not listed on
21 the medications list for the last visit), Soma 350 mg q.i.d., Valium 10 mg q.i.d., and Restoril 30
22 mg p.r.n. sleep. Ultram 100 mg q.i.d. was documented for the prior visit but not listed on the
23 progress note for this visit and there was no documentation as to why the Ultram was
24 discontinued if, in fact, it was discontinued. The assessment was Major Depressive Disorder
25 (296.32) with depressive symptoms. Respondent's treatment plan was to increase Zoloft to 150
26 mg q.a.m., provided a referral to North County "access line" for a pain specialist.

27 45. On or about April 24, 2013, the office visit for patient K.L.C. was cancelled because
28 she reported that she "fell last night and hurt herself."

1 46. On or about May 15, 2013, patient K.L.C. had a follow up visit with respondent who
2 documented, among other things, that the patient, was “walking with cane (back pain),” the
3 “Tramadol doesn’t work,” she had started physical therapy exercises, there were still issues with
4 her ex-husband’s alcohol use, and the Zoloft was upsetting her stomach. The current medications
5 were listed as Trazadone 100 mg q.h.s., Zoloft 100 mg q.a.m., Soma 350 mg q.i.d., Valium 10 mg
6 q.i.d., Restoril 30 mg p.r.n. sleep, and Ultram 100 mg q.i.d. The assessment was Major
7 Depressive Disorder (296.32) stable, Insomnia (327.02) stable, “Back Spasms – Soma,” and
8 “Lower back/Hip/knee pain – R.A. in hands/back/ [left] foot.” Respondent’s treatment plan was
9 to continue with current medications and return to clinic in “4 - 6 weeks – chose 3 months.”

10 47. On or about June 26, 2013, patient K.L.C. had a follow up visit with respondent who
11 documented, among other things, that the patient had a DV (domestic violence) incident with her
12 ex-husband, she “brought court papers – restraining order,” she “claims to be on 200 mg Zoloft
13 not 150 mg as ordered on 5/15/13,” she was sleeping most of the day, and feeling depressed. The
14 current medications were listed as Valium 10 mg q.i.d., Zoloft 100 mg q.a.m., Ultram 100 mg
15 q.i.d., Soma 350 mg q.i.d., Restoril 30 mg p.r.n. sleep, and Trazadone 75-150 mg q.h.s. The
16 assessment was Major Depressive Disorder (296.32) “still depressed,” L/S (lumbosacral)
17 pain/arthritis – also arthritis in hands/knees/feet/back – Ultram not working.” Respondent’s
18 treatment plan was to increase Zoloft 200 mg q.a.m., discontinue Ultram for “lack of efficacy,”
19 add Tylenol ES 500-1000 mg t.i.d. p.r.n. pain, and return to clinic in 4-6 weeks.

20 48. On or about September 22, 2013, patient K.L.C. had a follow up visit with respondent
21 who documented, among other things, that she was in the same living situation, her ex-husband
22 has to take “DUI/husband classes,” the assault charges against her ex-husband were dropped, she
23 didn’t get the Tylenol ES filled, her “spirits are high” from attending church, sleep was okay,
24 “appetite ‘waned,’” and the patient had “energy to spare.” The current medications were listed as
25 Trazadone 150-300 mg q.h.s. (which was different than the 75-150 mg that was recorded for her
26 prior visit), tramadol (Ultram) 100 mg q.i.d., Soma 350 mg q.i.d., Zoloft 200 mg q.a.m.,
27 Temazepam (restoril) 30 mg q.h.s. p.r.n. sleep , and Valium 10 mg q.i.d. The assessment was
28 Major Depressive Disorder (296.32) “residual symptoms.” Respondent’s treatment plan was to

1 start Tylenol ES 500-1000 mg t.i.d. p.r.n. pain, discontinue Tramadol, and return to clinic in 3
2 months.

3 49. On or about January 22, 2014, patient K.L.C. had a follow up visit with respondent
4 with no narrative history documented. The current medications were listed as Trazadone 150-300
5 mg q.h.s., tramadol (Ultram) 100 mg q.i.d., carisoprodol (Soma) 350 mg q.i.d., Zoloft 100 mg
6 q.a.m., temazepam (Restoril) 30 mg q.h.s. p.r.n. sleep , and Valium (diazepam) 10 mg q.i.d. The
7 assessment was Major Depressive Disorder (296.32). Respondent's treatment plan was to change
8 Zoloft to 100 mg q.a.m., and continue other current medications.

9 50. On or about April 23, 2014, patient K.L.C. had a follow up visit with respondent with
10 no narrative history documented. The current medications were listed as carisoprodol (Soma)
11 350 mg q.i.d., Valium (diazepam) 10 mg q.i.d., temazepam (Restoril) 30 mg q.h.s. p.r.n. sleep,
12 Trazadone 150-300 mg q.h.s. p.r.n. sleep, and Zoloft 100 mg q.a.m. There was no assessment
13 documented for this visit. The apparent treatment plan was to continue current medications.

14 51. A review of patient K.L.C.'s CURES report for the period of November 1, 2011, to
15 November 12, 2014, contained indications of patient K.L.C.'s misuse, abuse and/or diversion of
16 controlled substances including, but not limited to, obtaining large amounts of carisoprodol
17 (Soma) 350 mg (#360) and in 2012 and 2013 and diazepam (Valium) 10 mg (#360) in 2013.

18 52. Respondent committed gross negligence in his care and treatment of patient K.L.C.
19 including, but not limited to, the following:

- 20 (a) Respondent repeatedly prescribed excessive amounts of controlled
21 substances, including, but not limited to, hypnotic-sedative medications
22 and/or benzodiazepines, without any objective and/or justifiable basis
23 for prescribing such amounts of controlled substances; and when
24 considering some of the other controlled substances that were being
25 prescribed to patient K.L.C.;

26 ////

27 ////

28 ////

1 (b) Respondent repeatedly prescribed excessive amounts of controlled
2 substances, including benzodiazepines, such as Temazepam and
3 Diazepam, in combination with Soma, which were not justified based
4 on the patient's clinical presentation; and

5 (c) Respondent repeatedly prescribed controlled substances to patient
6 K.L.S. without reviewing CURES, without utilizing urine drug screens,
7 without consulting with and/or obtaining records from prior treating
8 physicians and/or without utilizing other risk screening tools.

9 **Patient R.MA.**

10 53. On or about August 30, 2011, patient R.MA., a then twenty year old male, who was
11 referred by another physician "for medication," had his initial visit with respondent. According
12 to the intake documents, the patient began experiencing depression at age 17, when his "problems
13 began." His prior medications were listed as Ambien, Klonopin, Seroquel, Tegretol, Wellbutrin
14 XL and Prozac and his current medications were "Klonopin from a friend" 2 mg b.i.d., and Xanax
15 2 mg b.i.d. The patient's substance abuse history was positive for beer, liquor, THC (marijuana)
16 and "pills." Patient R.MA. described a traumatic childhood and at least one prior arrest in April
17 2013¹¹ for "DUI/Possession of cocaine." Respondent documented that the patient was "just
18 intoxicated on THC/ETOH (alcohol)/ Club pills" and that he took a "glass bottle to back of head
19 8/25/11" and "fell on [his] face 2 months ago – interaction between ETOH [and] Tegretol."
20 Respondent's Axis I diagnoses was Major Depressive Disorder, recurrent, moderate (296.32) and
21 Insomnia (327.02) and the treatment plan was continue Klonopin 2 mg b.i.d., Xanax 2 mg b.i.d.,
22 add Paxil 10 mg q.a.m. for 7 days and then increase to 20 mg q.a.m.; add Trazadone 50-150 mg
23 q.h.s. p.r.n. sleep and return to clinic in 4-6 weeks.

24 54. On or about October 6, 2011, patient R.MA. had a follow up visit with respondent
25 who documented, among other things, that the patient was "not too good," having conflict with
26 his father, he "uses extra Xanax, Trazadone," and he was smoking ½ ounce of marijuana per day

27 ¹¹ Although this note is dated August 30, 2011, it indicates patient R.MA. had prior arrest
28 in April 2013¹¹ for "DUI/Possession of cocaine."

1 to help with sleep. The current medications were listed as Xanax 2 mg t.i.d. – q.i.d., Paxil 20 mg
2 q.a.m. “off last few days” and Trazadone discontinued. The assessment was Major Depressive
3 Disorder (296.32) still depressed and Insomnia (327.02) not responding to Trazadone.
4 Respondent’s treatment plan was to increase Xanax 2 mg t.i.d. – q.i.d., increase Paxil to 40 mg
5 q.a.m., discontinue Trazadone, add Lunesta¹² 3 mg q.h.s. p.r.n. sleep with a note to “consider
6 Remeron” and return to clinic in 6 weeks.

7 55. On or about November 22, 2011, patient R.M.A. had a follow up visit with respondent
8 who documented, among other things, that the patient’s Xanax was confiscated at the airport and
9 he had to come back early from Las Vegas “due to being out of meds,” he was not sleeping well,
10 he had “used friend’s Valium 10 mg q.i.d.” and, according to respondent, “describes conditions
11 symptoms of ADHD – poor focus and concentration – responded to friends Adderall.” The
12 current medications were listed as Paxil 40 mg q.a.m., Xanax 2 mg t.i.d. – q.i.d. p.r.n. anxiety,
13 and “Lunesta – never filled.” The assessment was Panic Disorder (300.01) with a note of
14 “[increased] attacks off Xanax [and] Okay on Valium,” Major Depressive Disorder (296.32) “not
15 responding to Paxil,” Insomnia and ADHD (Attention Deficit Hyperactivity Disorder (314.00).
16 Respondent’s treatment plan was discontinue Paxil due to no response; discontinue Xanax due to
17 “rebound anxiety,” add Valium 10 mg q.i.d. p.r.n. anxiety, add Remeron 7.5–15 mg q.h.s. p.r.n.
18 sleep, and add Adderall¹³ 5-10 mg b.i.d., and return to clinic in one month.

19 56. On or about November 29, 2011, patient R.M.A. had a follow up visit with respondent
20 who documented, among other things, that the patient reported “the Valiums are weak, but

21 ¹² Lunesta® (eszopiclone), a sedative, is a Schedule IV controlled substance pursuant to
22 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
23 Business and Professions Code section 4022. When properly prescribed and indicated, it is used
to treat insomnia.

24 ¹³ Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a
25 central nervous system stimulant of the amphetamine class, and is a Schedule II controlled
26 substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous
27 drug pursuant to Business and Professions Code section 4022. When properly prescribed and
28 indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the
DEA, amphetamines, such as Adderall®, are considered a drug of abuse. “The effects of
amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their
duration is longer.” (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and
other stimulants are contraindicated for patients with a history of drug abuse.

1 stopping the shaking, that he wanted to go back on Xanax because he “sleeps better,” and that his
2 “focusing [was] better.” The current medications were listed as Valium 10 mg q.i.d. 6 per day
3 p.r.n. anxiety, Remeron 15 mg q.h.s., and Adderall 5-10 mg b.i.d. with a note that Adderall 10-15
4 mg was discontinued. The assessment was Panic Disorder (300.01), Major Depressive Disorder
5 (296.32) “not responding to Paxil,” Insomnia, ADHD (314.00), with a note, which applied to
6 each condition, indicating “improved but anxious.” Respondent’s treatment plan was to
7 discontinue Valium – poor response, add Xanax 2 mg q.i.d. p.r.n. anxiety, and return to clinic in 3
8 weeks.

9 57. On or about December 22, 2011, patient R.MA. had a follow up visit with respondent
10 who documented, among other things, that the patient was having issues with his father and the
11 patient’s business, he ran out of Xanax and Adderall early, Remeron was not helping for sleep,
12 and he had “some sadness [and] some panic attacks.” The current medications were listed as
13 Remeron 15 mg q.h.s., Adderall 2 mg 5-10 mg b.i.d. (10-20 mg per day), and Xanax 2 mg q.i.d.
14 p.r.n. with a note of “(5-6 x day).” The assessment was Panic Disorder (300.01) “sporadic
15 attacks,” Major Depressive Disorder (296.32) “some depression,” Insomnia “sleeps on Xanax,”
16 ADHD (314.00) “struggles with focus and concentration on Adderall 15 mg b.i.d. Respondent’s
17 treatment plan was to increase Remeron to 30 mg q.h.s., increase Adderall to 20 mg b.i.d. (40 mg
18 per day), refill Xanax 2 mg q.i.d. p.r.n. anxiety (one week early) with a note that “will change to
19 5-6 a day p.r.n. anxiety[;]” and return to clinic in 4 to 6 weeks.

20 58. On or about January 19, 2012, patient R.MA. had a follow up visit with respondent
21 who documented, among other things, “MRI” (without any specific details about the MRI), that
22 the patient was “asking for cough syrup with codeine,” he had been out of work for 10 days and
23 had been on antibiotics, and that he was having “trouble sleeping.” The current medications were
24 listed as Remeron 30 mg q.h.s., Adderall 20 mg b.i.d., and Xanax 2 mg p.r.n. six (6) per day.”
25 The assessment was Panic Disorder (300.01), Major Depressive Disorder (296.32), Insomnia, and
26 ADHD (314.00) – with a note indicating “stable [as to each condition], but has partial response to
27 Adderall.” Respondent’s treatment plan was to increase Adderall to 20 mg q.i.d. (80 mg per day)
28 and return to clinic in 4 weeks.

1 59. On or about February 16, 2012, patient R.MA. had a follow up visit with respondent
2 who documented, among other things, that the patient “[a]lmost got DUI due to Xanax, police
3 confiscated 2 bottles of pills [and his] [c]ar was impounded...,” the police confiscated his
4 “medical THC card,” he had a “[b]izarre feeling in a.m. from Remeron,” and some “panic attacks
5 new.” The current medications were listed as Remeron 30 mg q.h.s., Adderall 20 mg q.i.d., and
6 Xanax 2 mg 4-6 tabs per day (8-12 mg per day). The assessment was Panic Disorder (300.01)
7 “[increased] panic off Xanax,” ADHD (314.00) stable, Major Depressive Disorder (296.32)
8 stable, and Insomnia (327.02) “broken sleep off Xanax.” Respondent’s treatment plan was to
9 refill Xanax and Adderall, discontinue Remeron, and return to clinic in 1 month.

10 60. On or about April 17, 2012, patient R.MA. had a follow up visit with respondent who
11 documented, among other things, that the patient appeared tired and sad, was having “issues with
12 father,” claimed his anxiety was worse and only Xanax helped, that he was only taking the Xanax
13 and Adderall, and that he “sleeps on Xanax.” The assessment was Panic Disorder (300.01)
14 “[increased] panic off Xanax,” ADHD (314.00) stable, Major Depressive Disorder (296.32)
15 stable, and Insomnia (327.02) “broken sleep off Xanax.” The current medications were listed as
16 Adderall 20 mg q.i.d., and Xanax 2 mg six (6) a day and “takes up to 8 [per] day” (16 mg per
17 day). The assessment was Panic Disorder (300.01) “some anxiety,” ADHD (314.00)
18 “stable/anorexia,” Major Depressive Disorder (296.32) “some depression,” and Insomnia
19 (327.02). Respondent’s treatment plan was “[h]ad trials of Paxil/Prozac [-] Will add Zoloft 50
20 mg q.a.m.,” refill Adderall, and return to clinic in 4-5 weeks.

21 61. On or about May 31, 2012, patient R.MA. had a follow up visit with respondent who
22 documented, among other things, that the patient was having “family issues,” “using a lot of
23 Xanax,” the Adderall decreased his appetite, he gets up later in the morning, and “may get DUI
24 for Xanax – may go to court.” The current medications were listed as Adderall 20 mg q.i.d., and
25 Xanax 2 mg “8–9 [per] day” (16-18 mg per day). The assessment was Panic Disorder (300.01)
26 “improved on Xanax,” ADHD (314.00) “stable,” Major Depressive Disorder (296.32)
27 “[increased] depression,” and Insomnia (327.02) “okay.” Respondent’s treatment plan was to
28

1 increase Zoloft to 100 mg q.a.m., refill Adderall, and change Xanax 2 mg to seven per day and 3
2 tabs q.h.s. (10 tabs a day for a total of 20 mg of Xanax per day), and return to clinic in one month.

3 62. On or about June 28, 2012, patient R.MA. was a no show for his appointment.
4 Respondent called patient R.MA. and documented, among other things, that the patient was still
5 having conflict with his father, the patient was going on vacation to Dubai and he wanted “3
6 month script for trip to Middle East.” The current medications were listed as Adderall 20 mg
7 q.i.d., Xanax 2 mg to seven per day and 3 tabs q.h.s. (20 mg per day), and Zoloft 100 mg q.a.m.
8 The assessment was Panic Disorder (300.01) “in remission, but relies on Xanax,” ADHD
9 (314.00) “uses Adderall for work to focus/concentrate,” Major Depressive Disorder (296.32)
10 “stable,” and Insomnia (327.02) “sleeps.” Respondent’s treatment plan was “one (1) month script
11 for Adderall [and] three (3) month scripts for Xanax/Zoloft – Zoloft @ 200 mg” (900 tabs of
12 Xanax¹⁴ and 180 tabs of Zoloft) and return to clinic in 3 months.

13 63. On or about September 4, 2012, patient R.MA. had a follow up visit with respondent
14 who documented, among other things, that the patient’s girlfriend wanted to break up with him,
15 the patient “has a felony case – caught with gun in house” the patient has no car, his driver’s
16 license was suspended, and he stopped taking Zoloft one month ago. The current medications
17 were listed as Adderall 20 mg q.i.d., Xanax 2 mg 10 per day (20 mg total per day), and Zoloft 200
18 mg q.a.m. (discontinued last month). The assessment was Panic Disorder (300.01) “sporadic
19 attacks,” ADHD (314.00) “[increased] Sx [symptoms] off Adderall,” Major Depressive Disorder
20 (296.32), and Insomnia (327.02) “broken sleep.” Respondent’s treatment plan was to refill
21 Adderall 20 mg q.i.d., decrease Xanax to 4 mg q.i.d. “(16 mg per day total)” and return to clinic
22 in 1 month.

23 64. On or about September 27, 2012, patient R.MA. had a follow up visit with respondent
24 who documented, among other things, that the patient was “out of Xanax early takes an extra 2
25

26 ¹⁴ During his interview before a Department of Consumer Affairs, Health Quality Unit
27 (HQIU) Investigator and Medical Consultant, respondent confirmed that he prescribed 900 tablets
28 of Xanax and claimed that the prescription was cancelled by phone. There is a notation in his
medication log for June 28, 2012, that indicates “CX by phone.” According to patient R.MA.’s
CURES report, patient R.MA. filled a prescription for Xanax 2 mg (#300) on July 31, 2012.

1 tablets (4 mg) at h.s. (bedtime) to sleep and 'overall doing well.' ” The current medications were
2 listed as Adderall 20 mg q.i.d., Xanax 4 mg q.i.d. “(4 mg 5x /day PRN).” The assessment was
3 Panic Disorder (300.01), ADHD (314.00), Major Depressive Disorder (296.32), and Insomnia
4 (327.02). Respondent’s treatment plan was to refill Adderall and Xanax, add Ambien 5-10 mg
5 q.h.s. p.r.n. sleep, and return to clinic on October 2, 2012. The patient was a no-show for the
6 office visit on October 2, 2012

7 65. On or about November 1, 2012, patient R.MA. had a follow up visit with respondent
8 who documented, among other things, that the patient “went to jail,” his “girlfriend left him,” he
9 had poor sleep from 6:00-8:00 a.m. on Ambien, he asked for Seroquel for sleep, no ETOH, and
10 “[c]ashed out lawyers – will go to court.” The current medications were listed as Adderall 20 mg
11 q.i.d., Xanax 4 mg q.i.d., and Ambien 5-10 mg q.h.s. p.r.n. sleep. The assessment was Panic
12 Disorder (300.01) “more anxious...,” ADHD “Inattentive Type” (314.00), Major Depressive
13 Disorder (296.32) “had trials of Prozac, Zoloft, Paxil,” and Insomnia (327.02) “poor sleep on
14 Ambien.” Respondent’s treatment plan was to refill Adderall 20 mg q.i.d., continue Xanax 4 mg
15 q.i.d., add Seroquel XR 50-400 mg q.h.s. p.r.n. sleep, “consider antidepressant – has had sporadic
16 seizures in past...,” and return to clinic in one month.

17 66. On or about November 29, 2012, patient R.MA. had a follow up visit with respondent
18 who documented, among other things, that the patient lost his wallet, had issues with his
19 girlfriend, lost his license and insurance card, and has low income. The current medications were
20 listed as Adderall 20 mg q.i.d., Xanax 4 mg q.i.d., and Seroquel XR 400 mg q.h.s. The assessment
21 was Panic Disorder (300.01), ADHD “Inattentive Type” (314.00), Major Depressive Disorder
22 (296.32), and Insomnia (327.02) with a note for all that indicated “mixed depressive anxiety.”
23 Respondent’s treatment plan was to add Viibryd (an antidepressant) to be gradually increased to
24 40 mg q.a.m. and return to clinic in one month.

25 67. On or about February 5, 2013, patient R.MA. had a cell phone consultation with
26 respondent, who documented, among other things, that the patient was, or had been, in Los
27 Angeles for business and left his prescription for Xanax in Los Angeles. He was now asking for
28 Halcion, stated he needs more Adderall and that he wanted to take five per day (150 mg), he had

1 short term memory problems, and it was hard to awaken with Seroquel XR. The current
2 medications were listed as Adderall 30 mg q.i.d. (which was inconsistent with the prior note on
3 November 29, 2013, which indicated Adderall 20 mg q.i.d.), Xanax 4 mg q.i.d., Viibryd 40 mg
4 with a notation of “off,” and Seroquel XR 400 mg q.h.s. – still taking p.r.n. The assessment was
5 Panic Disorder (300.21) “stable on Xanax,” ADHD “Inattentive Type” (314.00) “stable,” Major
6 Depressive Disorder (296.32) “stable,” and Insomnia (327.02) “broken sleep.” Respondent’s
7 treatment plan was refill Xanax and Adderall, add Halcion¹⁵ 0.125 mg – 0.25 mg q.h.s. p.r.n.
8 sleep, Seroquel XR 400 mg q.h.s. p.r.n. sleep, and return to clinic in one month.

9 68. On or about April 11, 2013, patient R.MA. had a follow up visit with respondent who
10 documented, among other things, that the patient indicated “I’m alive,” there was still conflict
11 with his father, and he had an upcoming trial in approximately two weeks for “possession of a
12 firearm [and] discharge in a negligent manner.” The current medications were listed as Adderall
13 30 mg q.i.d. (120 mg per day) and Xanax 4 mg q.i.d. The assessment was Panic Disorder
14 (300.21) “stable,” ADHD “Inattentive Type” (314.00) “stable,” Major Depressive Disorder
15 (296.32) “in remission,” and Insomnia (327.02) “broken sleep.” Respondent’s treatment plan was
16 add Sonata 10 mg q.h.s. p.r.n. sleep, and return to clinic in 4-6 weeks.

17 69. A review of patient R.MA.’s CURES report for the period of November 1, 2011, to
18 November 12, 2014, contained indications of patient R.MA.’s misuse, abuse and/or diversion of
19 controlled substances including, but not limited to, large quantities of Xanax (alprazolam)¹⁶ being

20 ¹⁵ Halcion® (triazolam), a benzodiazepine, is a centrally acting hypnotic-sedative
21 benzodiazepine that is a Schedule IV controlled substance pursuant to Health and Safety Code
22 section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code
23 section 4022. When properly prescribed and indicated, it is used for the short term treatment of
24 insomnia. Concomitant use of Halcion® with opioids “may result in profound sedation,
respiratory depression, coma, and death.” The Drug Enforcement Administration (DEA) has
identified benzodiazepines, such as Halcion®, as a drug of abuse. (Drugs of Abuse, DEA
Resource Guide (2011 Edition), at p. 53.)

25 ¹⁶ As an example, respondent was asked during his HQIU investigatory interview,
26 whether he was aware that between November 25, 2011, through December 31, 2011, patient
27 R.MA. had approximately 5522 mg of Xanax dispensed to him that he got from approximately 12
28 different pharmacies which amounted to approximately 26-28 mg of Xanax per day. Respondent
indicated he was not aware that patient R.MA. had received so much Xanax and had he been
aware it would have raised a “red flag” about patient R.MA. “hav[ing] an addiction problem
possibly.” (Interview Transcript, at pp. 28-31.)

(continued...)

1 filled over short periods of time by different pharmacies; and patient R.MA. filling prescriptions
2 for opiates¹⁷ that were prescribed by different physicians while respondent was prescribing
3 controlled substances to patient R.MA. During his interview before a Department of Consumer
4 Affairs, Health Quality Unit (HQIU) Investigator and Medical Consultant, respondent admitted
5 that he was not reviewing CURES while he was prescribing controlled substances to patient
6 R.MA. and, thus, was not aware of the prescribing pattern set forth in the CURES report.

7 70. Respondent committed gross negligence in his care and treatment of patient R.MA.
8 including, but not limited to, the following:

9 (a) Respondent repeatedly prescribed controlled substances to patient
10 R.MA., including hypnotic sedatives, benzodiazepines and/or
11 amphetamines, to a known substance abuser without any objective
12 and/or justifiable basis for prescribing such amounts of controlled
13 substances;

14 (b) Respondent repeatedly prescribed controlled substances to patient
15 R.MA. despite indications of abuse and/or addiction to the controlled
16 substances that were being prescribed; and

17 (c) Respondent repeatedly prescribed controlled substances to patient
18 R.MA. without reviewing CURES, without utilizing urine drug screens,
19 without consulting with and/or obtaining records from prior treating
20 physicians and/or without utilizing other risk screening tools

21 **PATIENT R.R.**

22 71. On or about March 30, 2007,¹⁸ respondent had his initial visit with patient R.R. a then
23 thirty-two year old female who was referred to him by a mental health clinic. According to the
24 intake documents, the patient used to take Adderall for ADHD but insurance would not cover the

25 _____
(...continued)

26 ¹⁷ There are risks associated with the concomitant use of Xanax and opiates which can
27 result in profound sedation, respiratory depression, coma and death.

28 ¹⁸ Conduct occurring more than seven (7) years from the filing date of this Accusation is
for informational purposes only and is not alleged as a basis for disciplinary action.

1 medication, she has anxiety and panic attacks, and that she was clean and sober for the past
2 seventeen (17) months from methamphetamine. Respondent did not order any toxicology testing
3 to confirm that respondent was, in fact, clean and sober for any illicit drugs or controlled
4 substances. No prior medical records were requested or reviewed nor is there any record of
5 respondent making any effort to consult with any prior treating physicians or other health care
6 professionals. Prior psychotropic medications were reported for this initial visit, but there was no
7 documented current or past prescribers or history of mental health illnesses. The Axis I
8 assessment (diagnoses) were ADHD, "combined type" (314.01) and Panic Disorder
9 (Agoraphobia) (300.21). Respondent's treatment plan was to prescribed Valium 10 mg b.i.d. to
10 t.i.d. "to target panic D/O (disorder)," Adderall XR 10 mg q.a.m. "to target ADHD" and
11 Wellbutrin XL 150 mg q.a.m. for seven days and then increase to 300 mg q.a.m.

12 72. During the period of or about March 30, 2007, to on or about March 24, 2009, patient
13 R.R. had near monthly visits with respondent, except for those visits that she failed to show up for
14 or those visits that were rescheduled. On July 12, 2007, respondent referenced patient R.R.'s
15 prior history of abusing "Crystal Meth" in the "Risk Assessment" section of a United Behavioral
16 Health Outpatient Treatment Progress Report form. During the period March 30, 2007, to on or
17 about March 24, 2009, patient R.R.'s primary Axis I diagnoses were documented as ADHD
18 (314.01), Panic Disorder (Agoraphobia) (300.21), Bipolar Disorder NOS [not otherwise
19 specified] (296.80) [first documented on or about July 23, 2008] and Premenstrual Dysphoric
20 Disorder [first documented on August 23, 2007]. Respondent's treatment plan during this period
21 of time was to continue the patient on Adderall 20 mg b.i.d, Valium 10 mg b.i.d. to t.i.d.,
22 Wellbutrin XL q.a.m. between 150 mg to 450 mg, and other periodic controlled substances and/or
23 dangerous drugs including, but not limited to, Pexeva 30 mg q.a.m., Dexedrine
24 (dextroamphetamine sulfate)¹⁹ 15 mg b.i.d. [increased to 30 mg on November 12, 2008], Abilify

25 ¹⁹ Dexedrine® (dextroamphetamine sulfate) is a central nervous system stimulant of the
26 amphetamine class. Dexedrine® is a Schedule II controlled substance pursuant to Health and
27 Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and
28 Professions Code section 4022. When properly prescribed and indicated, it is used for the
treatment of attention-deficit hyperactivity disorder and narcolepsy. The DEA has identified
amphetamines, such as Dexedrine®, as drugs of abuse. (Drugs of Abuse, A DEA Resource
(continued...))

1 (antidepressant) 10 mg q.h.s.. The progress note for July 26, 2007, indicates that patient R.R. “ran
2 out of Valium.” On April 3, 2008, patient R.R. was instructed to discontinue Adderall (which she
3 did not do) as documented on the progress note for May 1, 2008, indicating “[d]id not stop
4 Adderall as ordered.”

5 73. During the period of on or about April 29, 2009, to on or December 31, 2009, patient
6 R.R. had near monthly visits with respondent, except for those visits that she failed to show up for
7 or those that were cancelled. During this period of time, her primary Axis I diagnoses were
8 documented as Bipolar Disorder NOS [not otherwise specified] (296.80), ADHD “combined
9 type” (314.01), Panic Disorder (Agoraphobia) (300.21), Social Phobia (300.23) [added as a
10 diagnosis on May 27, 2009] and Premenstrual Dysphoric Disorder. Respondent’s treatment plan
11 during this period of time was to continue the patient on Adderall 20 mg b.i.d., Valium 10 mg
12 t.i.d. p.r.n. anxiety, and other periodic controlled substances and/or dangerous drugs including,
13 but not limited to, Abilify 10 mg q.h.s. [discontinued in early December 2009, due to “sedation”],
14 Wellbutrin XL 150 mg q.a.m. [added on September 16, 2009], and Dexedrine SR 30 mg b.i.d.
15 [added on October 14, 2009].

16 74. During the period of on or about January 1, 2010, to December 31, 2010, patient R.R.
17 had near monthly or bimonthly visits with respondent, except for those visits that she failed to
18 show up for or those that were cancelled. During this period of time her primary Axis I diagnoses
19 were documented as Bipolar Disorder NOS [not otherwise specified] (296.80), ADHD “combined
20 type” (314.01), Panic Disorder (Agoraphobia) (300.21), Social Phobia (300.23), and Premenstrual
21 Dysphoric Disorder. Respondent’s treatment plan during this period of time was to continue the
22 patient on Adderall 20 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, Dexedrine 30 mg b.i.d.,

23 _____
24 (...continued)

25 Guide (2011 Edition), at pp. 42-44.) The Federal Drug Administration has issued a black box
26 warning for amphetamines which provides that “Amphetamines have a high potential for abuse.
27 Administration of amphetamines for prolonged periods of time may lead to drug dependence and
28 must be avoided. Particular attention should be paid to the possibility of subjects obtaining
amphetamines for non-therapeutic use of distribution to others, and the drugs should be
prescribed or dispensed sparingly. [¶] Misuse of amphetamines may cause sudden death and
serious cardiovascular adverse events.” Dexedrine® and other stimulants are contraindicated for
patients with a history of drug abuse.

1 Wellbutrin XL 150 mg q.a.m., and other periodic controlled substances and/or dangerous drugs
2 including, but not limited to, Lamictal 75-100 mg q.h.s. [added on March 17, 2010].

3 75. During the period of on or about January 1, 2011, to December 31, 2011, patient R.R.
4 had two visits with respondent on June 14, 2011, and October 25, 2011.²⁰ The patient's
5 documented "current status" for the two visits was unremarkable and generally benign. During
6 this period of time her primary Axis I diagnoses were documented as Bipolar Disorder NOS [not
7 otherwise specified] (296.80) [until June 14, 2011], ADHD "combined type" (314.01) [until
8 October 25, 2011, when it was changed to ADHD "Inattentive Type" (314.00)], Panic Disorder
9 (Agoraphobia) (300.21) [until June 14, 2011], Social Phobia (300.23) [until June 14, 2011],
10 Premenstrual Dysphoric Disorder [until June 14, 2011] and Major Depressive Disorder (296.32)
11 [added on October 25, 2011]. Respondent's treatment plan during this period of time was to
12 continue the patient on Adderall 20 mg b.i.d. [increased to 20 mg t.i.d. on October 25, 2011],
13 Dexedrine 30 mg b.i.d., Valium 10 mg t.i.d. p.r.n. anxiety, and Lamictal 100 mg q.h.s. [changed
14 to 50 mg b.i.d. on October 25, 2011].

15 76. During the period of on or about January 1, 2012, to December 31, 2012, patient R.R.
16 had near monthly visits with respondent, except for her those appointments that she failed to
17 show up for or that were cancelled on March 15, October 24 and November 21, 2012. During
18 this period of time her primary Axis I diagnoses were documented as Major Depressive Disorder
19 (296.32) and ADHD "Inattentive Type" (314.00). Respondent's treatment plan during this period
20 of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine 30 mg b.i.d., Valium 10
21 mg t.i.d. p.r.n. anxiety, and Lamictal 50 mg b.i.d. [increased to 100 mg b.i.d. on July 31, 2012].

22 77. During the period of on or about January 1, 2013, to December 31, 2013, patient R.R.
23 had near monthly visits with respondent, except for her those appointments that she failed to
24 show up for or that were cancelled on August 24 and November 20, 2013. On March 27, patient

25 ²⁰ There was a gap of nearly six and one-half months between the patient's last visit with
26 respondent on December 3, 2010, and her visit on June 14, 2011, during which time respondent
27 continued to prescribe patient R.R. controlled substances. Patient R.R. did not show up for her
28 appointment on January 25, 2011; "could not be seen – insurance not active" on February 10,
2011, was a "late cancellation" on March 31, 2011; did not show up on May 7, 2011; and
cancelled "due to work" on November 22, 2011.

1 R.R. complained that she had “a ton of stress at work” and that she wanted more Valium. On
2 June 19, she reported she was hit by a car while riding her bike. On July 17, she reported she just
3 found out that her daughter had been sexually assaulted in March 2013, and she was accused of
4 being “Loopy” by CPS (Child Protective Services), and further reported that she might lose her
5 house. During 2013, patient R.R.’s primary Axis I diagnoses were documented as Major
6 Depressive Disorder (296.32) and ADHD “Inattentive Type” (314.00). Respondent’s treatment
7 plan during this period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine SR
8 30 mg b.i.d. [changed to 2 tabs 15 mg b.i.d. on December 10, 2013], Valium 10 mg t.i.d. to q.i.d.
9 p.r.n. anxiety [increased to up to 5 tabs a day on March 27, 2013, and then continued at 10 mg
10 q.i.d. beginning on April 24, 2013], and Lamictal 100 mg b.i.d. [increased to 150 mg b.i.d. on
11 April 24, 2013, and to 200 mg b.i.d. on December 10, 2013, an overall increase from 60 mg per
12 day to 120 mg per day].

13 78. During the period of on or about January 1, 2014, to December 31, 2014, patient R.R.
14 had near monthly or bimonthly visits with respondent. Many of the progress notes during this
15 period of time were cursory, failed to set forth a detailed narrative history and/or were missing
16 information including, but not limited to the assessment (diagnoses) and family history for some
17 of the visits. During 2014, patient R.R.’s primary Axis I diagnoses were documented, for some of
18 the visits, as Major Depressive Disorder (296.32) [which was changed to Bipolar Mood Disorder
19 NOS on July 8, 2014; and then Unspecified Manic Depressive Psychosis (296.80) on October 21,
20 2014] and ADHD (314.00). Respondent’s treatment plan during this period of time was to
21 continue the patient on Adderall 20 mg t.i.d., Dexedrine Spansule SR 30 mg 2 tabs b.i.d., Valium
22 10 mg q.i.d. p.r.n. anxiety, and Lamictal 200 mg b.i.d.

23 79. During the period of on or about January 1, 2015, to October 13, 2015, patient R.R.
24 had near monthly or bimonthly visits with respondent, with the exception of an approximate four
25 and one-half month gap between the visits of June 16, 2015, and the visit of October 30, 2015.
26 During 2015, patient R.R.’s primary Axis I diagnoses were documented as Unspecified Manic
27 Depressive Psychosis (296.80) and ADHD (314.00). Respondent’s treatment plan during this
28

1 period of time was to continue the patient on Adderall 20 mg t.i.d., Dexedrine Spansule SR 15 mg
2 2 tabs b.i.d., Valium 10 mg q.i.d. p.r.n. anxiety, and Lamictal 200 mg b.i.d.

3 80. Respondent committed gross negligence in his care and treatment of patient R.R.
4 including, but not limited to, the following:

5 (a) Respondent repeatedly prescribed excessive doses of hypnotic sedatives,
6 benzodiazepines and/or amphetamines, to a known substance abuser,
7 without any objective and/or justifiable basis for prescribing such amounts
8 of controlled substances; and

9 (b) Respondent repeatedly prescribed controlled substances to patient R.R.
10 without reviewing CURES, without utilizing urine drug screens, without
11 consulting with and/or obtaining records from prior treating physicians
12 and/or without utilizing other risk screening tools.

13 **PATIENT R.P.**

14 81. On or about November 6, 2010, respondent had his initial visit with patient R.P. a
15 then forty-nine year old female who saw respondent for medication management, and who was
16 referred by her therapist B.B., from "A Helping Hand Counseling" center. According to
17 respondent's intake documents, patient R.P. was suffering from Morgellon's disease, a skin
18 disorder, and the patient had suffered a manic episode that "was initiated by a fast titration of an
19 anti-depressant." The past psychiatric history was positive for, among other things, "multiple"
20 episodes over the last two years, with treatment by at least three other physicians, and two
21 inpatient admissions to Mesa Vista Hospital, a psychiatric inpatient facility, for "possible"
22 suicidal ideation. The patient's history was positive for two prior suicide attempts by overdose in
23 September 2010. Patient R.P. indicated, among other things, that during her latest manic episode
24 she was arrested for shoplifting. The patient's current medications were listed as Adderall XR 25
25 mg t.i.d., Prozac 60 mg q.h.s., Clonazepam 2 mg b.i.d. p.r.n. anxiety, Geodon (generally indicated
26 for the treatment of schizophrenia and/or as monotherapy for the acute treatment of manic or
27 mixed episodes of associated with Bipolar I disorder) 40 mg q.h.s., and Norco (hydrocodone and
28 acetaminophen). Respondent's Axis I diagnosis was Major Depressive Disorder, recurrent,

1 severe (296.33) with a rule out of Bipolar Disorder NOS. Respondent's treatment plan was to
2 refill Adderall XR 25 mg t.i.d. (with no detailed explanation as to why Adderall was part of the
3 treatment plan for patient R.P.), increase Prozac 20 mg to 80 mg q.h.s., refill Clonazepam 2 mg
4 b.i.d. p.r.n. anxiety, Geodon 40 mg q.h.s., with a notation that the patient needed a primary
5 doctor, "allergy – immunology doctor, and consider a pain specialist."

6 82. During the period of on or about November 7, 2010, to December 31, 2010, patient
7 R.P. had four additional visits with respondent. On November 22, 2010, respondent noted the
8 patient was "accused of misdemeanor and 2 felonies – burglary/grand theft & carrying a syringe
9 stemming from a visit at a dermatologist..." On December 4, 2010, patient R.P. reported, among
10 other things, difficulty in "getting whole count of Adderall XR" and issues with her seventeen
11 year old son who was addicted to narcotics. On December 20, 2010, patient R.P. reported that
12 her "son may have stolen some of her Klonopin." During the period of on or about November 7,
13 2010, to December 31, 2010, patient R.P.'s diagnosis was documented as Major Depressive
14 Disorder (296.33). Respondent's treatment plan during this period of time included continuing
15 Adderall XR 25 mg t.i.d. (increased to 30 mg q.i.d. on December 4, 2010), Prozac 80 mg q.h.s.,
16 Clonazepam 2 mg b.i.d. p.r.n. anxiety (which appears to have been refilled on November 16,
17 2010, and then discontinued), Valium 10 mg²¹ b.i.d. to q.i.d. p.r.n. anxiety (added on November
18 17, 2010, and then discontinued on December 4, 2010, due to mediocre to no response), Geodon
19 40 mg q.h.s. (increased to 60 mg q.h.s. on November 22, 2010) and Klonopin 2 mg b.i.d. p.r.n.
20 anxiety (resumed on December 4, 2014).

21 83. During the period of on or about January 1, 2011, to December 31, 2011, patient R.P.
22 had near monthly visits with respondent, except for her those appointments that she failed to
23 show up for or that were cancelled on January 22, May 16, June 25, July 16, October 10, October
24 24, and October 29, 2011. During her office visits of February 28, May 21, and August 1, 2011,
25 patient R.P. discussed her legal problems and impending incarceration for shoplifting and identity

26 ²¹ Respondent's medication record indicates that Valium 10 mg was added on November
27 17, 2010, but there is no associated chart note for that date with an explanation of why the Valium
28 was added as part of the treatment plan in addition to the Clonazepam.

1 theft for using her sister's personal information. On August 1, 2011, patient R.P. reported that
2 "some Klonopin may be missing." On August 13, October 29 and 31, and November 28, 2011,
3 respondent documented that patient R.P. was being prescribed Percocet²² (oxycodone and
4 acetaminophen) but there was no documentation as to who was prescribing the Percocet or why it
5 was being prescribed to patient R.P. According to patient R.P.'s CURES report during this time,
6 patient R.P. was receiving opiates (morphine sulfate, oxycodone/acetaminophen (APAP) and/or
7 hydrocodone/APAP) from other physicians during the time that respondent was also prescribing
8 her controlled substances and dangerous drugs. Respondent's Axis I diagnosis (assessment)
9 during this period of time was documented as Major Depressive Disorder (296.33) and ADHD
10 "Inattentive Type" (314.00) [added on February 28, 2011]. Respondents treatment plan during
11 this period of time included continuing with Adderall XR 30 mg q.i.d. (decreased to 25 mg q.i.d.
12 on January 31, 2011), Prozac 80 mg q.h.s., Valium 10 mg q.i.d. p.r.n. anxiety (resumed on
13 January 15, 2011, and discontinued on August 13, 2011), Geodon 60 mg q.h.s. (reduced to 40 mg
14 q.h.s. on January 15, 2011, and discontinued on February 28, 2011), Klonopin 2 mg b.i.d. p.r.n.
15 anxiety (discontinued on January 15, 2011; resumed on April 16, 2011; increased to 2 mg q.i.d.
16 on July 18, 2011; discontinued on August 1, 2011, and resumed on August 13, 2011), Ambify
17 5mg q.a.m. (added on August 1, 2011; increased to 10 mg q.a.m. on August 13, 2011) and Buspar
18 (buspirone hydrochloride)²³ 15 mg b.i.d. (tried for one month beginning on July 18, 2011, and
19 then discontinued).

20 84. During the period of on or about January 1, 2012, to October 26, 2012, patient R.P.
21 had near monthly visits with respondent, except for her appointment that she failed to show up for

22 _____
23 ²² Percocet® (oxycodone and acetaminophen), an opioid analgesic, is a Schedule II
24 controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a
25 dangerous drug pursuant to Business and Professions Code section 4022. When properly
26 prescribed and indicated, it is used for the management of moderate to moderately severe pain.
27 The Drug Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of
28 Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has
issued a black box warning for Percocet® which warns about, among other things, addiction,
abuse and misuse, and the possibility of "life-threatening respiratory distress."

²³ Buspar® (buspirone hydrochloride) is indicated for the management of anxiety
disorders or the short term relief of the symptoms of anxiety.

1 or that was cancelled on February 18, 2012. During this period of time, patient R.P. reported
2 continuing issues with her son who was a heroin addict, the loss of her home, and that she “has to
3 go to court for another shoplifting charge.” During this period of time, there were other
4 indications of misuse, abuse and/or diversion of controlled substances including, but not limited
5 to, patient R.P.’s multiple requests for specific dangerous drugs and controlled substances,²⁴ a
6 medication log entry for January 16, 2012, indicating that “Klonopin filled early...,” a report on
7 June 25, 2012, that her son “tried to steal meds from her husband,” a report on July 21, 2012, that
8 she “ran out of Abilify/Prozac 6 days ago,” a medication log entry of August 27, 2012, indicating
9 “Adderall Script Stolen,”²⁵ her report of August 18, 2012, that she “doubled her dosage of
10 Adderall which worked well” and a medication log entry of October 15, 2012, indicating “Lost
11 Adderall – Rf (refill) Adderall 20 mg (#120) 1 tab PO (orally) q.i.d.” Moreover, the CURES
12 report for patient R.P. indicates that she continued to receive opiates (morphine sulfate,
13 Oxycontin, and/or oxycodone/APAP) from other physicians during the same time that respondent
14 was prescribing her controlled substances and dangerous drugs. Respondent’s Axis I diagnosis
15 (assessment) during this period of time was documented as Major Depressive Disorder (296.33)
16 and ADHD “Inattentive Type” (314.00). Respondents treatment plan during this period of time
17 included continuing with Adderall XR 30 mg q.i.d. (discontinued on May 12, 2012; and resumed
18 and changed from Adderall XR 25 to Adderall XR 30 mg q.i.d. with an addition of Adderall 5 mg
19 b.i.d.; and changed again to Adderall 20 mg q.i.d. on August 18, 2012), Xanax 2 mg b.i.d. (added
20 on April 7, 2012), Prozac 80 mg q.h.s., Klonopin 2 mg b.i.d. p.r.n. anxiety (discontinued on April
21 7, 2012), and periodic prescriptions and adjustments of Abilify and Concerta.

22 ²⁴ As an example, patient R.P. reported she “does not like current Adderall XR dosage” on
23 January 21, 2012, she reported “Ritalin was not strong enough” on December 6, 2012, she
24 “want[ed] back on Adderall [-] Prefers it over the Ritalin...,” on March 10, 2012, and she “asked
for Xanax over Klonopin” on April 7, 2012.

25 ²⁵ During his interview with an HQUI investigation and Medical Consultant, respondent
26 could not recall whether he asked patient R.P. if she ever filed a police report for the Adderall that
27 she claimed was stolen and he never requested a urine drug screen to determine whether the
28 patient was potentially diverting the Adderall. The FDA’s box warning provides that
“Amphetamines have a high potential for abuse. Administration of amphetamines for prolonged
periods of time may lead to drug dependence. Pay particular attention to the possibility of
subjects obtaining amphetamines for non-therapeutic use or distribution to others and the should
be prescribed or dispensed sparingly...”

1 85. On or about October 26, 2012, patient R.P. was discharged as a patient at A Helping
2 Hand Counseling and as a patient of respondent, listed as the Medical Director. The discharge
3 letter provided, in pertinent part:

4 "Our records show that you have not been compliant with your treatment regime[n].
5 On more than one occasion, you have requested medication refills when you should
6 have had medication remaining. [¶] Your records and your account have been
7 reviewed and, as of today, you are not welcome as a patient of A Helping Hand
8 Counseling or Dr. Paniccia from this date forward.

9 "..."

10 86. Respondent committed gross negligence in his care and treatment of patient R.R.
11 including, but not limited to, the following:

- 12 (a) Respondent repeatedly prescribed excessive amounts of hypnotic
13 sedatives, benzodiazepines and/or amphetamines without any objective
14 and/or justifiable basis for prescribing such amounts of controlled
15 substances; and
16 (b) Respondent repeatedly prescribed controlled substances to patient R.P.
17 without reviewing CURES, without utilizing urine drug screens,
18 without consulting with and/or obtaining records from prior treating
19 physicians and/or without utilizing other risk screening tools.

20 **SECOND CAUSE FOR DISCIPLINE**

21 **(Repeated Negligent Acts)**

22 87. Respond is further subject to disciplinary action under sections 2227 and 2234, as
23 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
24 acts in his care and treatment of patients R.M., K.L.C., R.MA., R.R. and R.P., as more
25 particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which
26 are hereby incorporated by reference and realleged as if fully set forth herein.

27 **THIRD CAUSE FOR DISCIPLINE**

28 **(Repeated Acts of Clearly Excessive Prescribing)**

88. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
defined by section 725, subdivision (a), of the Code, in that he repeatedly prescribed clearly

1 excessive amounts of controlled substances to patients R.M., K.L.C., R.MA., R.R. and R.P., as
2 more particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above,
3 which are hereby incorporated by reference and realleged as if fully set forth herein.

4 **FOURTH CAUSE FOR DISCIPLINE**

5 **(Prescribing Without An Appropriate Examination and Medical Indication)**

6 89. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
7 defined by section 2242, of the Code, in that he repeatedly prescribed various controlled
8 substances to patients R.M., K.L.C., R.MA., R.R. and R.P., without performing an appropriate
9 prior examination and medical indication, as more particularly alleged in paragraphs 11 through
10 29, 32 through 70, and 74 through 86, above, which are hereby incorporated by reference and
11 realleged as if fully set forth herein.

12 **FIFTH CAUSE FOR DISCIPLINE**

13 **(Furnishing Drugs To Addict)**

14 90. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
15 defined by section 2241 of the Code, in that he prescribed controlled substances and dangerous
16 drugs to patients R.M., R.MA., R.R. and R.P. whom he knew or reasonably should have known
17 was an addict and/or was using or would be using the controlled substances and dangerous drugs
18 for a nonmedical purpose, as more particularly alleged in paragraphs 11 through 28, 53 through
19 70, and 74 through 86, above, which are hereby incorporated by reference and realleged as if fully
20 set forth herein.

21 **SIXTH CAUSE FOR DISCIPLINE**

22 **(Failure to Maintain Adequate and Accurate Records)**

23 91. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
24 defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate
25 records regarding her care and treatment of patients R.M., K.L.C., R.MA., R.R. and R.P., as more
26 particularly alleged in paragraphs 11 through 29, 32 through 70, and 74 through 86, above, which
27 are hereby incorporated by reference and realleged as if fully set forth herein.

28 ////

1 **DISCIPLINARY CONSIDERATIONS**

2 92. To determine the degree of discipline, if any, to be imposed on respondent,
3 complainant alleges that an Accusation was filed against respondent on or about September 16,
4 2002, in a prior disciplinary action entitled *In the Matter of the Accusation against: Gregory S.*
5 *Paniccia, M.D.*, Medical Board of California Case No. 10-2001-128852. The aforementioned
6 Accusation alleged that respondent engaged in unprofessional conduct when he improperly
7 prescribed excessive amounts of controlled substances to one patient. On August 25, 2003,
8 respondent's medical license was revoked, the revocation was stayed, and respondent was placed
9 on probation for two (2) years probation, on various terms and conditions, including successful
10 completion of a prescribing course, successful completion of a record keeping course,
11 performance of an additional forty (40) hours of continuing medical education (CME) for each
12 year of probation, a partial restriction on his ability to prescribe controlled substances which
13 prohibited him from prescribing Schedule II, III & IV controlled substances during the length of
14 his probation, a prohibition against practicing pain management medicine, and other standard
15 terms and conditions of probation. That decision is now final and is incorporated by reference as
16 if fully set forth herein.

17 **PRAYER**

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

- 20 1. Revoking or suspending Physician's and Surgeon's Certificate No. G76979, issued to
21 respondent Gregory Sean Paniccia, M.D.;
- 22 2. Revoking, suspending or denying approval of respondent Gregory Sean Paniccia,
23 M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code and
24 advanced nurse practitioners.
- 25 3. Ordering respondent Gregory Sean Paniccia, M.D., if placed on probation, to pay the
26 Board the costs of probation monitoring;
- 27 4. Taking action as authorized by section 822 of the Code as the Board, in its discretion,
28 deems necessary and proper; and

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

DATED: May 1, 2017 *Elizabeth Amaral*

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

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