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

In the Matter of the Accusation/Petition to Revoke Probation Against:	
Victor Delgado Contreras, M.D.	Case No. 800-2022-086562
Physician's and Surgeon's Certificate No. G 52723	
Respondent.	

DECISION

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

This Decision shall become effective at 5:00 p.m. on March 28, 2025.

IT IS SO ORDERED March 26, 2025.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

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

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **VICTOR DELGADO CONTRERAS, M.D.** **126 North 10th Street** **Santa Paula, CA 93060** **Physician's and Surgeon's Certificate No. G 52723,** Respondent.	Case No. 800-2022-086562 OAH No. 2024090931 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. VICTOR DELGADO CONTRERAS, M.D. (Respondent) is represented in this proceeding by attorney Gary Wittenberg, Esq., whose address is: 1901 Avenue of the Stars, Suite 1040, Los Angeles, CA 90067.

3. On or about July 2, 1984, the Board issued Physician's and Surgeon's Certificate No. G 52723 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation/Petition to Revoke Probation No. 800-2022-086562 and will expire on August 31, 2025, unless renewed.

JURISDICTION

4. Accusation/Petition to Revoke Probation No. 800-2022-086562 was filed before the Board and is currently pending against Respondent. The Accusation/Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on August 6, 2024. Respondent timely filed his Notice of Defense contesting the Accusation/Petition to Revoke Probation. A copy of Accusation/Petition to Revoke Probation No. 800-2022-086562 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation/Petition to Revoke Probation No. 800-2022-086562. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation/Petition to Revoke Probation No. 800-2022-086562, agrees that cause exists for

discipline and hereby surrenders his Physician's and Surgeon's Certificate No. G 52723 for the Board's formal acceptance.

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

CONTINGENCY

10. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

11. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G 52723 without further notice to, or opportunity to be heard by, Respondent.

12. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

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

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

ADDITIONAL PROVISIONS

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

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

16. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 52723, issued to Respondent VICTOR DELGADO CONTRERAS, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline

against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order on March 28, 2025.

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation/Petition to Revoke Probation No. 800-2022-086562 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement, in the case of the Accusation/Petition to Revoke Probation No. 800-2022-086562, in the amount of $20,679.25 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation/Petition to Revoke Probation No. 800-2022-086562 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure. Respondent shall pay the Medical Board of California its costs of investigation and enforcement in the case of the Accusation/Petition to Revoke Probation No. 800-2022-086562, in the amount of $20,679.25, prior to issuance of a new or reinstated license by another health care licensing agency.

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ACCEPTANCE

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

DATED: 01-09-2025

VICTOR DELGADO CONTRERAS, M.D.
Respondent

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

DATED: 1/9/24

GARY WITTENBERG, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: January 15, 2025

Respectfully submitted,

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

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation/Petition to Revoke Probation No. 800-2022-086562

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

In the Matter of the Accusation and Petition to Revoke Probation Against: **VICTOR DELGADO CONTRERAS, M.D.** **126 N. 10th St.** **Santa Paula, CA 93060** **Physician's and Surgeon's Certificate No. G 52723,** Respondent.	Case No. 800-2022-086562 **ACCUSATION AND PETITION TO REVOKE PROBATION**

PARTIES

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

2. On or about July 2, 1984, the Board issued Physician's and Surgeon's Certificate No. G 52723 to Victor Delgado Contreras, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2025, unless renewed.

JURISDICTION

3. This Accusation and Petition to Revoke Probation is brought before the Board, under the authority of the following laws and the Board's Decision effective February 20, 2015

(Decision), in the disciplinary action titled *In the Matter of the Accusation Against Victor Delgado Contreras, M.D.*, Board Case No. 04-2012-221998, which revoked Respondent's Physician's and Surgeon's Certificate, but stayed that revocation, and placed Respondent on probation with the Board for a period of ten (10) years with certain terms and conditions. A true and correct copy of the Board's Decision is attached hereto as **Exhibit A** and is incorporated herein by reference as if fully set forth herein. All section references are the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

STATUTORY PROVISIONS

5. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a

separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

(d) Incompetence.

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

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

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board no later than 30 calendar days after being notified by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

(h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

(i) Dissuading, intimidating, or tampering with a patient, witness, or any person in an attempt to prevent them from reporting or testifying about a licensee.

6. Unprofessional conduct under Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2236 of the Code states:

(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

(b) The district attorney, city attorney, or other prosecuting agency shall notify the Division of Medical Quality of the pendency of an action against a licensee charging a felony or misdemeanor immediately upon obtaining information that the defendant is a licensee. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee, and the clerk

shall record prominently in the file that the defendant holds a license as a physician and surgeon.

(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the board. The division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

8. Section 2236.1 of the Code states:

(a) A physician and surgeon's certificate shall be suspended automatically during any time that the holder of the certificate is incarcerated after conviction of a felony, regardless of whether the conviction has been appealed. The Division of Medical Quality shall, immediately upon receipt of the certified copy of the record of conviction, determine whether the certificate of the physician and surgeon has been automatically suspended by virtue of the physician and surgeon's incarceration, and if so, the duration of that suspension. The division shall notify the physician and surgeon of the license suspension and of the right to elect to have the issue of penalty heard as provided in this section.

(b) Upon receipt of the certified copy of the record of conviction, if after a hearing it is determined therefrom that the felony of which the licensee was convicted was substantially related to the qualifications, functions, or duties of a physician and surgeon, the Division of Medical Quality shall suspend the license until the time for appeal has elapsed, if an appeal has not been taken, or until the judgment of conviction has been affirmed on appeal or has otherwise become final, and until further order of the division. The issue of substantial relationship shall be heard by an administrative law judge from the Medical Quality Hearing Panel sitting alone or with a panel of the division, in the discretion of the division.

(c) Notwithstanding subdivision (b), a conviction of any crime referred to in Section 2237, or a conviction of Section 187, 261, 288, or former Section 262, of the Penal Code, shall be conclusively presumed to be substantially related to the qualifications, functions, or duties of a physician and surgeon and a hearing shall not be held on this issue. Upon its own motion or for good cause shown, the division may decline to impose or may set aside the suspension when it appears to be in the interest of justice to do so, with due regard to maintaining the integrity of and confidence in the medical profession.

(d) (1) Discipline may be ordered in accordance with Section 2227, or the Division of Licensing may order the denial of the license when the time for appeal has elapsed, the judgment of conviction has been affirmed on appeal, or an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw the plea of guilty and to enter a plea of not guilty, setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

(2) The issue of penalty shall be heard by an administrative law judge from the Medical Quality Hearing Panel sitting alone or with a panel of the division, in the

discretion of the division. The hearing shall not be had until the judgment of conviction has become final or, irrespective of a subsequent order under Section 1203.4 of the Penal Code, an order granting probation has been made suspending the imposition of sentence; except that a licensee may, at the licensee's option, elect to have the issue of penalty decided before those time periods have elapsed. Where the licensee so elects, the issue of penalty shall be heard in the manner described in this section at the hearing to determine whether the conviction was substantially related to the qualifications, functions, or duties of a physician and surgeon. If the conviction of a licensee who has made this election is overturned on appeal, any discipline ordered pursuant to this section shall automatically cease. This subdivision does not prohibit the division from pursuing disciplinary action based on any cause other than the overturned conviction.

(e) The record of the proceedings resulting in the conviction, including a transcript of the testimony therein, may be received in evidence.

(f) The other provisions of this article setting forth a procedure for the suspension or revocation of a physician and surgeon's certificate shall not apply to proceedings conducted pursuant to this section.

REGULATIONS

9. California Code of Regulations, title 16, section 1360, states:

(a) For the purposes of denial, suspension or revocation of a license pursuant to Section 141 or Division 1.5 (commencing with Section 475) of the code, a crime, professional misconduct, or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license if to a substantial degree it evidences present or potential unfitness of a person holding a license to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such crimes, professional misconduct, or acts shall include but not be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of state or federal law governing the applicant's or licensee's professional practice.

(b) In making the substantial relationship determination required under subdivision (a) for a crime, the board shall consider the following criteria:

(1) The nature and gravity of the crime;

(2) The number of years elapsed since the date of the crime; and

(3) The nature and duties of the profession.

COST RECOVERY

10. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the

investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

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

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

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

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Conviction of a Crime)

11. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2236, of the Code, in that he has been convicted of a crime substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged hereinafter.

12. The facts and circumstances surrounding the crime are as follows:

A. At times relevant to this Accusation, the Medicare program was a federal health care benefit program, affecting commerce, that provided benefits to individuals who were 65 years and older or disabled. Medicare was administered by the Centers for Medicare and Medicaid Services ("CMS"), a federal agency under the United States Department of Health and Human Services. Medicare is a "health care benefit program" as defined by Title 18, United States Code, Section 24(b).

B. To qualify for reimbursement for hospice services, Medicare required a physician to certify that a beneficiary was terminally ill. A beneficiary was considered to be "terminally ill" if the beneficiary's life expectancy was six months or less if the beneficiary's illness ran its normal course. Hospice services reimbursed by Medicare were palliative in nature and included, but were not limited to, medications to manage pain symptoms, necessary medical equipment, and bereavement services to surviving family members.

C. Respondent was a physician licensed in the state of California with a practice in Santa Paula, California. Between in or around July 2016 and in or around February 2019, Respondent worked for Arcadia Hospice Provider, Inc. ("Arcadia") and Saint Mariam Hospice, Inc. ("St. Mariam"), both controlled by J.A. and both located in Pasadena, California. During that period, Respondent knowingly and willfully participated in a scheme to obtain money from Medicare by means of material false or fraudulent pretenses, representations, or promises with J.A. and others. At the time of his employment with Arcadia and St. Mariam, Respondent was on probation with the Board and, as a result, was subject to certain restrictions.

D. In particular, at the direction of Arcadia and St. Mariam employees,

Respondent would purport to evaluate and/or certify/recertify patients for hospice enrollment with Arcadia and St. Mariam. In doing so, Respondent would typically be provided with a patient's information and a diagnosis for the patient by Arcadia or St. Mariam employees. These patients were almost always patients for whom Respondent was not the primary care physician, and Respondent did not contact the patients' primary care physicians to discuss the patients' conditions or terminal prognoses. Respondent typically used the patient diagnosis that Arcadia and St. Mariam employees provided in documenting a history and physical ("H&P") for the patient and/or a certification/recertification of terminal illness. In doing so, Respondent, acting with reckless indifference as to the truth or falsity of his statements, falsely stated and certified/recertified that the patients had terminal illnesses that made them eligible for hospice. Respondent knew and intended that (1) Medicare would rely on the fact that Respondent, as a licensed physician, had determined the patients' hospice eligibility and (2) those H&Ps and certifications/recertifications would enable Arcadia and St. Mariam to submit false and fraudulent claims to Medicare for hospice services purportedly provided to those patients. Pursuant to the scheme, Respondent's evaluations and certifications/recertifications led to the submission of a total of approximately $2,301,914.68 in false claims by Arcadia and approximately $1,616,032.25 in false claims by St. Mariam, for a total of approximately $3,917,946.93 in false claims submitted, on which claims a total of $3,289,889.13 was paid ($1,902,009.92 to Arcadia and $1,387,879.21 to St. Mariam).

E. Pursuant to the scheme and in order to execute it, in Los Angeles County, Respondent aided and abetted J.A. and others in the submission by Arcadia of a false claim to Medicare on or about July 3, 2017, in the amount of approximately $7,697.84 for purported hospice care provided to beneficiary O.B.

13. On or about February 15, 2022, in the matter of *United States of America v. Victor Delgado Contreras*, United States District Court, Central District of California case number 2:22-cr-00043-AB-2, Respondent was charged with Health Care Fraud, in violation of 18 U.S.C. § 1347, including that on or about August 1, 2017, Respondent, together with J.A., aiding and abetting each other, knowingly and willfully executed and willfully caused the execution of the

fraudulent scheme described above by submitting and causing to be submitted to Medicare a false and fraudulent claim for payment of hospice services relating to Arcadia, in the amount of $7,697.84, with O.B. as the beneficiary (Count Five of the criminal complaint).

14. On or about July 24, 2024, in the matter of *United States of America v. Victor Delgado Contreras*, United States District Court, Central District of California case number 2:22-cr-00043-AB-2, following a plea of guilty, Respondent was convicted of one count of Health Care Fraud, in violation of 18 U.S.C. § 1347 (Count Five of the criminal complaint).

SECOND CAUSE FOR DISCIPLINE

(Dishonest and/or Corrupt Acts)

15. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 52723 to disciplinary action under sections 2227 and 2234, subdivision (e) of the Code, in that he has engaged in dishonest and/or corrupt acts substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged in the First Cause for Discipline above, which is hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

16. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 52723 to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in the First Cause for Discipline above, which is hereby incorporated by reference and realleged as if fully set forth herein.

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FIRST CAUSE TO REVOKE PROBATION

(Obey All Laws)

17. At all times after the effective date of the Board's Decision, Probation Condition No. 11 stated:

> 11. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

18. At all times after the effective date of the Board's Decision, Probation Condition No. 17 stated:

> 17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

19. Respondent's probation is subject to revocation because he failed to comply with Probation Condition No. 11, in that he failed to obey all federal, state and local laws, as more particularly alleged in the First Cause for Discipline above, which is hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking the probation that was granted by the Medical Board of California in Case No. 800-2012-221998, and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. G 52723 issued to Respondent Victor Delgado Contreras, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate No. G 52723, issued to Respondent Victor Delgado Contreras, M.D.;

3. Revoking, suspending or denying approval of Respondent Victor Delgado Contreras, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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

5. Ordering Respondent Victor Delgado Contreras, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and,

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

DATED: AUG 0 6 2024

Jenna Jones for
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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

In the Matter of the Accusation Against:	)	
VICTOR DELGADO CONTRERAS, M.D.	)	Case No. 04-2012-221998
Physician's and Surgeon's Certificate No. G52723	)	
Respondent	)	

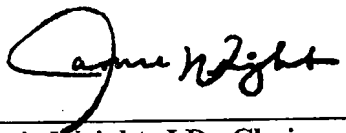
DECISION

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

This Decision shall become effective at 5:00 p.m. on February 20, 2015.

IT IS SO ORDERED: January 23, 2015.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the Accusation Against: **VICTOR DELGADO CONTRERAS, M.D.** **126 North 10th Street** **San Paula, CA 93060** **Physician's and Surgeon's Certificate No. G52723,** Respondent.	Case No. 04-2012-221998 OAH No. 2014030657 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Edward Kim, Deputy Attorney General.

2. Respondent VICTOR CONTRERAS, M.D. ("Respondent") is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about July 2, 1984, the Medical Board of California issued Physician's and Surgeon's Certificate No. G52723 to VICTOR CONTRERAS, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the

charges brought in Accusation No. 04-2012-221998 and will expire on August 31, 2015, unless renewed.

JURISDICTION

4. Accusation No. 04-2012-221998 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 11, 2014. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 04-2012-221998 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in Accusation No. 04-2012-221998. Respondent has also carefully read, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent admits the truth of each and every charge and allegation set forth in the Fourth and Seventh Causes for Discipline in Accusation No. 04-2012-221998. In addition, Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the remaining charges and allegations contained in Accusation No. 04-2012-221998, except for the Tenth Cause for Discipline, and that he has thereby subjected

his license to disciplinary action. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations, except for the Tenth Cause for Discipline, contained in Accusation No. 04-2012-221998 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent hereby gives up his right to contest the charges in the Accusation.

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

CONTINGENCY

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

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

///

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G52723 issued to Respondent VICTOR CONTRERAS, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for ten (10) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act (provided that this exception shall be in effect if and only if the United States Drug Enforcement Agency issues a new DEA registration to Respondent or reinstates Respondent's DEA registration with respect to controlled substances).

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

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

In the event that Respondent receives a new DEA registration or Respondent's DEA registration is reinstated, Respondent shall immediately surrender such DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of such new DEA registration or reinstatement, Respondent shall submit proof that Respondent has surrendered Respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

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

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

Notwithstanding anything to the contrary contained herein, Respondent shall only be required to abide by this term and condition number 2 in the event that he has a valid DEA registration.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this

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

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

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

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

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

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

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

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in

addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

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

at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

8. PROHIBITED PRACTICE. During probation, Respondent is prohibited from practicing, performing, or treating patient in the area of pain management, including without

limitation, any pharmacological approaches to prevent, reduce, or stop pain sensations in a patient (hereinafter collectively referred to as "Pain Management Practice"). After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from the Pain Management Practice. Any new patients must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

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

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

10. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

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

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been

compliance with all the conditions of probation.

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

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

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

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be

available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the

Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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

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

ACCEPTANCE

I have carefully read the Stipulated Settlement and Disciplinary Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into

this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/23/14

VICTOR CONTRERAS, M.D.
Respondent

ENDORSEMENT

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

Dated: 12/24/14

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 04-2012-221998

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

In the Matter of the Accusation Against: **VICTOR DELGADO CONTRERAS, M.D.** **126 North 10th Street** **Santa Paula, CA 93060** **Physician's and Surgeon's Certificate No. G52723,** Respondent.	Case No. 04-2012-221998 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 2, 1984, the Board issued Physician's and Surgeon's Certificate Number G52723 to Victor Delgado Contreras, M.D. (Respondent). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2015, unless renewed.

JURISDICTION

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

indicated.

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

5. Section 2234 of the Code states:

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

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of [Chapter 5 of the Medical Practice Act].

"(b) Gross negligence.

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

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

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including without limitation, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not

apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. Section 2261 of the Code states: AKnowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

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

8. Section 725 of the Code states:

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

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

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

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section

for treating intractable pain in compliance with Section 2241.5. "

9. Section 2241 of the Code states:

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

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

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

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

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

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

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

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

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

2241.5.

10. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

11. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

12. Section 2305 of the Code states:

The revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter [Chapter 5, the Medical Practice Act] shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

13. Section 11190 of the Health and Safety Code states:

"(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

(1) The name and address of the patient.

(2) The date.

(3) The character, including the name and strength, and quantity of controlled substances involved.

(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(C) NDC (National Drug Code) number of the controlled substance dispensed.

(D) Quantity of the controlled substance dispensed.

(E) ICD-9 (diagnosis code), if available.

(F) Number of refills ordered.

(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(H) Date of origin of the prescription.

(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

(d) This section shall become operative on January 1, 2005.

(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005."

14. Section 4170 of the Code states, in pertinent part:

"(a) No prescriber shall dispense drugs or dangerous devices to patients in his or her office

or place of practice unless all of the following conditions are met:

"(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

"(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

"(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

"(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

"(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

"(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

"(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

". . ."

15. Section 4076 of the Code states, in pertinent part:

"(a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

"(1) Except where the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section

3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either Section 4052.1 or 4052.2 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

"(2) The directions for the use of the drug.

"(3) The name of the patient or patients.

"(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either Section 4052.1 or 4052.2.

"(5) The date of issue.

"(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

"(7) The strength of the drug or drugs dispensed.

"(8) The quantity of the drug or drugs dispensed.

"(9) The expiration date of the effectiveness of the drug dispensed.

"(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription."

". . ."

16. Section 827, subdivision (a)(1), of Title 21 of the United States Code states, in part:

"(a) Inventory

Except as provided in subsection (c) of this section

"(1) every registrant under this subchapter shall, on May 1, 1971, or as soon thereafter as such registrant first engages in the manufacture, distribution, or dispensing of controlled

substances, and every second year thereafter, make a complete and accurate record of all stocks thereof on hand, except that the regulations prescribed under this section shall permit each such biennial inventory (following the initial inventory required by this paragraph) to be prepared on such registrant's regular general physical inventory date (if any) which is nearest to and does not vary by more than six months from the biennial date that would otherwise apply; . . ."

17. Section 827, subdivision (a)(3), of Title 21 of the United States Code states, in part:

"(3) on and after May 1, 1971, every registrant under this subchapter manufacturing, distributing, or dispensing a controlled substance or substances shall maintain, on a current basis, a complete and accurate record of each such substance manufactured, received, sold, delivered, or otherwise disposed of by him, except that this paragraph shall not require the maintenance of a perpetual inventory."

PERTINENT DRUGS

18. (a) **Adderall** is an amphetamine, and is defined in Health and Safety Code section 11055, subdivision (d)(1), as a Schedule II controlled substance. It is generally used to treat attention deficit hyperactivity disorder, but also has a high potential for abuse. It is a dangerous drug as defined in Business and Professions Code section 4022.

(b) **Benzodiazepines** are a class of drugs that produce central nervous system (CNS) depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), clonazepam (e.g., Klonopin), diazepam (e.g., Valium), and temazepam (e.g., Restoril) are the five most prescribed, as well as the most frequently encountered benzodiazepines on the illicit market. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses.

(c) **Clonazepam** is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is also sold under the brand name Klonopin. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a

dangerous drug as defined in Business and Professions Code section 4022.

(d) **Cocaine** is illegal to possess under California Health and Safety Code section 11350.

(e) **Diazepam** is a benzodiazepine drug commonly used to relieve anxiety, muscle spasms, and seizures and to control agitation caused by alcohol withdrawal. Valium is a brand name for a form of diazepam. It is a Schedule IV controlled substance as defined in Health and Safety Code section 11057, subdivision (d)(9), and it is a dangerous drug as defined in Business and Professions Code section 4022.

(f) **Fentanyl** is a potent, synthetic narcotic opioid analgesic with a rapid onset and short duration of action. It is sold under several brand names, including Sublimaze, Actiq, Durogesic, Duragesic, Fentora, Matrifen, Haldid, Onsolis, Instanyl, Abstral and Lazand. Duragesic and Durogesic are trade names of fentanyl transdermal patches. The patches release fentanyl, a potent opioid, slowly through the skin. One patch may provide an extended period of pain relief. Duragesic patches are often prescribed with another opioid (such as morphine sulfate) to handle breakthrough pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug pursuant to Business and Professions Code section 4022.

(g) **Hydrocodone** is a semisynthetic opioid analgesic similar to but more active than codeine; it is used as the bitartrate salt or polistirex complex, as an oral analgesic and antitussive. It is marketed, in its varying forms, under a number of brand names, including Vicodin, Hycodan (or generically Hydromet), Lorcet, Lortab, Norco, and Hydrokon, among others. Hydrocodone also has a high potential for abuse. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I), and a dangerous drug pursuant to Business and Professions Code section 4022.

(h) **Hydromorphone** is an opioid pain medication used to treat moderate to severe pain. It has been marketed, in its varying forms, under a number of brand names, including Dilaudid. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug pursuant to Business and

Professions Code section 4022.

(i) **Methadone** is an opiate (narcotic) analgesic that is used in the treatment of opioid dependence to prevent withdrawal symptoms in patients who were addicted to opiate drugs. It can also be used to relieve moderate to severe pain that has not been relieved by non-narcotic pain relievers. It is defined as a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14), and a dangerous drug pursuant to Business and Professions Code section 4022.

(j) **Norco** is a brand name for acetaminophen (paracetamol) and hydrocodone. Acetaminophen is a widely used over-the-counter analgesic (pain reliever) and antipyretic (fever reducer), which is commonly used for the relief of headaches, other minor aches and pains, and is a major ingredient in numerous cold and flu remedies. In combination with opioid analgesics, acetaminophen can also be used in the management of more severe pain such as post surgical pain and providing palliative care in advanced cancer patients. Acute overdoses of acetaminophen can cause potentially fatal liver damage and, in rare individuals, a normal dose can do the same; the risk is heightened by alcohol consumption. It is sold in varying forms, including under the brand name Tylenol. Acetaminophen comes in combination with other medications, including hydrocodone.

(k) **Opana** is a brand name for oxymorphone hydrochloride. Oxymorphone is in a group of drugs called narcotic pain relievers. It is similar to morphine. Oxymorphone is used to treat moderate to severe pain. The extended-release form of this medication is for around-the-clock treatment of pain. Oxymorphone is not for treating pain just after surgery unless the patient was already taking oxymorphone before the surgery.

(l) **Oxycodone** is an opioid analgesic medication synthesized from thebaine. It is a semi-synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is generally used as an analgesic, but it also has a high potential for abuse. Repeated administration of oxycodone may result in psychic and physical dependence. Oxycodone is commonly prescribed for moderate to severe chronic pain. It is sold in its various forms under several brand names, including OxyContin (a time-release formula). Oxycodone is

also available in combination with acetaminophen (Endocet, Percocet, Roxicet, Tylox, etc.); aspirin (Endodan, Percodan, Roxiprin, etc.); and ibuprofen (Combunox). It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as defined in Business and Professions Code section 4022.

(m) **Roxicet** is brand name for a drug that contains a combination of acetaminophen and oxycodone.

(n) **Roxicodone** is a brand name for oxycodone hydrochloride, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. The usual adult dose is one 5 mg tablet every 6 hours as needed for pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1), and a dangerous drug pursuant to Business and Professions code section 4022. It is also a Schedule II controlled substance as defined by the Code of Federal Regulations Title 21, section 1308, 12(b)(1).

(o) **Soma** is a trade name for carisoprodol. It is a muscle-relaxant and sedative. It is dangerous drug as defined in Business and Professions Code section 4022.

(p) **Suboxone** is a drug used to treat opiate addiction that contains buprenorphine and naloxone. Buprenorphine is an opioid medication that is similar to other opioids such as morphine, codeine, and heroin, however, it produces less euphoric effects and therefore may be easier to stop taking. Naloxone blocks the effects of opioids such as morphine, codeine, and heroin.

(q) **Subutex** is a formulation of buprenorphine, which is used to treat opioid dependence.

(r) **Xanax** is a brand name for alprazolam, which is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. It is a dangerous drug as defined in Business and Professions code section 4022, and a schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d). Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous

ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent is subject to disciplinary action under section 2234, subdivisions (b), of the Code in that Respondent was grossly negligent in connection with the care and treatment of patients. The circumstances are as follows:

DEA Investigation and Search Warrant

20. On or about, December 15, 2011, the U.S. Drug Enforcement Agency (DEA) contacted the Board about its investigation into allegations that Respondent was overprescribing controlled substances, based upon the arrest of a female employee of Respondent who claimed that he was providing drugs to patients in exchange for sex. Thereafter, a search on CURES [1] showed that during a twelve month period, Respondent had prescribed 3,500 prescriptions for controlled substances, including[2] large quantities of oxycodone, methadone and Vicodin.

21. On or about April 11, 2012, the DEA executed a search warrant at Respondent's office, located at 600 W. Main Street, Santa Paula, California, for patient records and pharmaceuticals. During the exhaustive search of Respondent's office, the DEA seized records of patients, including the records of patients[3] C.J., G.S., N.A., T.A., L.A., R.B., and A.L. and over

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[1] The California Department of Justice, Bureau of Narcotics Enforcement maintains the California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II and III controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from all Schedule II and III controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of Schedule II and III drugs. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice. CURES contains over 100 million entries of controlled substance drugs that were dispensed in California.

[2] All references to the word "including," used herein shall be references to the phrase, "including, without limitation."

[3] All patients are referred to herein by their initials to protect their privacy. The full names of all patients will be disclosed to Respondent upon a timely request for discovery. In addition, anytime the (continued...)

100 DEA 222 receipts dated between 2009 and 2012. The investigators also found no orderly procedure for storing and maintaining a drug log, in connection with controlled substances and DEA 222 receipts. Two of Respondent's sons, who were employees of Respondent at his office, were interviewed in a back office room that contained a twin bed, patient files, a sink and cabinets with expired medications. Respondent's sons explained that about 25% of Respondents' patients paid him in cash, and up to 30% of the pharmacists want to speak to him for clarification about his diagnosis on the prescriptions. They also explained to the investigator that Respondent treated patients with Suboxone and that Respondent lived with his fiancé, C.J.

22. Later that day on or about April 11, 2012, during the DEA search, Respondent was asked about a safe in his office. He opened the safe and a patient chart for C.J. was seized. When questioned about the location of his DEA 222 receipts (a controlled substance order form that must be completed for controlled substance purchases and must be retained by the purchaser for a period of time (see Title 21 of the Code of Federal Regulations, 1300 et. seq.), Respondent answered that he was not sure. He then went to the back office room with the bed, and pulled the bed from the wall and opened the bottom drawer, which contained loose receipts that were folded, crumbled and not in any order. Respondent then explained that while he did not keep a log for controlled substances, he indicated in a patient's chart when he provides controlled substances.

Respondent's 2012 Interview

23. On or about April 11, 2012, the DEA and Board interviewed Respondent. He explained that his practice comprised seeing 15 patients per day, including Workers' Compensation and pain management patients. Regarding his residence, Respondent first provided his sons' address. However, after being confronted about his sons' claim that that he was living with his fiancé, Respondent said that he was living at the clinic part-time, and that he was planning to move in with his sons.

24. Regarding new pain patients, Respondent said he focuses on three areas. First, he establishes what issue the patient wants to have addressed by his doctor visit. Second, he

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word "including" is used in this document, it shall mean, "including, but not limited to."

determines what kind of work-up the patient had previously, and requires the patient to bring prior records to him. And third, he evaluates as currently as possible what the nature of the illness or injury is, what treatments have been tried and worked, and asks if they are employed or disabled. Respondent also claimed to run CURES reports on nearly all of his patients when possible, but did not always print the reports.

25. According the Respondent, the principles of pain management are to ensure the patient achieves three goals. First, whether the amount of medication is effectively managing the pain. Second, whether the patient is able to function better. And third, Respondent desires to receive feedback from family members. Respondent said he talks to family members to find out how the patient is functioning. However, he does not always indicate in the patient's chart if he has talked to the family. Respondent also explained that drug testing is ordered once or twice a year, and the results are placed in the patient files. Respondent also explained how he interacts with new patients. He said he initially takes the history of the current condition and asks the patient to substantiate his claims. He then asks what the patient has already tried.

26. Regarding prescribing large quantities of controlled substances, Respondent said, "The end justifies the means." When questioned specifically about a patient receiving 1,080 oxycodone at a time, Respondent said, it is a "dynamic process moving forward. The intent is to try to pursue rotating medications." Respondent also explained that he does not use a pain scale, but he may verbally ask a patient to rate the pain between 0-10. The response is not always entered in the chart.

27. Regarding the ordering of controlled substances, Respondent said that he is not familiar with the rules and regulations for ordering controlled substances. He explained that he wrote prescriptions for the office and had them filled at a pharmacy. He stated that he did not label the medication, or put patient names on the medications given to patients at the office. He stated that he dispensed Alprazolam to patients in small quantities and indicated that in the patient's chart. He also explained that he sold prescriptions to patients for cash, but did not keep a controlled substance log.

28. Regarding the DEA 222 receipts that were located, Respondent explained that they

were are all for controlled substances given solely to C.J. He had been providing her with controlled substances (oxycodone, methadone, and Fentanyl patches) for ten years. According to Respondent, he did not keep a log for these drugs because the medications were not kept in the office long enough. He also admitted that he did not do a bi-annual inventory of his pharmaceuticals. He further said C.J. was not an addict. When asked if she was diverting the controlled substances, he said he directly observed her using all the medications herself. Respondent said, "her health plan only covers so much." She had extensive consultations prior to her being treated by him. He did not need to refer her to other doctors. He explained that her chart was kept in the safe because she worked at the office. He explained that she did billing and her work schedule varied. When asked how long they have lived together, Respondent said he did not know how long they had been together. Respondent also stated that he had never had sex with C.J. and only rented a room from her.

Respondent's DEA Certificate.

29. On or about May 8, 2012, Respondent's DEA registration AC2755746 was surrendered for cause and retired from the DEA computer system.

Respondent's January 2013 Interview

30. On or about January 10, 2013, the Board interviewed Respondent. During the interview, Respondent explained that his patient C.J. was also a former employee of his office who assisted with medical billing and administrative duties, who had not worked in his office for about nine months. He also explained that although he had never received any formal training in pain management, ten percent of his practice in April of 2012 comprised pain management. He also stated that he both wrote prescriptions and dispensed medicine at his medical office, including such medications as Suboxone (as part of his addiction medicine practice), Demerol, fentanyl patches, hydrocodone, and Oxycodone. Respondent further explained that he used DEA 222 forms to obtain controlled substances from pharmacies and he would bring them back to his office to be dispensed.

31. Regarding prescribing large amounts of opiates to opiate-tolerant patients, Respondent explained that there was no plateau, meaning that there was never a point when

providing more medication did not provide a beneficial relief, i.e., there was no ceiling for such drugs. He stated that, "It doesn't matter how much they're on, if you bump it up, you're gonna get more pain relief." In other words, according to Respondent, there was no dose-response curve for opiates. According to Respondent, increasing opiate dosages does not increase the risk of respiratory depression. Regarding methadone, Respondent stated he did not have any concerns with respect to its effect on the endocrine system of patients.

32. Respondent also explained that he provided urine drug test screens in his office and that the results were reviewed by him. He never sent out urine drug tests to toxicology labs. He further stated that he documented the results of his in-office urine screens in the patient charts.

33. Respondent also explained that he brought additional records to the interview that he found for some patients that were not included among the records that the DEA confiscated during the execution of the search warrant on or about April 11, 2012.

Respondent's "Discovered" Additional Records.

34. Following January 10, 2013, Respondent provided additional medical records to the Board for patients C.J., L.A., R.B., and A.L. (New Records). Among those New Records was a page from R.B.'s medical records that included two progress notes dated February 16, 2012 (written on the top portion) and March 2, 2012 (written on the bottom portion), respectively. This page was in contrast to the corresponding page in the records (Original Records) that were seized from Respondent's office by the DEA during the execution of the search warrant on or about April 11, 2012. Among the records for R.B. that were seized by the DEA at that time was a page that only included the chart note dated February 16, 2012, and wherein the bottom half of the page was blank.

Respondent's October 2013 Interview.

35. On or about October 23, 2013, the Board interviewed Respondent again regarding the additional records. During that interview, Respondent explained that the reason for the additional pages contained in the New Records was because he had found a "dummy chart." According to the Respondent, all of his patient records were kept in his medical office. He also stated that he usually kept them in a central location. However, a "dummy chart" was sometimes created to

document a patient's progress, when the original chart could not be located due to the fact that the original record sometimes might be used in another area of the office, e.g., for billing purposes. When asked about the additional notation for March 2, 2012, that was not present on the page that contained the note for February 16, 2012 in the Original Records, Respondent did not have an explanation.

Gross Negligence; Drug Laws.

36. During the relevant time periods herein, Respondent acquired, prescribed and dispensed medications to patients, C.J., G.S., N.A., T.A., L.A., R.B. and A.L., including, controlled substances from his office. Under federal law, Respondent was also required to maintain, on a current basis, a complete and accurate record of each such drug received, sold, delivered, or otherwise disposed of by him. (21 U.S.C. 827(a)(3).) With respect to Respondent's dispensing, federal regulations require that the records include the number of units or volume of such finished form dispensed, the name and address of the person to whom it was dispensed, the date of dispensing, the number of units or volume dispensed and the written or typewritten name or initials of the individual who dispensed the substance on behalf of the dispenser. (21 CFR 1304.22(c); see also id.; 21 CFR 1304.03(a)-(b), 1304.04(a) (g), 1304.21, 1304.22(c).) However, during his interview with the DEA and the Board, Respondent admitted that he was not familiar with the rules and regulations for ordering controlled substances, and that he did not label the drugs, or put patient names or directions on the drugs given to patients at the office. Respondent did not keep adequate records of all transactions involving those controlled substances. He also admitted that did not keep a controlled substance log for the drugs he dispensed to his patients. Indeed, although Respondent had purchased and dispensed large quantities of controlled substances throughout his care for C.J., he had no dispensing logs for this patient. He also failed to keep his DEA 222 receipts in an orderly manner.[4] Such conduct represents gross negligence

[4] Respondent was also required to maintain, for a period of two years, records documenting the receipt of all controlled substances he acquired, as well as an initial inventory when he first engaged in controlled substances activities and biennial inventories thereafter for each controlled substance he acquired. 21 CFR. 1304.04(a), 1304.11, 1304.21(a).

and a lack of knowledge.

Patient C.J.

37. Respondent saw patient, C.J., a 32-year-old-woman, in or around January 2000 and continued to treat her through in or around April 2012. His initial chart notes for this patient failed to include a detailed evaluation of her pain or any discussion of the risks or benefits of the medications. At his January 2013 interview, Respondent explained that C.J. was a "unique case" due to her "intractable migraine headache syndrome," severe degenerative disk disease, and lupus. According to Respondent, she fell within the population of pain patients with pain that represented only two percent of the chronic pain patients. He said that given C.J.'s debilitating pain, he focused on attempting to improve her functionality. He said further that he could write a book on her because his doses for her were the highest he ever prescribed to anyone. He stated that her fentanyl would be in excess of 1000 mg per hour. During his treatment and care for C.J., Respondent prescribed and directly disbursed, a very large amount of controlled substances to her. When asked about the large amount of medications she was receiving, Respondent referred to the fact that C.J. was in fact "still alive and breathing," as justification. He further stated, "I stand by all the dosages that I gave [C.J.] . . . the proof is, she's not dead." However, Respondent's medical records for C.J. failed to contain any detailed evaluation of her pain or discussion of the risks and benefits of Respondent prescribing large amount of medications to her. With respect to the DEA 222 forms that were obtained during the DEA search of Respondent's office, he acknowledged that they were for C.J. He also claimed that he was sure she did not divert any drugs because he directly observed her using them. Respondent also claimed that he would have known if she was an addict or diverting drugs, because it would have become apparent to him because C.J. would "slip up." Respondent also could not explain why his sons believed he was engaged to C.J.; he said that he was a "very private man." He also changed his previous statement made at his 2012 interview and explained that he did not rent a room from C.J., but instead was "house sitting" for her.

38. The Original Records for C.J. included progress notes from January 2000 through 2003, and for the dates of November 23, 2010, December 24, 2010, January 17, 2011, February 3,

2011, and February 21, 2011. The New Records for C.J. included additional progress notes for the following visits: November 11, 2011, December 15, 2011, January 20, 2012, February 2, 2012 and March 27, 2012.

39. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, C.J. filled the following prescriptions for Fentanyl and oxycodone at P. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
5/19/11	Oxycodone	Tablet	30	300	N 20002
5/19/11	Fentanyl	Patch	100	45	N 20001
6/6/11	Oxycodone	Tablet	30	300	N 20008
6/6/11	Fentanyl	Patch	100	45	N 20007
6/23/11	Oxycodone	Tablet	30	300	N 20013
6/23/11	Fentanyl	Patch	100	45	N 20012
7/11/11	Oxycodone	Tablet	30	330	N 20017
7/11/11	Fentanyl	Patch	100	45	N 20016
7/28/11	Oxycodone	Tablet	30	330	N 20025
7/28/11	Fentanyl	Patch	100	45	N 20024
7/28/11	Promethazine	Tablet	25	60	6000377
8/15/11	Fentanyl	Patch	100	45	N 20037
8/15/11	Oxycodone	Tablet	30	330	N 20038
9/1/11	Fentanyl	Patch	100	45	N 20070
9/19/11	Oxycodone	Tablet	30	330	N 20071
10/7/11	Fentanyl	Patch	100	45	N 20092
10/7/11	Oxycodone	Tablet	30	330	N 20093
10/25/11	Fentanyl	Patch	100	45	N 20114
10/25/11	Oxycodone	Tablet	30	330	N 20115

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
11/11/11	Fentanyl	Patch	100	45	N 20143
11/11/11	Oxycodone	Tablet	30	360	N 20144
11/28/11	Fentanyl	Patch	100	45	N 20164
11/28/11	Oxycodone	Tablet	30	330	N 20165
12/15/11	Fentanyl	Patch	100	45	N 20196
12/15/11	Oxycodone	Tablet	30	360	N 20197
1/3/12	Oxycodone	Tablet	30	360	N 20229
1/3/12	Fentanyl	Patch	100	45	N 20228
1/20/12	Oxycodone	Tablet	30	360	N 20275
1/20/12	Fentanyl	Patch	100	45	N 20274
2/6/12	Oxycodone	Tablet	30	360	N 20322
2/6/12	Fentanyl	Patch	100	45	N 20321
2/6/12	Ondansetron	Tablet	8	20	6003219
2/23/12	Fentanyl	Patch	100	45	N 20355
2/23/12	Oxycodone	Tablet	30	360	N 20356
3/12/12	Fentanyl	Patch	100	45	N 20396
3/12/12	Promethazine	Tablet	25	120	6003711
3/12/12	Oxycodone	Tablet	30	360	N 20397
3/28/12	Fentanyl	Patch	100	45	N 20426
3/27/12	Oxycodone	Tablet	30	360	N 20427

b. On or about each of the following dates, C.J. filled the following prescriptions for Fentanyl and oxycodone at S. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
3/11/11	Oxycodone hcl	Tablet	30	100	N423613
3/11/11	Fentanyl	Patch	100	15	N423612

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/7/11	Oxycodone hcl	Tablet	30	100	N426707
4/7/11	Fentanyl	Patch	100	15	N426706
4/21/11	Oxycodone hcl	Tablet	30	100	N428334
4/21/11	Fentanyl	Patch	100	15	N428335
5/27/11	Fentanyl	Patch	100	20	N432416
7/8/11	Fentanyl	Patch	100	10	N436735
7/8/11	Hydrocodone-apap	Tablet	10-325	100	C436736

c. On or about each of the following dates, C.J. filled the following prescriptions for Methadone, Fentanyl and oxycodone at H.C. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
10/3/09	Methadone HCL	Tablet	10	600	859118
12/2/09	Fentanyl	Patch	100	10	866077
2/13/10	Fentanyl	Patch	75	10	874350
2/24/10	Fentanyl	Patch	75	15	875592
2/11/11	Fentanyl	Patch	100	10	914042
4/12/11	Fentanyl	Patch	100	10	920535
4/29/11	Fentanyl	Patch	100	10	922553
5/12/11	Fentanyl	Patch	100	15	923988
5/12/11	Oxycodone hcl	Tablet	30	100	923989
6/1/11	Fentanyl	Patch	100	15	926048
6/1/11	Oxycodone hcl	Tablet	30	200	926049
6/20/11	Fentanyl	Patch	100	10	928500
7/2/11	Hydrocodone-Apap	Tablet	10-325	100	930098
7/2/11	Fentanyl	Patch	100	15	930097

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
7/22/11	Fentanyl	Patch	100	15	932711
8/8/11	Fentanyl	Patch	100	10	934712
8/30/11	Fentanyl	Patch	100	15	937595
9/15/11	Fentanyl	Patch	100	20	939893
9/26/11	Fentanyl	Patch	100	20	941317
10/25/11	Fentanyl	Patch	100	20	945376
11/14/11	Fentanyl	Patch	100	20	948047
12/1/11	Fentanyl	Patch	100	20	950382
12/1/11	Methadone hcl	Tablet	10	200	950383
12/19/11	Fentanyl	Patch	100	20	952663
12/31/11	Fentanyl	Patch	100	20	954309
1/16/12	Fentanyl	Patch	100	20	956242
2/6/12	Fentanyl	Patch	100	20	959275
2/25/12	Fentanyl	Patch	100	20	961916
3/7/12	Fentanyl	Patch	100	20	963538
3/19/12	Fentanyl	Patch	100	20	965054
4/3/12	Fentanyl	Patch	100	20	967066

d. On or about each of the following dates, C.J. filled the following prescriptions at CV. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/12/10	Acyclovir	Tablet	800	50	0140132
4/13/10	Butalb-Apap-Caff	Tablet	50-325-40	100	0140248
9/4/10	Azithromycin	Tablet	250	10	0157373
7/15/11	Phentermine	Tablet	37.5	30	C0196842

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
9/3/11	Promethazine-Codeine	Syrup		360 mls	C0202803
9/3/11	Phentermine	Tablet	37.5	30	C0202809
10/10/11	Hydrocodone-Acetominophen	Tablet	10-325	100	C0207368
10/21/11	Promethazine	Tablet	50	60	0208888
10/21/11	Promethazine	Suppository	25	12	0208897
10/21/11	Tizanidine HCl.	Tablet	4	30	0208875
11/1/11	Phentermine	Tablet	37.5	30	C0210186
11/10/11	Hydrocodone-Acetominophen	Tablet	10-325	100	C0211487
11/14/11	Zanaflex	Capsule	4	30	0211937
12/19/11	Phentermine	Tablet	37.5	30	C0216475
12/31/11	Phentermine	Tablet	37.5	30	C0218156
12/31/11	Ondansetrol HCL	Tablet	8	20	0218157
1/13/12	Acyclovir	Tablet	800	50	0219942
1/13/12	Hydrocodone-Acetominophen	Tablet	10-325	100	C0219943
1/19/12	Benazepril HCL	Tablet	20	30	0220920
2/7/12	Azithromycin	Tablet	250	6	0223639
2/7/12	Butal-Asa-Caff	Capsule		100	C0223641
2/7/12	Levetiracetam	Tablet	500	60	0223640
3/22/12	Butal-Asa-Caff	Capsule		100	C0229912
3/22/12	Ondansetron ODT	Tablet	8	30	0229914
3/22/12	Levetiracetam	Tablet	500	60	0229913
3/23/12	Metolazone	Tablet	5	30	0230178
3/30/12	Neo-Bacit-Poly-HC	Ointment		3.5	0231006

40. Respondent's records for C.J. include a pain assessment, dated February 6, 2002 and one documented urine toxicology screening, dated November 23, 2010. However, Respondent's notes fail to include a detailed pain evaluation; there is no focused history, physical exam, or diagnostic work up. Respondent's records for C.J. frequently fail to provide adequate details, including the findings from any physical examination.

41. Respondent wrote many prescriptions for controlled substances for C.J. without corresponding progress notes. For example, Respondent's records include copies of prescriptions for C.J. beginning in or around May 2007 through in or around March 5, 2010, for fentanyl or Duragesic patches and MS Contin without corresponding progress notes.

42. Although Respondent's records also include laboratory reports and radiology reports from in and around 2006 through in and around 2007, no corresponding office visit notes referencing these lab results and discussions of them with the patient exist.

43. On several occasions, patient C.J. filled prescriptions written by Respondent at different pharmacies for unusually large quantities of medications. For example, on or about May 19, 2011, C.J. filled a prescription for fentanyl, 100 mcg/hr (45 patches) at P. Pharmacy. Thereafter, she returned to P. Pharmacy on an approximate bi-weekly basis to fill other prescriptions for the same amount and strength of fentanyl patches. In addition, on or about May 27, 2011, C.J. filled a prescription for fentanyl, 100 mcg/hr (20 patches) at S. Pharmacy. On or about each of the following date, C.J. also received, from H.C. Pharmacy, fentanyl, 100 mcg/hr (15 patches): May 12, 2011, June 1, 2011, June 20, 2011, July 2, 2011 and July 22, 2011. C.J. continued to obtain prescriptions from Respondent and had them filled at P., S. and H.C. pharmacies for large quantities of fentanyl patches. During this time period, C.J. obtained an amount of fentanyl patches that exceeded the normal dosage. And, these were in addition to the fentanyl patches Respondent admitted to dispensing to C.J. directly from him office.

44. Respondent also prescribed oxycodone to C.J. in large amounts that she filled at multiple pharmacies. C.J. filled prescriptions for 30 mg of oxycodone, on or about each of the following dates: April 21, 2011, at S. Pharmacy (100 pills); May 19, 2011, at P. Pharmacy (300 pills); and May 12, 2011, at H.C. Pharmacy (100 pills). This exceeds the normal dosage.

45. The following conduct, acts and/or omissions of Respondent, with regard to patient C.J., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including large amounts of oxycodone and/or Fentanyl patches per month;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Patient G.S.

46. Respondent initially saw G.S., a 28-year-old man suffering from chronic pain syndrome involving his low back on or about May 18, 2004. According to Respondent, G.S. had a history of falling out of a second story window and landing on his head. G.S. suffered spine trauma and chronic pain. G.S. had been on Soma and Valium.

47. The next visit with Respondent does not occur until on or about February 6, 2009,

when G.S. was 33 years old, and presented with a normal physical exam. He diagnosed G.S. with "traumatic brain injury and chronic myofascial syndrome." On that day, Respondent prescribed to G.S., Soma, 350 mg (90 pills) and Valium 10 mg (70 pills), prn anxiety. However, Respondent's records did not include a diagnosis of anxiety for G.S. Furthermore, Respondent failed to document any discussion of other treatment alternatives offered or the risks and benefits of taking these possibly addicting medications in a patient with a history of addiction. Given G.S.'s history of traumatic brain injury, the possible side effects of these drugs should have been discussed and considered at subsequent visits.

48. Many of Respondent's subsequent progress notes were very sparse through May, 2009. A note, dated September 2, 2009, showed a positive urine screen for "oxy" with a note advising the patient stop using "oxy + Amphet + Alcohol" and to get a sponsor. However, Respondent did not advise G.S. to stop using Soma and Valium despite these notations. During this time period, Respondent continued to prescribe controlled substances to Respondent (including several prescriptions for diazepam (70 tablets each on a monthly basis) that were filled in 2010) and continued to see G.S. sporadically until on or about November 4, 2010.

49. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, G.S. filled the following prescriptions for Diazepam and Carisoprodol:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
2/6/09	Diazepam	Tablet	10	70	105484
2/6/09	Carisoprodol	Tablet	350	90	105483
3/5/09	Carisoprodol	Tablet	350	90	107858
3/5/09	Diazepam	Tablet	10	70	107860
4/1/09	Carisoprodol	Tablet	350	90	110088
4/1/09	Diazepam	Tablet	10	70	110089
5/6/09	Carisoprodol	Tablet	350	90	113036
5/6/09	Diazepam	Tablet	10	70	113037

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
6/4/09	Carisoprodol	Tablet	350	90	115442
6/4/09	Diazepam	Tablet	10	70	115443
7/10/09	Carisoprodol	Tablet	350	90	118175
7/10/09	Diazepam	Tablet	10	70	118174
9/2/09	Diazepam	Tablet	10	70	121961
9/2/09	Carisoprodol	Tablet	350	90	121960
10/1/09	Diazepam	Tablet	10	70	124236
10/1/09	Carisoprodol	Tablet	350	90	124235
11/4/09	Diazepam	Tablet	10	70	127310
12/3/09	Carisoprodol	Tablet	350	90	130039
12/3/09	Diazepam	Tablet	10	70	130040
2/15/10	Carisoprodol	Tablet	350	90	136440
2/15/10	Diazepam	Tablet	10	70	136441
3/24/10	Diazepam	Tablet	10	70	140162
3/24/10	Carisoprodol	Tablet	350	90	140161
4/20/10	Diazepam	Tablet	10	70	142599
4/20/10	Carisoprodol	Tablet	350	90	142600
5/21/10	Diazepam	Tablet	10	70	145298
5/21/10	Carisoprodol	Tablet	350	90	145297
6/25/10	Diazepam	Tablet	10	70	148248
6/25/10	Carisoprodol	Tablet	350	90	148247
7/19/10	Carisoprodol	Tablet	350	90	149981
7/19/10	Diazepam	Tablet	10	70	149982
8/20/10	Diazepam	Tablet	10	70	152576
8/20/10	Carisoprodol	Tablet	350	90	152575

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
9/23/10	Diazepam	Tablet	10	70	155331
9/23/10	Carisoprodol	Tablet	350	90	155330

50. During his January 2013 interview, Respondent explained that G.S. had a history of addiction and was drug tested by Respondent. G.S. had also once been incarcerated and was monitored by his probation officer. He had a history of relapse, but had a sponsor and was going to 12 step meetings. G.S. was "torn between his drug-using girlfriend" taking her back or thwarting her. He also could not recall if he ran any CURES reports, or the number of drug screens he gave G.S.

51. Respondents' medical records for G.S. failed to document a proper evaluation and assessment of the patient, including regarding his diagnosis of migraine headaches and myofascial pain syndrome. They also failed to include a discussion of alternative treatments such as physical therapy or counseling. Respondent also stated during his January 2013 interview that G.S. suffered from anxiety the entire time he was treating him. Respondent further explained that he did not refer the patient to a psychologist because he was already seeing a therapist. However, he failed to coordinate care with any other healthcare providers and failed to reassess over time whether G.S.' medications were still needed, or whether they should have been adjusted over an 18 month period of time. Also, although Respondent stated that G.S. was in a drug treatment program where he was being treated and had to do drug tests, his records failed to adequately document this pertinent information. Respondent also failed to enter into an adequate pain contract with G.S. Respondent saw G.S. on or about November 4, 2010, and prescribed 70 pills of Valium (diazepam) to him on that day. On or about November 10, 2010, G.S. died and the cause of death listed was methadone and diazepam intoxication.

52. The following conduct, acts and/or omissions of Respondent, with regard to patient G.S., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's

disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including in large amounts;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Patient N.A.

53. Respondent began treating N.A. on or about March 17, 2010, with a history of chronic pain syndrome (low back and left wrist), multi-joint osteoarthritis and opiate dependence (Methadone, Norco and Soma use). She was referred to Respondent by her husband. In addition, she had hypertension, hyperlipidemia, and she was treated with Lisinopril, Lipitor and Prevacid. Respondent diagnosed her with chronic pain syndrome, lumbar disc disease with radiculopathy, and associated muscle spasms. His plan included prescriptions for Methadone, 10 mg (24 pills), and Soma, 350 mg (120 pills). His records for N.A. included a chronic pain questionnaire, and a pain management agreement, each dated March 17, 2010. Respondent continued to treat N.A. for her pain and chronic conditions until on or about January 10, 2012 (a period of nearly two years). However, his records for this patient failed to include any discussion of other treatment

alternatives.[5] During his January 2013 interview, he stated that he did try alternatives and did not refer her to psychological counseling or therapy because of her financial limitations.

54. Beginning on or about March 17, 2010, Respondent continued N.A.'s prescriptions for Methadone and Soma. During the time period Respondent treated N.A., his prescribing went on to include, Roxicodone, 30 mg (60 pills, Q6H); Methadone[6] 10 mg (360 pills, three times a day; Soma, 350 mg (90 pills, one three times a day); and Ativan, 1 mg (30 pills, one daily). N.A. had been receiving Soma (120 pills each month) until on or about February 10, 2011, when the Soma was reduced to 90 pills per month. He also began prescribing benzodiazepines concomitantly with oxycodone and methadone, which increased the risk of overdose. Respondent records do not adequately explain his rationale for prescribing these medications to the patient.

55. Respondent also treated N.A. for hypertension. He continued to refill her medications for Lisinopril beginning on or about March 17, 2010, until on or about January 10, 2012. On or about March 17, 2010, N.A.'s blood pressure was 160/100. However, Respondent failed to adequately document and/or treat this elevated blood pressure. Similarly on or about May 14, 2010, N.A.'s blood pressure was 160/100. Respondent increased her Lisinopril mediation at that time from 5 mg to 10 mg. On or about June 10, 2010, N.A.'s blood pressure was 160/90. However, Respondent failed to adequately document and/or treat this condition. The next visit where N.A.'s blood pressure was checked was July 30, 2010. At this time, the patient's blood pressure was 140/86. However, Respondent did not have a plan to address this. High blood pressures were documented on or about each of the following dates: October 19, 2010 (150/100) and November 1, 2012 (150/100). Some notes simply state "VSS" and no blood pressure was documented at all (August 2, 2010, April 5, 2011, Mary 2, 2011, June 29, 2011, July 28, 2011), without any mention of the medication or treatment plan.

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[5] Respondent stated during his January 2013 interview that she had tried the standard non-steroidal anti-inflammatories for her osteoarthritis, but they "weren't touching it."

[6] Respondent stated during his January 2013 interview that Methadone was a great medication for relieving chronic pain.

56. Respondent also treated N.A. for hyperlipidemia. Throughout the time Respondent treated N.A., he continued to refill her prescription for Lipitor, 40 mg. However, he failed to order any blood tests or obtain any copies of any test results for cholesterol for N.A. He did not follow up with the patient regarding possible side effects (myalgia) in a patient with chronic pain.

57. On or about December 7, 2010, Respondent ordered a neurosurgery consult. At that time, a further workup was ordered and a final recommendation was pending. Although a progress note dated May 2, 2011, stated, "follow through with neurosurgery," Respondent failed to address the final recommendations from the specialist. Further, a report indicated that the patient's symptoms did not correlate to the MRI findings.

58. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, N.A. filled the following prescriptions at F.E.:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
1/18/2012	Methadone HCL	Tablet	10	360	201830
2/17/2012	Metolazone	Tablet	5	60	205470
2/17/2012	Oxycodone HCL	Tablet	30	60	205469
2/17/2012	Methadone HCL	Tablet	10	360	205465
2/17/2012	Carisoprodol	Tablet	350	90	205466
2/17/2012	Lorazepam	Tablet	1	30	205467
3/16/2012	Oxycodone HCL	Tablet	30	60	208642
3/16/2012	Methadone HCL	Tablet	10	360	208643
4/16/2012	Methadone HCL	Tablet	10	300	211882
4/16/2012	Carisoprodol	Tablet	350	90	211881
4/16/2012	Lorazepam	Tablet	1	30	211880
4/16/2012	Oxycodone HCL	Tablet	30	60	211884

b. On or about each of the following dates, N.A. filled the following prescriptions

at R. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
3/17/10	Methadone	Tablet	10	240	754797
3/17/10	Carisoprodol	Tablet	350	120	754798
4/16/10	Methadone	Tablet	10	240	756590
4/16/10	Carisoprodol	Tablet	350	120	756591
4/16/10	Qualaquin	Capsule	324	30	756649
5/14/10	Methadone	Tablet	10	240	758124
5/14/10	Carisoprodol	Tablet	350	120	758125
6/10/10	Methadone	Tablet	10	240	759646
6/10/10	Carisoprodol	Tablet	350	120	759647
7/6/10	Methadone	Tablet	10	360	760960
7/6/10	Carisoprodol	Tablet	350	120	760962
7/6/10	Lorazepam	Tablet	1	30	760963
7/30/10	Oxycodone	Tablet	30	60	762377
8/2/10	Methadone	Tablet	10	240	762417
8/2/10	Lorazepam	Tablet	1	30	762419
8/2/10	Methadone	Tablet	10	120	762421
8/26/10	Methadone	Tablet	10	240	763692
8/26/10	Methadone	Tablet	10	120	763693
8/26/10	Lorazepam	Tablet	1	30	763695
8/26/10	Oxycodone	Tablet	30	60	763696
9/22/10	Oxycodone	Tablet	30	60	765182
9/22/10	Methadone	Tablet	10	360	765183
9/22/10	Lorazepam	Tablet	1	30	765185
10/19/10	Methadone	Tablet	10	360	766821

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
10/19/10	Lorazepam	Tablet	1	30	766823
10/19/10	Carisoprodol	Tablet	350	120	766822
10/19/10	Oxycodone	Tablet	30	30	766824
11/16/10	Oxycodone	Tablet	30	60	768323
11/16/10	Methadone	Tablet	10	360	768324
11/16/10	Carisoprodol	Tablet	350	120	768325
11/16/10	Lorazepam	Tablet	1	30	768326
12/10/10	Oxycodone	Tablet	30	60	769762
12/10/10	Methadone	Tablet	10	360	769763
12/10/10	Lorazepam	Tablet	1	30	769765
12/10/10	Carisoprodol	Tablet	350	120	769764
1/12/11	Lorazepam	Tablet	1	30	771668
1/12/11	Carisoprodol	Tablet	350	120	771667
1/12/11	Oxycodone	Tablet	30	60	771669
1/12/11	Methadone	Tablet	10	360	771666
2/10/11	Methadone	Tablet	10	360	773514
2/10/11	Carisoprodol	Tablet	350	90	773515
2/10/11	Lorazepam	Tablet	1	30	773516
2/10/11	Oxycodone	Tablet	30	60	773517
2/10/11	Lisinopril	Tablet	10	30	773518
3/3/11	Lorazepam	Tablet	1	30	774766
3/3/11	Carisoprodol	Tablet	350	90	774761
3/3/11	Methadone	Tablet	10	360	774760
3/3/11	Oxycodone	Tablet	30	60	774764
4/5/11	Oxycodone	Tablet	30	60	776567

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/5/11	Fluoxetine	Capsule	20	30	776568
4/5/11	Methadone	Tablet	10	360	776564
4/5/11	Carisoprodol	Tablet	350	90	776565
4/5/11	Lorazepam	Tablet	1	30	776566
5/2/11	Oxycodone	Tablet	30	60	777982
5/2/11	Methadone	Tablet	10	360	777983
5/2/11	Lorazepam	Tablet	1	30	777985
5/2/11	Carisoprodol	Tablet	350	90	777984
6/2/11	Lorazepam	Tablet	1	30	779783
6/2/11	Carisoprodol	Tablet	350	90	779782
6/2/11	Methadone	Tablet	10	360	779781
6/2/11	Oxycodone	Tablet	30	60	779784
6/29/11	Methadone	Tablet	10	360	781268
6/29/11	Carisoprodol	Tablet	350	90	781269
6/29/11	Lorazepam	Tablet	1	30	781270
6/29/11	Oxycodone	Tablet	30	60	781267
7/28/11	Methadone	Tablet	10	360	783012
7/28/11	Lorazepam	Tablet	1	30	783014
7/28/11	Carisoprodol	Tablet	350	90	783013
7/28/11	Oxycodone	Tablet	30	60	783015
9/1/11	Carisoprodol	Tablet	350	90	785156
9/1/11	Methadone	Tablet	10	360	785155
9/1/11	Lorazepam	Tablet	1	30	785157
9/1/11	Oxycodone	Tablet	30	60	785159
9/30/11	Carisoprodol	Tablet	350	90	786986

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
9/30/11	Lorazepam	Tablet	1	30	786987
9/30/11	Methadone	Tablet	10	360	786985
9/30/11	Oxycodone	Tablet	30	60	786984
10/28/11	Lorazepam	Tablet	1	30	788772
10/28/11	Carisoprodol	Tablet	350	90	788771
10/28/11	Methadone	Tablet	10	360	788770
10/28/11	Oxycodone hcl	Tablet	30	60	788769
11/23/11	Oxycodone	Tablet	30	60	790458
11/23/11	Methadone	Tablet	10	360	790454
11/23/11	Carisoprodol	Tablet	350	90	790455
11/23/11	Lorazepam	Tablet	1	30	790456
12/23/11	Lorazepam	Tablet	1	30	792437
12/23/11	Carisoprodol	Tablet	350	90	792436
12/23/11	Methadone	Tablet	10	360	792435
12/23/11	Oxycodone hcl	Tablet	30	60	792438
12/23/11	Lisinopril	Tablet	10	30	792439
1/18/12	Oxycodone hcl	Tablet	30	60	793838
1/18/12	Carisoprodol	Tablet	350	90	793837
1/18/12	Lorazepam	Tablet	1	30	793839

59. The following conduct, acts and/or omissions of Respondent, with regard to patient N.A., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including in large amounts;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Patient T.A.

60. Patient T.A. was the former male spouse of patient N.A. He was first seen by Respondent on or about October 11, 2004, in connection with a certification for the Department of Motor Vehicles. He had a history of Hepatitis C, high blood pressure, and had been employed in manual physical labor for some time. According to Respondent, the patient had "failed back syndrome," i.e., multiple back surgeries to no avail. He also had limited financial resources.

61. On or about July 20, 2006, Respondent saw T.A., and prescribed Methadone, 40 mg, (360 pills) to him for his "chronic pain syndrome." However, Respondent failed to document and/or perform a physical examination for T.A. His records failed to include any vital signs or discussion of other alternatives for treating pain. Thereafter, Respondent continued to inadequately treat the patient and/or document his care.

62. A progress note dated August 10, 2007, merely states "urine drug screen negative." However, Respondent failed to maintain in his records, a copy of the corresponding lab report. There is also no discussion about why it was negative, given that the patient was receiving

Methadone. Although other drugs screens for this patient were noted to be positive for "MTD," Respondent's records failed to include the corresponding lab reports. His records also failed to include any CURES reports or pain management plans.

63. On or about January 4, 2008, Respondent prescribed Methadone, 10 mg (1440 pills) to T.A. This supply would be equivalent to approximately 48 pills per day for a total of 480 mg daily, an excessive dose. This is significant given Methadone's half-life of approximately 30 hours (and increases the risk for overdose.) Respondent continued to prescribe a large quantity of Methadone to T.A. on a regular basis through in or around April 2012. In addition, Respondent also prescribed oxycodone, lorazepam and carisoprodol on regular basis during that same time period.

64. In light of T.A.'s hepatitis C, he was at risk for a compromised liver and should have received a lower Methadone dose. However, Respondent failed to adequately evaluate and monitor, through testing, T.A.'s liver function. During a period of several years, Respondent only measured the patient's transaminases two times – on or about May 29, 2007, and June 8, 2010.

65. During his interview with the DEA on or about April 4, 2012, Respondent was asked to review the chart for patient T.A. and to explain what his understanding of methadone was according to the Physician's Desk Reference (PDR). Respondent said a dosage would be three or four times daily for a patient on 10 mg. T.A. was receiving 400 mg of methadone per day when he was treated by Respondent, and Respondent explained that the patient came to him on a high dose for "failed back syndrome." The investigator pointed out to Respondent that the methadone dosage went progressively higher over time. Respondent said he titrates for the optimum level of functioning. He goes by what the patient tells him and attempts to contact the previous physician. Respondent stated that he does not use methadone for addiction treatment.

66. There are two different progress notes with the same date for November 16, 2006, and December 12, 2006. It cannot be determined which date is correct.

67. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, T.A. filled the following prescriptions at R. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
1/5/10	Methadone	Tablet	10	1440	750316
2/4/10	Methadone	Tablet	10	1440	752235
3/3/10	Methadone	Tablet	10	1440	753848
4/5/10	Methadone	Tablet	10	1440	755848
5/3/10	Methadone	Tablet	10	1440	757394
6/2/10	Methadone	Tablet	10	1440	759094
7/6/10	Methadone	Tablet	10	1440	760957
7/30/10	Methadone	Tablet	10	1440	762363
8/30/10	Methadone	Tablet	10	1440	763862
8/30/10	Metolazone	Tablet	5	30	763863
10/4/10	Methadone	Tablet	10	1440	765790
11/2/10	Methadone	Tablet	10	1440	767517
11/29/10	Methadone	Tablet	10	1440	768861
1/4/11	Methadone	Tablet	10	1440	771060
2/1/11	Methadone	Tablet	10	1440	772880
2/25/11	Methadone	Tablet	10	1440	774371
3/29/11	Methadone	Tablet	10	1440	776138
4/27/11	Methadone	Tablet	10	1440	777773
5/26/11	Methadone	Tablet	10	1440	779459
6/27/11	Methadone	Tablet	10	1440	781110
7/25/11	Methadone	Tablet	10	1440	782743
8/24/11	Methadone	Tablet	10	1440	784595
9/22/11	Methadone	Tablet	10	1440	786446
10/21/11	Methadone	Tablet	10	1440	788341
10/21/11	Metolazone	Tablet	5	60	788342
11/21/11	Methadone	Tablet	10	1440	790192

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
12/19/11	Methadone	Tablet	10	1440	792018
1/16/12	Methadone	Tablet	10	1440	793695
2/16/12	Methadone	Tablet	10	1440	795835
3/12/12	Methadone	Tablet	10	1440	797476
4/12/12	Methadone	Tablet	10	1200	799468
4/12/12	Morphine Sulfate e SR	Tablet	15	120	799469

68. The following conduct, acts and/or omissions of Respondent, with regard to patient T.A., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including methadone;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Patient L.A.

69. Respondent first began seeing L.A. in or around February 1998 for "social stressors." His note, dated February 11, 1998, states that he "discussed tapering pain med," but failed to list the medication. On or about January 27, 1999, Respondent prepared a very brief note that stated, "Rx Vicodin for sinus h/a." Neither of these initial two progress notes included a history, physical or treatment plan. Respondent continued to treat L.A. over several years, and prescribed medications, including narcotics, to L.A. for migraine headaches. Respondent's first pain assessment form was completed on or about April 16, 2001, two years into his treatment of L.A. A pain management agreement is dated May 10, 2001. In or around 2001 through 2002, Respondent attempted to manage L.A.'s pain with narcotic medication, with increasing dosage amounts; however, he fails to refer her to a pain management specialist or a neurologist. On or about June 24, 2004, Respondent prescribed 120 Actiq, 800 mg, and 30 Duragesic patches because she was going out of town on vacation, and had anxieties about traveling. He later increased the dose of Actiq to 1600 mg, on or about July 8, 2004, and stated at his January 2013 Interview that this was due to her possibly developing tolerance. He further added, that with "longer-term patients who are already opiate-tolerant," they will not overdose and not stop breathing. And, he stated that, provided a doctor is responsible, he could use whatever quantity of medication needed.

70. For several years prior and through in or around 2011, Respondent continued to treat L.A., a woman with migraine headaches. During the time, Respondent treated L.A., he prescribed controlled substances in escalating strength and quantity without adequate physical examinations and assessments of the patient. He also continued to fail to refer her to specialists or address treatment alternatives. His records during that time period also failed to include pain evaluations, contracts or CURES reports. Respondent also provided additional medications to this patient due to varying excuses such as increased stress, losing medication or other minor pains. However, Respondent failed to recognize that the patient's pattern of an increasing need of

more medication was consistent with addiction.

71. On or about July 27, 2006, Respondent prescribed Actiq, 600 mcg (60 pills) and Methadone 40 mg (180 tablets) to L.A. On or about October 23, 2008, Respondent increased L.A.'s prescription to Actiq 600 mcg (60 pills) and Methadone 80 mg TID (written as 10 mg, 720 pills).

72. In addition to using Duragesic, Actiq and Methadone, L.A. also received regular prescriptions for Norco 10/325. However, Respondent's records did not include adequate corresponding records. Furthermore, his records failed to document possible risks or side effects from simultaneously taking Duragesic, Norco and Methadone.

73. Although Respondent admitted during his January 2013 Interview that he had no formal pain management training, and that he trained himself, he stated that in his experience, a referral to a neurologist is not helpful and would not have helped L.A. He also admitted that CT and MRI scans of L.A.'s brain were normal, and her eyes appeared normal on examination as well. Additionally, he stated that he failed to document his drug screens of the patient. He also provided BuSpar and Wellbutrin to the patient for anxiety, but failed to document whether L.A. was seeing a therapist. Instead, Respondent treated her as a family practice physician.

74. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, L.A. filled the following prescriptions at P. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
1/4/08	Methadone	Tablet	40	100	N285150
1/4/08	Methadone	Tablet	40	10	N285152
1/7/08	Fentanyl OT	Lozenge	1200	30	N285374
1/29/08	Methadone HCL	Tablet	10	100	N288237
1/29/08	Methadone HCL	Tablet	10	620	N288238
2/20/08	Azithromycin	Tablet	250	6	291224
3/5/08	Methadone HCL	Tablet	10	100	N293101

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
3/5/08	Methadone HCL	Tablet	10	620	N293103
4/11/08	Methadone HCL	Tablet	10	100	N297797
4/11/08	Methadone HCL	Tablet	10	620	N297801
4/11/08	Amoxicillin	Capsule	500	21	297798
6/2/08	Methadone HCL	Tablet	10	100	N303989
6/2/08	Methadone HCL	Tablet	10	620	N303988
7/16/08	Methadone HCL	Tablet	10	620	N308938
7/16/08	Methadone HCL	Tablet	10	100	N308937
9/2/08	Methadone HCL	Tablet	10	100	N314118
9/2/08	Methadone HCL	Tablet	10	620	N314119
10/29/08	Methadone HCL	Tablet	10	100	N320722
10/29/08	Methadone HCL	Tablet	10	620	N320724
11/13/08	Penicillin VK	Tablet	500	28	322475
12/29/08	Methadone HCL	Tablet	10	620	N327633
12/29/08	Methadone HCL	Tablet	10	100	N327632
1/29/09	Hydromorphone	Tablet	8	30	N331469
2/17/09	Methadone HCL	Tablet	10	100	N334094
2/17/09	Methadone HCL	Tablet	10	620	N334095
4/4/09	Methadone HCL	Tablet	10	100	N340272
4/4/09	Methadone HCL	Tablet	10	620	N340273
5/23/09	Methadone HCL	Tablet	10	720	N346341
7/11/09	Methadone HCL	Tablet	10	600	N352106
8/14/09	Methadone HCL	Tablet	10	600	N355896
9/28/09	Methadone HCL	Tablet	10	600	N360775
10/7/09	Hydrocodone-Apap	Tablet	10-325	20	C361957

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
10/7/09	Azithromycin	Tablet	250	6	361959
10/16/09	Hydrocodone-Apap	Tablet	10-325	20	C363193
10/26/09	Hydrocodone-Apap	Tablet	10-325	20	C364248
11/6/09	Hydrocodone-Apap	Tablet	10-325	30	C365965
11/6/09	Methadone HCL	Tablet	10	600	N365966
11/12/09	Hydrocodone-Apap	Tablet	10-325	30	C366789
11/19/09	Hydrocodone-Apap	Tablet	10-325	30	C367673
12/01/09	Hydrocodone-Apap	Tablet	10-325	30	C368926
12/8/09	Hydrocodone-Apap	Tablet	10-325	30	C369817
12/10/09	Methadone HCL	Tablet	10	600	N370131
12/16/09	Hydrocodone-Apap	Tablet	10-325	30	C370745
12/30/09	Hydrocodone-Apap	Tablet	10-325	30	C372203
1/5/10	Hydrocodone-Apap	Tablet	10-325	30	C372817
1/19/10	Hydrocodone-Apap	Tablet	10-325	30	C374396
1/23/10	Methadone HCL	Tablet	10	600	N375000
1/30/10	Hydrocodone-Apap	Tablet	10-325	30	C375833
2/12/10	Hydrocodone-Apap	Tablet	10-325	30	C377745
2/19/10	Hydrocodone-Apap	Tablet	10-325	30	C378631
3/1/10	Hydrocodone-Apap	Tablet	10-325	30	C379689
3/4/10	Methadone HCL	Tablet	10	600	N380355
3/11/10	Hydrocodone-Apap	Tablet	10-325	30	C381189

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
3/22/10	Hydrocodone-Apap	Tablet	10-325	30	C382251
4/9/10	Hydrocodone-Apap	Tablet	10-325	30	C384626
4/12/10	Methadone HCL	Tablet	10	600	N384778
4/21/10	Penicillin VK	Tablet	500	28	385913
4/26/10	Hydrocodone-Apap	Tablet	10-325	30	C386404
5/11/10	Methadone HCL	Tablet	10	600	N388203
5/11/10	Ferrous Sulfate	Tablet	325	90	388204
5/17/10	Hydrocodone-Apap	Tablet	10-325	30	C388830
5/17/10	Penicillin VK	Tablet	500	28	388831
5/28/10	Hydrocodone-Apap	Tablet	10-325	30	C390224
6/7/10	Methadone	Tablet	10	600	N391213
6/25/10	Hydrocodone-Apap	Tablet	10-325	30	C393307
7/2/10	Penicillin VK	Tablet	500	28	394136
7/2/10	Methadone HCL	Tablet	10	600	N394137
7/9/10	Phentermine	Tablet	37.5	30	C394859
7/30/10	Penicillin VK	Tablet	500	28	397084
7/30/10	Hydrocodone-Apap	Tablet	10-325	30	C397085
8/2/10	Methadone HCL	Tablet	10	600	N397339
8/26/10	Methadone HCL	Tablet	10	600	N400057
9/9/10	Phentermine	Tablet	37.5	30	C401435
9/9/10	Hydrocodone-Apap	Tablet	10-325	30	C401436
9/23/10	Penicillin VK	Tablet	500	28	403170
9/27/10	Methadone	Tablet	10	720	N403588

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
10/5/10	Hydrocodone-Apap	Tablet	10-325	30	C404483
10/11/10	Hydrocodone-Apap	Tablet	10-325	30	C405183
10/19/10	Hydrocodone-Apap	Tablet	10-325	30	C406102
10/19/10	Penicillin VK	Tablet	500	28	406027
10/26/10	Hydrocodone-Apap	Tablet	10-325	30	C406812
10/26/10	Methadone HCL	Tablet	10	720	N406925
11/9/10	Hydrocodone-Apap	Tablet	10-325	30	C408452
11/9/10	Phentermine	Tablet	37.5	30	C408454
12/6/10	Methadone HCL	Tablet	10	720	N411784
12/14/10	Phentermine	Tablet	37.5	30	C412880
12/14/10	Hydrocodone-Apap	Tablet	10-325	30	C412881
1/6/11	Hydrocodone-Apap	Tablet	10-325	30	C415544
1/12/11	Methadone HCL	Tablet	10	720	N416347
1/19/11	Penicillin VK	Tablet	500	28	417155
1/20/11	Hydrocodone-Apap	Tablet	10-325	30	C417317
1/27/11	Phentermine	Tablet	37.5	30	C418178
2/7/11	Hydrocodone-Apap	Tablet	10-325	30	C419385
2/17/11	Penicillin VK	Tablet	500	28	420832
2/18/11	Hydrocodone-Apap	Tablet	10-325	30	C420904
2/18/11	Methadone HCL	Tablet	10	720	N420921
2/28/11	Phentermine	Tablet	37.5	30	C421875
2/28/11	Hydrocodone-Apap	Tablet	10-325	30	C421876

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
3/7/11	Penicillin VK	Tablet	500	28	422901
3/14/11	Hydrocodone-Apap	Tablet	10-325	30	C423809
3/14/11	Penicillin VK	Tablet	500	28	423849
3/19/11	Methadone	Tablet	10	720	N424543
3/29/11	Phentermine	Tablet	37.5	30	C425490
3/29/11	Hydrocodone-Apap	Tablet	10-325	30	C425491
4/8/11	Hydrocodone-Apap	Tablet	10-325	30	C426855
4/22/11	Hydrocodone-Apap	Tablet	10-325	30	C428441
4/28/11	Methadone HCL	Tablet	10	720	N429119
4/29/11	Phentermine	Tablet	37.5	30	C429235
4/29/11	Hydrocodone-Apap	Tablet	10-325	30	C429233
5/6/11	Hydrocodone-Apap	Tablet	10-325	30	C430155
5/19/11	Hydrocodone-Apap	Tablet	10-325	30	C431523
5/26/11	Hydrocodone-Apap	Tablet	10-325	30	C432185
6/2/11	Hydrocodone-Apap	Tablet	10-325	30	C432834
6/2/11	Methadone	Tablet	10	720	N432900
6/8/11	Hydrocodone-Apap	Tablet	10-325	30	C433576
6/20/11	Hydrocodone-Apap	Tablet	10-325	30	C434848
6/24/11	Phentermine	Tablet	37.5	30	C435267
7/5/11	Hydrocodone-Apap	Tablet	10-325	30	C436278
7/11/11	Methadone HCL	Tablet	10	720	N437036
7/20/11	Hydrocodone-Apap	Tablet	10-325	30	C438095

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
8/1/11	Hydrocodone-Apap	Tablet	10-325	30	C439318
8/1/11	Phentermine	Tablet	37.5	30	C439330
8/10/11	Hydrocodone-Apap	Tablet	10-325	30	C440400
8/18/11	Hydrocodone-Apap	Tablet	10-325	30	C441399
8/22/11	Methadone HCL	Tablet	10	720	N441786
8/29/11	Hydrocodone-Apap	Tablet	10-325	30	C442537
9/1/11	Phentermine	Tablet	37.5	30	C443012
9/14/11	Hydrocodone-Apap	Tablet	10-325	30	C444408
9/26/11	Methadone HCL	Tablet	10	720	N445654
10/3/11	Phentermine	Tablet	37.5	30	C446345
10/11/11	Hydrocodone-Apap	Tablet	10-325	30	C447464
10/21/11	Hydrocodone-Apap	Tablet	10-325	30	C448862
10/27/11	Methadone HCL	Tablet	10	720	N449501
11/1/11	Phentermine	Tablet	37.5	30	C449941
11/1/11	Hydrocodone-Apap	Tablet	10-325	30	C449939
11/8/11	Hydrocodone-Apap	Tablet	10-325	30	C450804
11/17/11	Hydrocodone-Apap	Tablet	10-325	30	C451886
11/28/11	Hydrocodone-Apap	Tablet	10-325	30	C452923
11/28/11	Phentermine	Tablet	37.5	30	C452926
12/13/11	Methadone HCL	Tablet	10	720	N454936
12/15/11	Hydrocodone-Apap	Tablet	10-325	30	C455121
12/22/11	Hydrocodone-Apap	Tablet	10-325	30	C455957

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
12/27/11	Phentermine	Tablet	37.5	30	C456133
1/3/12	Hydrocodone-Apap	Tablet	10-325	30	C456812
1/16/12	Hydrocodone-Apap	Tablet	10-325	30	C458568
1/20/12	Phentermine	Tablet	37.5	30	C459148
2/4/12	Methadone HCL	Tablet	10	648	N461041
2/17/12	Phentermine	Tablet	37.5	30	C462257
3/6/12	Hydrocodone-Apap	Tablet	10-325	30	C464625
3/14/12	Phentermine	Tablet	37.5	30	C465615
3/23/12	Hydrocodone-Apap	Tablet	10-325	30	C466715
4/4/12	Methadone HCL	Tablet	10	720	N467997
4/3/12	Phentermine	Tablet	37.5	30	C467773

75. The following conduct, acts and/or omissions of Respondent, with regard to patient L.A., individually and/or collectively, constitutes gross negligence::

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including escalating doses of

narcotic medications (to treat L.A.'s headaches), opiates (and large doses of Methadone), and large doses of Norco, Duragesic patches, methadone and Actiq;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Patient R.B.

76. On or about February 26, 2010, Respondent began seeing R.B., a 25-year-old obese man (over 300 lbs.) who worked in automotive and transmission repair, and was suffering from chronic pain. A physical exam and medical note from a prior physician, dated July 23, 2009, detailed the patient's medical history, as well as exam results (including MRI results of the lumbar spine disc - bulging with no nerve impingement, and treatment with over-the-counter extra strength Tylenol). Respondent's physical exam note for February 26, 2010, under back, indicated a "decreased range of motion." He prescribed Norco, 10/325 (180 tablets) and Roxicodone, 30 mg, (180 tablets) to R.B. There was also a signed pain contract dated at the time of this visit. There was also a note, dated August 12, 2010, for this patient that was blank.

77. Respondent's records for R.B., however, fail to include any urine toxicology screenings or CURES reports. His records also fail to adequately document his rationale and why he prescribed the medications to this patient, including large amounts of opioid-based drugs. Indeed, although he recommends a drug screening as documented in the note dated January 25, 2012, no test result are included in his records. Furthermore, Respondent explained during his January 2013 Interview that there was a built in "safety protection" for R.B., in that he was opiate tolerant. At one point, he was averaging 35 to 36 tablets a day of 30 mg Roxicodone.

78. During the first month of the patient's treatment with Respondent, R.B. was prescribed approximately 6 pills per day of Norco and Roxicodone, respectively. That would be

equivalent to approximately 60 mg of hydrocodone from the Norco and 162 mg of oxycodone from the Roxicodone. Over the next two years of seeing the patient, Respondent increased the narcotic drugs he prescribed to the patient without adequate documentation of the need or rationale for the changes. By in or around April 2012, R.B. was receiving approximately 700 oxycodone and 180 Norco approximately every three weeks.

79. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, R.B. filled the following prescriptions at P. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/2/12	Hydroco/apap	Tablet	10-325	180	C300860
4/2/12	Oxycodone	Tablet	30	700	N20442
3/19/12	Oxycodone	Tablet	30	700	N20411
3/2/12	Oxycodone	Tablet	30	700	N20375
2/16/12	Hydrocodone/apap	Tablet	10-325	180	C300663
2/16/12	Oxycodone	Tablet	30	700	N20335
1/25/12	Oxycodone	Tablet	30	700	N20297
1/5/12	Oxycodone	Tablet	30	700	N20235
4/19/12	Fentanyl	Patch	100	10	N20475
4/19/12	Oxycodone	Tablet	30	500	N20474
9/29/11	Hydroco/Apap	Tablet	10-325	180	300090
10/17/11	Oxycodone	Tablet	30	600	N20104
9/23/11	Oxycodone	Tablet	30	600	N20075
9/7/11	Oxycodone	Tablet	30	600	N20058
7/25/11	Oxycodone	Tablet	30	360	N20022
8/19/11	Oxycodone	Tablet	30	360	N20040
8/8/11	Hydroco/apap	Tablet	10-325	180	C300090

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
10/24/11	Hydroco/apap	Tablet	10-325	180	C300248
11/7/11	Oxycodone	Tablet	30	700	N20131
11/29/11	Oxycodone	Tablet	30	700	N20169
11/29/11	Hydroco/apap	Tablet	10-325	180	C300338
12/16/11	Oxycodone	Tablet	30	700	N20199
12/16/11	Hydroco/apap	Tablet	10-325	180	C300413

b. On or about each of the following dates, R.B. filled the following prescriptions at S. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/14/10	Hydroco/apap	Tablet	10-325	180	C384951
4/14/10	Oxycodone hcl	Tablet	30	200	N384954
3/1/11	Oxycodone hcl	Tablet	30	300	N422157
3/1/11	Alprazolam	Tablet	2	30	C422158
3/1/11	Hydrocodone/apap	Tablet	10-325	180	C422156
4/20/11	Oxycodone hcl	Tablet	30	300	N428176
4/20/11	Alprazolam	Tablet	2	30	C428177
4/20/11	Hydrocodone/apap	Tablet	10-325	180	C428175
5/16/11	Oxycodone hcl	Tablet	30	300	N431088
5/16/11	Alprazolam	Tablet	2	30	C431089
5/16/11	Hydrocodone/apap	Tablet	10-325	180	C431086
6/15/11	Alprazolam	Tablet	2	30	C434259
6/15/11	Hydrocodone/apap	Tablet	10-325	180	C434256
6/30/11	Oxycodone hcl	Tablet	30	300	N435957

7/11/11	Alprazolam	Tablet	2	30	C436905
7/11/11	Hydrocodon/apap	Tablet	10-325	180	C436904

c. On or about each of the following dates, R.B. filled the following prescriptions at C.C. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
8/12/10	Hydroco/apap	Tablet	10-325	180	C935792
8/12/10	Oxycodone hcl	Tablet	30	300	N935793
8/12/10	Alprazolam	Tablet	2	30	C935794
9/7/10	Alprazolam	Tablet	2	30	C936848
9/7/10	Hydrocodone/apap	Tablet	10-325	180	C396846
9/7/10	Oxycodone hcl	Tablet	30	300	N936847
12/6/10	Alprazolam	Tablet	2	30	C941190
12/6/10	Hydrocodone/apap	Tablet	10-325	180	C941188
12/6/10	Oxycodone hcl	Tablet	30	300	N941189
12/31/10	Alprazolam	Tablet	2	30	C942298
12/31/10	Hydrocodone/apap	Tablet	10-325	180	C942297
12/31/10	Oxycodone hcl	Tablet	30	300	N942296
3/25/11	Hydrocodone/apap	Tablet	10-325	180	C946475
3/25/11	Oxycodone	Tablet	30	300	N946476
3/25/11	Alprazolam	Tablet	2	30	C946477

80. On or about each of the following dates, Respondent prescribed the following amounts of narcotics to R.B.:

(a) Roxicodone, 30 mg (300 tablets), Norco, 10/325 mg (180 tablets) and Xanax, 2 mg (30 tablets), on June 24, 2010.

(b) Roxicodone, 30 mg (300 tablets), Norco, 10/325 mg (180 tablets) and Xanax, 2 mg (30 tablets), on July 19, 2010.

(c) Roxicodone, 30 mg (300 tablets), Norco, 10/325 mg (180 tablets) and Xanax, 2 mg (30 tablets), on August 12, 2010.

(d) Approximately every 3 weeks the same prescribing pattern continues until in or around July 2011.

(e) Oxycodone, 30 mg (360 tablets), on each of July 25, 2011 and August 19, 2011.

(f) Oxycodone, 30 mg (600 tablets), on each of September 7, 2011 and October 17, 2011

(g) Roxicodone, 30 mg (700 tablets), on each of November 29, 2011, December 16, 2011, January 5, 2012, January 25, 2012, February 16, 2012, March 2, 2012, March 19, 2012 and April 2, 2012.

(h) Norco 10/325 (180 tablets), approximately every three weeks from November 29, 2011 until April 2, 2012.

81. The following conduct, acts and/or omissions of Respondent, with regard to patient R.B., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen (including, the risks of prescribing the drugs together, e.g., the risks for CNS depression, hypotension and sedation; or the risks of operating machinery while using the

drugs he was prescribed) and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including in large amounts;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing, and, his failure to adequately document his rationale for increasing the strength and quantity of narcotics for the patient, or any discussion of the possible diversion with escalating quantity of medications.

Patient A.L.

82. Respondent saw A.L. on at least two occasions in April and May 2005, and prescribed Duragesic patches to him on each occasion. Thereafter, from in or around 2009 through in or around 2012, Respondent prescribed narcotics to A.L., a doctor, and, one of his colleagues. A CURES report showed that Respondent prescribed Norco, 10/325 (120 tablets) to A.L. approximately every 3-4 weeks beginning in or around December 2009 through October 2010, and that A.L. self-prescribed as well. This prescribing increased to 180 pills by in or around November 2010. However, Respondent failed to maintain any records of this prescribing to A.L. The Original Records for A.L. only contained two entries, dated April 15, 2005, and May 20, 2005. The New Records, however, included additional records for this patient.

83. Respondent wrote several prescriptions for this patient, including:

a. On or about each of the following dates, A.L. filled the following prescriptions at P. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
12/29/11	Hydroco/Apap	Tablet	10-325	90	C300446

b. On or about each of the following dates, A.L. filled the following prescriptions at V. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
6/27/10	Hydroco/Apap	Tablet	10-325	60	4135268
7/22/10	Hydroco/Apap	Tablet	10-325	60	4135268
8/18/10	Hydroco/Apap	Tablet	10-325	60	4135268

c. On or about each of the following dates, A.L. filled the following prescriptions at R. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
4/21/10	Hydroco/Acetam	Tablet	10-325	30	756803

d. On or about each of the following dates, A.L. filled the following prescriptions at C.V. Pharmacy:

Date Filled	Drug	Drug Form	Strength	Quantity	RX Number
7/6/10	Hydroco/Apap	Tablet	10-325	120	C0920409
8/28/10	Hydroco/Apap	Tablet	10-325	120	C0933506
10/11/10	Hydroco/Apap	Tablet	10-325	120	C0944999
11/1/10	Hydroco/Acet	Tablet	10-325	180	C0950294
12/24/10	Hydroco/Acet	Tablet	10-325	180	C0963979
2/22/11	Hydroco/Acet	Tablet	10-325	180	C0979771
4/13/11	Hydroco/Acet	Tablet	10-325	180	C0992595
5/30/11	Hydroco/Acet	Tablet	10-325	180	C1003704
7/17/11	Hydroco/Acet	Tablet	10-325	180	C1015110
10/14/11	Hydroco/Acet	Tablet	10-325	180	C1037588

84. The following conduct, acts and/or omissions of Respondent, with regard to patient A.L., individually and/or collectively, constitutes gross negligence:

(a) Respondent's failure to adequately perform a history and physical of the patient;

(b) Respondent's failure to adequately evaluate the patient and/or verify the patient's disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patient and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat the patient's chronic pain;

(e) Respondent's attempt to manage the patient's pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments;

(g) Respondent's prescribing of controlled substances, including in large amounts;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death; and

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing.

Gross Negligence

85. With respect to each patient described above (viz., C.J., G.S., N.A., T.A., L.A., R.B. and A.L.), individually and/or collectively, Respondent failed to adequately perform an evaluation (including history and physical), treat, obtain an informed consent, refer for medical specialist consultation, periodically review; document, and/or comply with applicable controlled substance laws.

86. Respondent's overall conduct, acts and/or omissions with regard to the patients

described above (viz., C.J., G.S., N.A., T.A., L.A., R.B. and A.L.), individually and/or collectively, constitutes gross negligence as follows:

(a) Respondent's failure to adequately perform histories and physicals;

(b) Respondent's failure to adequately evaluate the patients and/or verify their disease;

(c) Respondent's failure to adequately formulate a treatment plan with objectives and/or follow-up with the patients and/or periodically review the treatment plan;

(d) Respondent's failure to adequately treat chronic pain;

(e) Respondent's attempt to manage pain without obtaining adequate CURES reports, urine toxicology screens and/or a pain management/treatment agreement and/or considering consultation with other medical experts;

(f) Respondent's failure to discuss the risks (including side effects) and benefits of his drug treatment regimen and/or alternative therapies/treatments, with the patients;

(g) Respondent's prescribing of controlled substances;

(h) Respondent's continuous prescribing of controlled substances, without indication and/or accurate and adequate medical documentation;

(i) Respondent's failure to adequately document, his management of the patient's chronic pain; and his obtaining informed consent regarding the consequences to the patient when receiving of high doses of controlled medications, such as addiction, overdose and death;

(j) Respondent's failure to otherwise adequately and/or accurately document any of the foregoing; and

(k) Respondent's distribution of controlled substances to each patient described above, individually and/or collectively, including, when he failed to (i) maintain a log of the mediations, (ii) label the medications, (iii) maintain an inventory of the mediation, and (iv) maintain a record of receipt and distribution; in each case above, in an adequate manner.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

87. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent engaged in repeated negligent acts in the care and treatment of

patients. The circumstances are as follows:

88. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth. The allegations of the First Cause for Discipline represent repeated negligent acts.

89. In addition, Respondent committed the following repeated negligent acts.

Patient N.A.

90. Respondent was negligent when he failed to adequately treat N.A.'s hypertension and hyperlipidemia, including by failing to adequately follow-up with her and/or document his care for her, and/or failing to follow up with a neurosurgery consult for her, despite the red flags with her symptoms and disease processes, particularly since his justification for the medications he provided to her rested on her symptoms and disease processes.

Medical Records.

91. Respondent was negligent when he failed to keep adequate and/or accurate medical records for each of the patients described in this Accusation. Respondent's office visit progress notes for each of these patients often included the exact same information as in prior notes. His records also contained inconsistencies and inaccurate information. Furthermore, prescriptions for patients L.Z. and D.O. were not adequately documented in Respondent's medical records for these patients. For example, Respondent failed to adequately document the varying medications taken by L.Z. and D.O., including without limitation, controlled substances, some of which were changed by Respondent without an adequate explanation in the record.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

92. Respondent is subject to disciplinary action under section 2234, subdivision (d) of the Code, in that Respondent was incompetent in connection with the care and treatment of patients. The circumstances are as set forth in the allegations of the First and Second Causes for Discipline, which are incorporated herein by reference as if fully set forth.

93. In addition, Respondent's care of patient N.A. represents a lack of knowledge regarding the availability of health care for the patient through governmental providers, including

for alternative means of therapy and counseling.

94. Further, Respondent's care of patient L.A. represents a lack of knowledge regarding recognition of addiction in this patient (including, addictive behavior with escalating pain needs, tolerance development, and drug seeking behavior when doses are decreased); adequate documentation and/or management of chronic pain; and/or the possible diversion of medications when prescribing large quantities to a single patient; and/or the adverse consequences to patient's receiving high doses controlled medications such as addiction, overdose and death.

95. Further, Respondent's care of patient R.B. represented a lack of knowledge regarding, the need to have a regimented protocol for monitoring this patient; recognition of addiction in this patient (including, addictive behavior with escalating pain needs, tolerance development, and drug seeking behavior when doses are decreased); adequate documentation and/or management of chronic pain; and/or the possible diversion of medications when prescribing large quantities to a single patient; and/or the adverse consequences to patient's receiving high doses controlled medications such as addiction, overdose and death.

96. Respondent's overall conduct, acts and/or omissions with regard to the patients described above (viz., C.J., G.S., N.A., T.A., L.A., R.B. and A.L.), individually and/or collectively, represents a lack of knowledge as follows:

(a) Respondent's lack of knowledge regarding the distribution of controlled substances to each patient described above, individually and/or collectively, including, when he failed to (i) maintain a log of the mediations, (ii) label the medications, (iii) maintain an inventory of the mediation, and (iv) maintain a record of receipt and distribution; in each case above, in an adequate manner;

(b) Respondent's lack of knowledge with respect to the drugs he prescribed and dispensed to his patients as described above and their pharmacology;

(c) Respondent's lack of knowledge regarding the laws and regulations regarding proper, record-keeping, documentation and/or accounting of the controlled substances he obtained and/or dispensed from his office; and

(d) Respondent's lack of knowledge regarding: adequate documentation; management of

chronic pain; the possible diversion of medications when prescribing large quantities to a single patient; and/or the adverse consequences to the patient receiving high doses of controlled medications such as addiction, overdose and death.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate/Accurate Medical Records)

97. Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to keep adequate and accurate records related to the provision of medical services to patients. The circumstances are as set forth in the allegations of the First through Third Causes for Discipline, which are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

98. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent clearly excessively prescribed narcotic medications to patients. The circumstances are as set forth in the allegations of the First through Fourth Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

99. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed drugs to each of the patients above, without appropriate prior examinations and/or medical indications. The circumstances are as set forth in the allegations of the First through Fifth Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(Violation of Drug Statute)

100. Respondent is subject to disciplinary action under section 2238 of the Code and 11190 of the Health and Safety Code and Section 827, subdivisions (a)(1) and (a)(3), of Title 21 of the United States Code in that Respondent failed to make a record of his prescriptions to his patients for controlled substances and failed to maintain complete and accurate records of all

medications he had on stock and how they were disposed of. The circumstances are as set forth in the allegations of the First through Sixth Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Dispensing Dangerous Drugs Without Proper Labeling)

101. Respondent is subject to disciplinary action under sections 4076 and 4170 of the Code, in that Respondent dispensed dangerous drugs without proper labeling. The circumstances are as set forth in the allegations of the First through Seventh Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth.

NINTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

102. Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct. The circumstances are as set forth in the allegations of the First through Eighth Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth.

TENTH CAUSE FOR DISCIPLINE

(False Records; Dishonesty)

103. Respondent is subject to disciplinary action under section 2234, subdivision (e), and/or 2266 of the Code in that he knowingly made or signed a certificate or other document directly or indirectly related to the practice of medicine which falsely represented the existence or nonexistence of a state of facts, and/or was dishonest. The circumstances are as set forth in the allegations of the First through Ninth Causes for Discipline, inclusive, which are incorporated herein by reference as if fully set forth, including the allegations in paragraphs 32, 33, 34, and 35, which contain untrue statements since the New Records were created at a later time.

DISCIPLINE CONSIDERATIONS

104. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that effective on or about July 12, 1999, in a decision in a prior disciplinary action against Respondent before the Board, in Case Number 05-1997-79346 (which is

incorporated herein as if set forth in full), Respondent's Physician's and Surgeon's Certificate No. G52723 was revoked, the revocation was stayed, and he was placed on probation for four years, with terms and conditions, for unprofessional conduct (including a 30 day suspension), in connection with a criminal conviction for violation of section 243, subdivision (e), of the Penal Code, battery on a cohabitating partner, and failing to maintain adequate medical records related to his care and treatment of a patient, in violation of Code sections 490, 2236 and 2266. On or about August 1, 2003, Respondent completed the terms and conditions of probation.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G52723, issued to Victor Delgado Contreras, M.D.;

2. Revoking, suspending or denying approval of Victor Delgado Contreras, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Victor Delgado Contreras, M.D. to pay the Medical Board of California, if placed on probation, the costs of probation monitoring; and

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

DATED: February 11, 2014

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

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