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OPINIONS AND ORDERS

OPINION, U.S. COURT OF APPEALS FOR THE NINTH CIRCUIT (NOVEMBER 27, 2024)

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

FARES JERIES RABADI, M.D.,

Petitioner,

v.

U.S. DRUG ENFORCEMENT ADMINISTRATION; MERRICK B. GARLAND, Attorney General; ANNE MILGRAM, Administrator, Drug Enforcement Administration,

Respondents.

No. 22-70114

DEA No. 20-14

On Petition for Review of an Order of the Drug Enforcement Agency

Argued and Submitted November 12, 2024
San Francisco, California

Filed November 27, 2024

Before: Sidney R. THOMAS and Eric D. MILLER, Circuit Judges, and Donald W. MOLLOY,* District Judge.

Opinion by Judge Sidney R. Thomas

OPINION

THOMAS, Circuit Judge:

Dr. Fares Jeries Rabadi petitions for review of the Drug Enforcement Administration ("DEA") Administrator's final order revoking his certificate of registration to dispense controlled substances. The DEA Administrator had jurisdiction to revoke Rabadi's registration under 21 U.S.C. § 824(a)(4).[1] We have jurisdiction to review the DEA's final order under 21 U.S.C. § 877. We deny Rabadi's petition for review.

"We review questions of constitutional law de novo." *Decker Coal Co. v. Pehringer*, 8 F.4th 1123, 1129 (9th Cir. 2021). We must set aside an agency decision that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). A decision "based on a consideration of relevant factors" and with "no clear error of judgment" is not arbitrary or capricious. *Fry v. DEA*, 353 F.3d 1041, 1043 (9th Cir. 2003).

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* The Honorable Donald W. Molloy, United States District Judge for the District of Montana, sitting by designation.

[1] The Attorney General delegated this statutory authority to the DEA Administrator. 28 C.F.R. § 0.100(b).

I

Rabadi has been a licensed physician in California since 1998. In April 2018, the DEA initiated an investigation into Rabadi after being alerted to his high-risk prescribing practices of controlled substances. In March 2020, the DEA issued an Order to Show Cause and Immediate Suspension of Registration stating that Rabadi's continued registration to dispense controlled substances would be inconsistent with the public interest as defined by the Controlled Substances Act. *See* 21 U.S.C. §§ 823(g)(1),[2] 824(a)(4). The agency alleged Rabadi "violated federal and California law" by "issuing numerous prescriptions for . . . controlled substances outside the usual course of professional practice and not for a legitimate medical purpose to seven individuals."

Rabadi requested a hearing before an administrative law judge ("ALJ"), which occurred in September 2020. At the hearing, the government's expert witness testified that Rabadi failed to conduct adequate examinations or keep adequate medical records and prescribed high dosages of controlled substances, often in dangerous combinations.

Rabadi testified that he acted within the standard of care. He explained the lack of documentation in his records by saying, "I rely on my photographic memory." Addressing the dosages he prescribed, Rabadi said his

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[2] The version of the statute that was in effect at the time of Rabadi's proceedings listed the public interest factors at 21 U.S.C. § 823(f). Section 823(f) was re-designated as § 823(g)(1) as part of an amendment effective December 2, 2022. Medical Marijuana and Cannabidiol Research Expansion Act, Pub. L. No. 117-215, 136 Stat. 2257 (2022). The language itself has not changed.

patients would "not overdose" because "all the study dosages . . . were five-six times more than the FDA-approved dose." The ALJ sustained an objection to Rabadi's discussion of "study dosages" on the grounds that "tangential reports" were outside the scope of the hearing. Rabadi did not raise the "study dosages" again or elaborate further.

The ALJ issued his Recommended Rulings, Findings of Fact, Conclusions of Law, and Decision in December 2020. The ALJ found Rabadi's testimony not credible and recommended revoking his registration.

The DEA Administrator published a final Decision and Order in the *Federal Register* on May 19, 2022, adopting the ALJ's recommendations with minor modifications. The Administrator revoked Rabadi's registration as inconsistent with the public interest under 21 U.S.C. §§ 823(g)(1) and 823(a)(4). Rabadi petitioned for review.

II

Rabadi argues that the DEA's revocation of his registration is invalid because DEA ALJs are unconstitutionally insulated from removal by two layers of "for-cause" protections.[3] For hearings before the DEA, the Administrator appoints an ALJ as a presiding

[3] Although Rabadi did not challenge the ALJ's removal restrictions in the agency proceedings below, he was not required to do so because the agency had "no special expertise" over his "purely constitutional claim[]" and would not be "capable of remedying any defects" in the removal scheme. *Carr v. Saul*, 593 U.S. 83, 93–94 (2021).

officer. 21 C.F.R. §§ 1316.42(f), 1316.52.[4] The ALJ is removable only "for good cause" by the Merit Systems Protection Board. 5 U.S.C. § 7521.[5] The Merit Systems Protection Board members in turn may be removed "only for inefficiency, neglect of duty, or malfeasance in office." 5 U.S.C. § 1202(d). Rabadi contends that these two layers of removal protections are constitutionally impermissible.

Rabadi's argument fails under *Decker Coal Co. v. Pehringer*, 8 F.4th 1123 (9th Cir. 2021). In *Decker Coal*, we considered the same ALJ removal protections that Rabadi challenges here and found them constitutional. *Id.* at 1130. We limited *Decker Coal*'s holding to the application of 5 U.S.C. § 7521 to Department of Labor ("Labor") ALJs, *id.* at 1136, but the same reasoning relied on in *Decker Coal* applies to DEA ALJs.

In *Decker Coal*, we first noted that the Supreme Court "specifically left open the question whether two-level protections for ALJs are constitutionally permissible." *Decker Coal*, 8 F.4th at 1133 (citing *Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 561 U.S. 477, 507 n.10, 508 (2010)). In *Free Enterprise Fund*, the Court held that the "highly unusual," 561 U.S. at 505, two-layer removal scheme for Public Company Accounting Oversight Board ("PCAOB") members unconstitu-

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[4] While DEA regulations specify that the presiding officer is an ALJ, Congress allows the presiding officer to be an ALJ, "the agency," or "one or more members of the body which comprises the agency." 5 U.S.C. § 556(b).

[5] Section 7521 applies to any ALJs appointed under 5 U.S.C. § 3105. DEA ALJs are appointed under 5 U.S.C. § 3105 pursuant to 5 U.S.C. § 556(b)(3) and 21 C.F.R. § 1316.42(f).

tionally infringed on the President's Article II powers. *Id.* at 484.

In *Decker Coal*, we distinguished the PCAOB from the Department of Labor on three grounds and found the Labor ALJ removal protections constitutional. First, we concluded that the powers of Labor ALJs are "purely adjudicatory," unlike the policymaking and enforcement powers of PCAOB members. *Decker Coal*, 8 F.4th at 1133. Second, we noted that Congress did not mandate that the Department of Labor use ALJs as hearing examiners. *Id.* at 1133–34. Third, we underscored that Labor ALJ decisions are reviewed for substantial evidence and legal error by officials who are removable at will (the Benefits Review Board and the Secretary of Labor) and accordingly the President has sufficient control. *Id.* at 1134–35.

All three of these grounds apply in equal or greater force to DEA ALJs. First, DEA ALJs perform purely adjudicatory functions just like Labor ALJs. 21 C.F.R. § 1316.52 (describing the powers of presiding officers at hearings). Second, Congress does not mandate that the DEA use ALJs as presiding officers for administrative hearings. 5 U.S.C. § 556(b) (the presiding officer can be an ALJ, the agency, or a member of the agency). Third, DEA ALJ decisions are reviewed de novo by the DEA Administrator. *See* 5 U.S.C. § 557(b). The ALJ provides only a recommended decision to the Administrator, who issues the final decision and final findings of fact and conclusions of law. 21 C.F.R. §§ 1316.65, 1316.67. The President appoints the Administrator and presumably may remove her at will, as no statute limits her removal. Reorganization Plan No. 2 of 1973, § 5, 28 U.S.C. § 509 note (stating the Administrator "shall be appointed by the President

by and with the advice and consent of the Senate" but not specifying the Administrator's removability); *Collins v. Yellen*, 594 U.S. 220, 248 (2021) ("When a statute does not limit the President's power to remove an agency head, we generally presume that the officer serves at the President's pleasure."). Accordingly, the President's control is even more direct here than in *Decker Coal*, where the Labor ALJ's factual findings could only be reviewed for substantial evidence. 8 F.4th at 1134.

As in *Decker Coal*, the DEA "ALJs are judges who make decisions that are subject to vacatur by people without tenure protection" and accordingly "the President continues to enjoy an 'ability to execute the laws—by holding his subordinates accountable for their conduct.'" *Id.* at 1135 (quoting *Free Enter. Fund*, 561 U.S. at 496). In short, there is no principled distinction to be drawn between the administrative structure at issue in *Decker Coal* and that at issue here.

Contrary to Rabadi's argument, the Fifth Circuit decision in *Jarkesy v. SEC*, 34 F.4th 446 (5th Cir. 2022), does not undermine this conclusion. In *Jarkesy*, the Fifth Circuit held that removal restrictions on Securities and Exchange Commission ("SEC") ALJs were unconstitutional. *Id.* at 465. *Jarkesy* is distinguishable on two key grounds, and the Supreme Court did not adopt that aspect of the Fifth Circuit's holding when it affirmed the decision on other grounds. *SEC v. Jarkesy*, 144 S. Ct. 2117, 2127–28 (2024).

First, the decisions of DEA ALJs are subject to mandatory review by the DEA Administrator, 21 C.F.R. §§ 1316.65, 1316.67, while the decisions of SEC ALJs can become final without agency review. *Lucia v. SEC*, 585 U.S. 237, 249 (2018) (explaining "the SEC

can decide against reviewing an ALJ decision at all," in which case "the ALJ's decision itself 'becomes final'" (quoting 17 C.F.R. § 201.360(d)(2))); *see also Jarkesy*, 34 F.4th at 464 (noting that SEC ALJ decisions "often . . . are final and binding"). Second, the President can control DEA ALJs through the DEA Administrator, who is removable at will, while SEC Commissioners have for-cause removal protections. *Jarkesy*, 34 F.4th at 465. For these two reasons, DEA ALJs are less insulated from Presidential control than SEC ALJs.

In sum, we conclude that the removal protections under 5 U.S.C. § 7521 are constitutional as applied to DEA ALJs.

III

Rabadi also claims the DEA Administrator's order was arbitrary and capricious because (1) the Administrator failed to consider Rabadi's defense that high dosages of prescribed drugs could still be safe and (2) the Administrator's analysis of Rabadi's lack of a conviction record[6] in assessing the public interest was contrary to the presumption of innocence. Neither claim has merit.

First, the Administrator justifiably ignored Rabadi's defense, which was an unsupported statement Rabadi made during his testimony. Rabadi testified that his patients would not overdose if they took the dosages he prescribed because "all the study dosages . . . were

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[6] One of the factors for determining whether a registration to dispense controlled substances is inconsistent with the public interest is: "The applicant's conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances." 21 U.S.C. § 823(g)(1)(C).

five-six times more than the FDA-approved dose." Rabadi did not cite or submit any studies supporting his claim. In her final order, the Administrator chose not to consider Rabadi's statement because it had not been noticed prehearing. DEA regulations require that a party submit evidence prior to offering it at the hearing to provide notice to the opposing party. 21 C.F.R. § 1316.57. The Administrator's decision to ignore Rabadi's statement was not arbitrary or capricious, as no study had been submitted and the testimony was not noticed in Rabadi's prehearing statement.

Second, in analyzing Rabadi's lack of a conviction record, the agency did not presume that Rabadi was guilty of any criminal misconduct or hold that against him. Instead, the Administrator cited agency precedent for the proposition that the absence of a criminal record is "not dispositive" because "a person who has engaged in criminal misconduct" might not be prosecuted or convicted. The Administrator concluded that Rabadi's lack of a criminal record had no effect on whether his registration to dispense controlled substances was consistent with the public interest. In determining the public interest, the Administrator "may give each factor the weight [she] deems appropriate." *Morall v. DEA*, 412 F.3d 165, 174 (D.C. Cir. 2005) (quoting *Henry J. Schwarz, Jr., M.D.*, 54 Fed. Reg. 16,422, 16,424 (Apr. 24, 1989)). Accordingly, the Administrator's decision to find Rabadi's lack of a conviction record not dispositive was not arbitrary or capricious.

IV

For the foregoing reasons, we deny Rabadi's petition for review of the DEA Administrator's order

revoking his registration to dispense controlled substances. The removal protections for DEA ALJs are constitutional and do not undermine the validity of the proceedings against Rabadi. The Administrator's order properly ignored a defense that was neither noticed nor supported, and appropriately analyzed the public interest factors. The decision was not arbitrary or capricious.

PETITION DENIED.

**DECISION AND ORDER,
U.S. DRUG ENFORCEMENT AGENCY
(FILED MAY 18, 2022,
PUBLISHED MAY 19, 2022)**

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87 Fed. Reg. 30564

DEPARTMENT OF JUSTICE
Drug Enforcement Administration

FARES JERIES RABADI, M.D.

Docket No. 20-14

Before: Anne MILGRAM,
U.S. Drug Enforcement Agency Administrator.

On March 2, 2020, a former Acting Administrator of the Drug Enforcement Administration (hereinafter, DEA or Government), issued an Order to Show Cause and Immediate Suspension of Registration (hereinafter collectively, OSC) to Fares Jeries Rabadi, M.D. (hereinafter, Respondent). Administrative Law Judge Exhibit (hereinafter, ALJ Ex.) 1 (OSC), at 1. The OSC immediately suspended Respondent's DEA Certificate of Registration Number BR6081018 (hereinafter, registration or COR) "because [Respondent's] continued registration constitutes an 'imminent danger to the public health or safety.'" *Id.* (citing 21 U.S.C. 824(d))) The OSC also proposed revocation of Respondent's registration, the denial of any pending applications for renewal or modification of such registration, and the denial of any pending applications for additional DEA

registrations pursuant to 21 U.S.C. 824(a)(4) and 823(f) because Respondent's "continued registration is inconsistent with the public interest." *Id.*

In response to the OSC, Respondent timely requested a hearing before an Administrative Law Judge. ALJ Ex. 2. The hearing in this matter was conducted on September 29-30, 2020, via video teleconference technology. On December 22, 2020, Administrative Law Judge Mark M. Dowd, (hereinafter, ALJ) issued his Recommended Rulings, Findings of Fact, Conclusions of Law and Decision (hereinafter, Recommended Decision or RD) to which both parties filed Exceptions. I have addressed both the Respondent's and Government's Exceptions in footnotes added to the corresponding parts of the RD. While I have made some modifications to the RD based on the Exceptions, none of those changes and none of Respondent's arguments persuaded me to reach a different conclusion than the ALJ in this matter. I issue my final Order in this case following the Recommended Decision.*A

*A I have made minor, nonsubstantive, and grammatical changes to the RD and nonsubstantive conforming edits. Where I have added to the ALJ's opinion to include additional information, I have noted the additions in brackets or in footnotes marked with an asterisk and a letter. Where I have made substantive changes, omitted language for brevity or relevance, or where I have modified the ALJ's opinion, I have noted the edits in brackets and have included specific descriptions of the modifications in brackets or in footnotes marked with an asterisk and a letter. Within those brackets and footnotes, the use of the personal pronoun "I" refers to myself—the Administrator.

Recommended Rulings, Findings of Fact, Conclusions of Law, and Decision of the Administrative Law Judge*B

The issue to be decided by the Administrator is whether the record as a whole establishes by a preponderance of the evidence that the DEA Certificate of Registration, No. BR6081018, issued to Respondent should be revoked, and any pending applications for modification or renewal of the existing registration should be denied, and any pending applications for additional registrations should be denied, because his continued registration would be inconsistent with the public interest under 21 U.S.C. 823(f) and 824(a)(4)

After carefully considering the testimony elicited at the hearing, the admitted exhibits, the arguments of counsel, and the record as a whole, I have set forth my recommended findings of fact and conclusions of law below.

The Allegations

The Government alleges the Respondent violated federal and California law,[1] by issuing numerous

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*B I have omitted the RD's discussion of the procedural history to avoid repetition with my introduction.

1 [Omitted for brevity. Specifically, Respondent was charged with violating:]

a. Cal. Health & Safety Code § 11153(a), requiring that a "prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice";

b. Cal. Health & Safety Code § 11154(a), directing that "no person shall knowingly prescribe, administer,

prescriptions for Schedule II through IV controlled substances outside the usual course of professional practice and not for a legitimate medical purpose to seven individuals as recently as December 31, 2019. These prescriptions fell below minimal medical standards applicable to the practice of medicine in California. Therefore, these prescriptions violated federal and California state law.

The Government alleges the Respondent regularly prescribed highly addictive and intoxicating combinations of controlled substances to his patients, and that

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dispense, or furnish a controlled substance to or for any person . . . not under his or her treatment for a pathology or condition . . . ";

c. Cal. Bus.& Prof. Code § 2242, prohibiting the "[p]rescribing, dispensing, or furnishing [of controlled substances] . . . without an appropriate prior examination and a medical indication," the violation of which constitutes unprofessional conduct;

d. Cal. Bus. & Prof. Code § 2234, defining unprofessional conduct to include: "[g]ross negligence"; "[r]epeated negligent acts"; "[i]ncompetence"; or "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon"; and

e. Cal. Bus. & Prof. Code § 725, further defining unprofessional conduct to include "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs. . . . "

Additionally, [Respondent was alleged to have issued prescriptions outside of] California's applicable standard of care as outlined in the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons," Medical Board of California, 7th ed. 2013 (the "Guide"). [Omitted for brevity.] *See* ALJ Ex. 1. [The Government did not address (b) or (d) above in its Posthearing Brief, so I will not address those allegations herein.]

he consistently failed to: (1) Perform adequate physical evaluations and obtain appropriate patient histories; (2) make appropriate diagnoses based on sufficient clinical evidence and document these diagnoses in his medical records; (3) document a legitimate medical purpose for the controlled substances that he prescribed; (4) monitor his patients' medication compliance; and (5) respond to red flags of drug abuse and diversion. These failures constitute extreme departures from the standard of care in California, and that his actions were dangerous and reckless. Because of these failures, he regularly put his patients at significant risk for harm, including overdose or death. He also continued to prescribe controlled substances to these patients despite the fact that he knew they were suffering from opioid dependencies. [The OSC went on to provide specific examples of Respondent's alleged failures related to seven individuals: S.B., M.B., B.C., J.C., D.D., J.M., and K.S. ALJX 1, at 14.] For each of the seven patients, he continued to prescribe opioids to them, even while noting that each patient suffered from an opioid dependency.*C

The Hearing

Government's Opening Statement [2]

DEA initiated an investigation into Dr. Rabadi, a California registered physician, upon receipt of a report from the Department of Health and Human Services Office of Inspector General. Tr. 23. The report

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*C Omitted for brevity.

2 The Respondent waived the opportunity to make an opening statement. Tr. 30.

characterized him as a "high-risk prescriber" due to his prescribing of a large number of highly diverted and highly abused drugs. Initially, DEA reviewed Dr. Rabadi's prescribing practices through the California PDMP. Tr. 23. Significant red flags were revealed, including dangerous combinations of controlled substances. Three drugs, hydrocodone acetaminophen, alprazolam and carisoprodol constituted over 95% of the controlled substance prescriptions he issued between November 20, 2015, and November 21, 2018. Tr. 24. In combination, these three drugs make up a highly dangerous and diverted cocktail commonly known among drug seekers as the Holy Trinity.

On November 6, 2018, an undercover agent (hereinafter, UC) posing as a prospective patient with back pain, sought treatment from Dr. Rabadi. Dr. Rabadi declined to treat UC, explaining that he was an internist and did not treat back pain. Tr. 24.

In February of 2019, DEA executed federal search warrants on Dr. Rabadi's clinic, home, and three safety deposit boxes. DEA seized a number of prescriptions and patient files. Tr. 24. DEA also seized an unusually large amount of cash from Dr. Rabadi's home and clinic examination room suggestive of diversion and mis-prescribing. Tr. 25. Subpoenas to pharmacies produced prescriptions for a number of Dr. Rabadi's patients, including the seven patients at issue in this case. Tr. 25.

The Government's expert, Dr. Timothy Munzing, will testify that his review of the patient files and prescriptions revealed, in his opinion, that Dr. Rabadi prescribed controlled substances to each of the seven patients outside the usual course of professional practice in California. Tr. 25. Dr. Munzing will testify that

Dr. Rabadi never established a legitimate medical purpose for the controlled substances he prescribed, and was not acting in the usual course of professional practice. Tr. 25. Dr. Munzing will testify that Dr. Rabadi consistently failed to meet fundamental elements of the California standard of care for prescribing controlled substances, including failure to obtain appropriate medical histories, failure to perform minimally appropriate physical exams, failure to make appropriate diagnoses based on sufficient medical evidence, failure to document appropriate treatment plans, failure to document a legitimate medical purpose for the controlled substances, failure to discuss the risks and benefits of the cocktails and controlled substances he prescribed, failure to conduct even a single urine drug screen, and failure to respond to red flags of abuse and diversion. Tr. 27. Dr. Rabadi prescribed controlled substances in dangerous and addictive combinations and outside the usual course of professional practice and without establishing a legitimate medical purpose. Dr. Rabadi diagnosed neck and back pain without sufficient medical evidence. Tr. 27. Dr. Rabadi frequently and plausibly diagnosed opioid dependency for patients on long term opioid use. Dr. Rabadi frequently issued Norco prescriptions to treat M.B., B.C., J.C., D.D., J.M., and K.S. for opioid dependency, which was a dangerous and illegal course that was outside the standard of care. Tr. 27-28. Dr. Rabadi prescribed Xanax in dangerously high dosages to Patients S.B., B.C., J.M., and K.S. of six to eight mgs per day, almost twice the recommended maximum dosage for anxiety disorder. Tr. 28. With early refills of Xanax, the Respondent exposed J.M. to more than 10 mgs per day for nearly two years. Tr. 29. He further exposed these

patients to the risk of overdose and death by concurrently prescribing them opioids. Tr. 28.

Thus, the Respondent was not providing medical care to these patients, he was exposing them to risk of harm by handing out dangerous and addictive drugs without medical justification. Dr. Rabadi's controlled substance prescriptions to Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. were not issued for a legitimate medical purpose, were not issued by a practitioner acting within the usual course of professional practice in California, and were issued in violation of the standard of care in California and in violation of the laws of the United States. Tr. 29. Accordingly, the Government then requested that the tribunal recommend revocation of Dr. Rabadi's DEA certificate of registration.[3]

Government's Case-in-Chief

The Government presented its case-in-chief through the testimony of two witnesses. First, the Government presented the testimony of a DEA Diversion Investigator (DI). Secondly, the Government presented the testimony of Dr. Timothy Munzing, M.D.

Diversion Investigator

DI has served as a Diversion Investigator at DEA's Los Angeles Field Division for three years. Tr. 33-34.

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3 Government allegations included a reference to statistics that 95% of the Respondent's prescriptions were for the "Holy Trinity" suggesting that evidence, in itself, demonstrated illegitimate prescribing by the Respondent. The Government confirmed that those statistics did not form an independent allegation. Tr. 32-33.

Previously, she served with United States Citizenship and Immigration Service for four years. Tr. 75. As a DI, she enforces compliance with the Controlled Substances Act (CSA), looking for signs of diversion within the registration system, including monitoring for regulatory compliance. Tr. 34-35. She has attended the basic diversion investigation training at the DEA Academy, which included training to spot signs of diversion, investigating diversion and enforcing compliance with the CSA, both in the criminal and administrative settings. Tr. 35. She has also received training regarding CURES—the California prescription drug monitoring program.

Regarding the Respondent, in April 2018, DEA received a report from the Department of Health and Human Service (HHS) that the Respondent was on a "high-risk model for overprescribing of controlled substances." Tr. 37, 75. DEA ran two CURES reports, one in April of 2018, which revealed numerous red flags, including prescribing hydrocodone at the maximum strength and a large amount of polypharmaceutical cocktails or combinations of a benzodiazepine and an opioid. Additionally, the volume of opioid prescribing was high, at over 9,000 prescriptions over the course of three years from November 2015 to November 2018. Tr. 38-39, 42, 56-57, 82; GX 16-19. Fifty-percent of these were for hydrocodone. Tr. 42. According to DI, the combination of a benzodiazepine and an opioid are significant as they are highly sought after by the black market and are dangerous to the patient. Tr. 39. The Respondent also prescribed a large number of combinations of the highly sought after "Holy Trinity," which includes a narcotic, a muscle relaxant and a benzodiazepine-96% of his prescriptions during

that three-year period.[*D] Tr. 40, 42-43. These highly addictive and highly dangerous combinations were prescribed over a long period of time. Tr. 40-41.

Due to these red flags, on September 26, 2018, DEA sent an undercover agent (UC) to the Respondent's clinic—posing as a prospective patient. Tr. 43. The first attempt was foiled as the clinic was closed. The second attempt occurred on October 30, 2018. Tr. 44, 75-76. The clinic was again closed. The third attempt occurred on November 6, 2018. UC complained of back pain and shoulder pain and sought help from Dr. Rabadi. Dr. Rabadi declined to help the UC—explaining that he was not taking new patients and that he was an internist and not a pain specialist. Tr. 45, 75-76. Ultimately, DEA obtained five search warrants, four of which were executed on February 21, 2019. Tr. 46, 76-77. The fifth was served on February 22, 2019. Tr. 74. They were served on his clinic, on his home and on two safety deposit boxes at two separate banks. Tr. 46. DEA seized 1.2 million dollars in cash at his home.[4]

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*D To be clear, the DI did not testify that 96% of the prescriptions that Respondent issued were issued in the "Holy Trinity" combination. Rather, DI testified that 96% of Respondent's issued controlled substance prescriptions were for either hydrocodone (a narcotic), alprazolam (a benzodiazepine), or carisoprodol (a muscle relaxant). Tr. 42.

4 The Respondent objected to the evidence of the cash seizure as irrelevant and immaterial. The objection was carried. Tr. 47-49. [I find that this evidence, while useful to understanding the course of DEA's investigation, is immaterial to the ultimate issue in this case, which is whether or not Respondent issued controlled substance prescriptions that were outside the usual course of professional practice and beneath the standard of care. Accordingly, I have not considered this information in making my decision.]

Dr. Rabadi was home when the search warrant was served. Tr. 77. He agreed to be interviewed regarding his prescribing practices. Tr. 77. At his clinic, DEA seized patient files and some prescriptions for S.B., B.C., M.B., J.C., D.D., J.M. and K.S. Tr. 49-50. Additional prescriptions and fill stickers were obtained from pharmacies.[5] Tr. 50-55; GX 1-15. Thereafter, in January 2020, DEA issued an administrative subpoena to the Respondent for any and all updated medical records and prescriptions for the noted patients. Tr. 55-56.[6] In all, DEA obtained twenty-seven files or updated files. Tr. 78.

Dr. Timothy Munzing

Dr. Munzing is a physician licensed in California and holds a DEA Certificate of Registration there. Tr. 86-87; GX 23. Dr. Munzing graduated from UCLA Medical School in 1982. Tr. 89. He completed his internship and residency in family medicine at the Kaiser Permanente Medical Center in Los Angeles in 1985. Tr. 89. He then went to Kaiser Permanente Orange County, where he has been employed for the last 35 years in the family medicine department. He is also available as a consultant. Tr. 90.

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5 DI noted record-keeping deficiencies on the part of some of the pharmacies, Tr. 51-55, but clarified they were not a negative reflection on the Respondent. Tr. 79-80.

6 The Government authenticated Government Demonstrative Exhibits 1-8, which were summary charts for each of the seven subject patients containing the subject prescriptions and patient files consistent with the seized and stipulated to records. Tr. 57-73.

In his family medicine practice, he takes care of his patients from "cradle to grave." Tr. 90. Most of his present patients are adults. Tr. 90. Twenty-five percent of his work is spent treating his patients. Tr. 92. In his clinical practice, he has prescribed controlled substances, including opioids and benzodiazepines. Tr. 92. Thirty-two years ago Dr. Munzing founded a family medicine practice residency program, and continues to be the residency director for twenty-four residents. Tr. 90. He also sits on the National Accreditation Board for Family Medicine Residency. He is a member of the American Medical Association, the California Medical Association, and the American Academy of Family Physicians, to name a few. Tr. 91; GX 23. He also serves as a full clinical professor at the University of California Irvine, and at the Kaiser Permanente School of Medicine. Tr. 91. He has been called as an expert witness by the California Medical Board for the past ten years, and by federal law enforcement for the past six years. Tr. 623. Dr. Munzing has been qualified approximately thirty-five times to offer his expert opinion for the California Medical Board, DEA, FBI, and the Department of Justice, including his opinion on the standard of care for prescribing controlled substances, and whether a prescription was issued for a legitimate medical purpose in the usual course of professional practice. Tr. 92-94, 623. He has testified as an expert in five or six prior DEA Administrative hearings. Most of his opinions have related to illegal prescribing of opioids. Tr. 95. Internal rules of Kaiser Permanente prevent him from testifying on behalf of physicians. Tr. 624. Dr. Munzing estimated he had received approximately $20,000 for his time on the instant case at $400 per hour. Tr. 624.

He is familiar with the California standard of care for prescribing controlled substances. Tr. 94. The California standard of care is informed by publications by the California Medical Board. Tr. 95-97; GX 20 at 59-61, GX 21. In particular, "The Laws Governing the Practice of Medicine by Physicians and Surgeons," sets out minimum requirements for care, including history and physical examination, assessment of pain, physical and psychological functioning, substance abuse history, treatment plan, and maintaining accurate and complete records. Tr. 374-80. In forming his opinions in this case, Dr. Munzing reviewed the medical records and prescriptions for the subject patients. Tr. 100-01. Dr. Munzing was qualified, without objection, as an expert in California medical practice, including the applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine. Tr. 101-02.

Dr. Munzing explained that the standard of care is generally "what a responsible, knowledgeable physician can do" under similar circumstances. Tr. 102-03. In prescribing controlled substances this would include performing a physical examination, taking a history, including both a medical history and a psychological and substance abuse history, attempting to obtain prior medical records, formulating a diagnosis, evaluating risk factors for the controlled medications including the risk of abuse, discussing the risks with the patient to obtain informed consent, developing a customized treatment plan with goals and objectives, documenting all of the above in the medical record, and providing ongoing monitoring of the patient and of his treatment, including urine drug screens (UDS) and alternate

therapies. Tr. 103-112, 114-25, 128-35. Ongoing and comprehensive documentation is critical for accurate evaluation of a patient's condition and treatment. Tr. 142-50. The goal is to maximize function, while minimizing risk. Tr. 139-40. Compliance with all relevant California statutes and regulations is also required by the standard of care. Tr. 104. It requires addressing, resolving and documenting red flags. Tr. 112. Dr. Munzing identified the FDA "black box" warning regarding combining opioids with benzodiazepines, titled New Safety Measures Announced for Opioid Analgesics, dated August 31, 2016. Tr. 151; GX 22 at 1-3, 4, 25, 40. The FDA specifically noted diazepam, Klonopin, and Xanax should not be combined with opioids unless absolutely necessary, and for no longer than absolutely necessary. Tr. 153-55.

Dr. Munzing testified that the higher the morphine milligram equivalent (MME) prescribed, the increased risk of addiction and overdose. Tr. 126-28. Prescribing controlled substances for psychological illness requires an even greater emphasis on history, and a more-focused physical exam [of the "heart, lung, vital signs . . . seeing if [there is] any evidence of some other medical diagnosis" in addition to the mental health disorder.] Tr. 136, 138-39, 141. The General Anxiety Disorder screening tool, GAD-7, is a useful tool in assessing a patient's level of anxiety. Tr. 136-37.

Dr. Munzing reviewed the patient files, prescriptions, and CURES data for Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. [and concluded that the prescriptions at issue were "not consistent with the standard of care in the state of California"] Tr. 156-57. Dr. Munzing noted that the history for these seven patients was deficient. Tr. 157. There was

no indication prior medical records were obtained. Tr. 157. The physical exams, if present, were missing key elements. There were no documented CURES checks. Tr. 158. Diagnoses appeared and disappeared. Opioids were prescribed at high dosages. There was no indication of the necessary patient monitoring and there was no documentation of informed consent. Tr. 159-60, 207. Dr. Munzing summarized that none of the controlled prescriptions issued for the charged patients were issued for a legitimate medical purpose by a practitioner acting within the usual course of professional practice. Tr. 620-21. According to Dr. Munzing, all of the relevant prescriptions were issued outside the standard of care. Tr. 621.

Patient S.B.

As per the parties' stipulations, between February 2, 2017, and January 30, 2019, S.B. was prescribed hydrocodone, carisoprodol, Adderall and alprazolam. Tr. 162-63; GDX 1. Dr. Munzing characterized the patient file as meager. He characterized the controlled substance prescriptions as being outside the standard of care. Tr. 163, 207, 241-44. For S.B.'s initial visit on August 3, 2016, she was diagnosed with Generalized Anxiety Disorder (GAD), Attention Deficit Disorder (ADD), and Fibromyalgia. Tr. 163-65; GX 1 at 62, 66. There were no supporting findings from a physical examination or history for the fibromyalgia diagnosis, which typically is reached after a certain number of tender points are determined. Tr. 166. Similarly, there were no supporting findings from a physical examination or history to support the GAD or ADD diagnoses. Tr. 166-71, 241-44. There was no physical functioning level documented nor mental functioning level documented. Tr. 171. Without sufficient evaluation and sup-

porting documentation for the three diagnoses, Dr. Munzing deemed the diagnoses inappropriate. Tr. 241-44. Without an appropriate diagnosis, there was no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44. Similarly, there was no documented treatment plan. Tr. 241-44. On February 2, 2017, S.B. presented to the clinic suffering from fibromyalgia and ADD. Tr. 173; GX 1 at 59. The Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed hydrocodone, carisoprodol, and Adderall. Tr. 173-74. Again, there was no medical history justifying the diagnosis. The physical exam conducted on February 2, 2017, consisted of blood pressure, cardiovascular, heart and lung, all of which were normal. Again, the physical exam was insufficient to justify the fibromyalgia and ADD diagnoses. Tr. 175. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 175-76. For the progress notes of June 28, 2017, the Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed hydrocodone, carisoprodol, and Adderall. Tr. 177. Again, there was no medical history justifying the diagnoses. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 177-78; GX 1 at 57. Again, blood pressure and heart and lung exams were performed. Tr. 177. There was insufficient medical evidence to justify the three diagnoses. Tr. 177-78. For the progress note for December 21, 2018, S.B. presented with eczema and fibromyalgia. Tr. 179; GX 1 at 49. The Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox. She was prescribed hydrocodone. No history was recorded. Again, blood

pressure and heart and lung exams were performed. Tr. 180. There was no documentation of the pain level or functionality level, to justify continued controlled substance prescribing. Tr. 180. There was insufficient medical evidence to justify the fibromyalgia diagnosis. Tr. 181. In the progress notes for January 30, 2019, S.B. reported to the clinic with ADD and rhinitis. Tr. 181; GX 1 at 47. She was prescribed Adderall for the ADD. No medical history was taken. ADD patient progress was reported as "stable." There was insufficient medical evidence to justify the ADD diagnosis. Tr. 183. Dr. Munzing deemed the ADD diagnoses inappropriate. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescription. Tr. 185-86. During the subject period of the Respondent's treatment of S.B., he never obtained any prior medical records. Tr. 184. He never recorded a history, which would justify his diagnoses for Fibromyalgia, GAD, or ADD. Tr. 184-85. He never reported a sufficient physical or mental exam to justify the Fibromyalgia, GAD, or ADD diagnoses. *Id.* He never reported a sufficient evaluation to justify his diagnoses for Fibromyalgia, GAD, or ADD. *Id.* The relevant controlled substance prescriptions for S.B. were not issued within the California standard of care, nor were they issued within the usual course of professional practice. Tr. 186-87, 244.

Dr. Munzing observed that the diagnoses would come and go in the records and were inconsistently reported, which is atypical for chronic diagnoses. Tr. 188-97. A chronic disease, with symptoms that appear to come and go would raise the question of whether the patient had the disease at all. Tr. 192. Even a lessening of symptoms should cause evaluation as to

whether tapering of medication would be appropriate. Tr. 196.

Dr. Munzing noted that the Respondent prescribed S.B. both hydrocodone and Soma to treat Fibromyalgia on numerous occasions. Tr. 197-98. On other occasions, he prescribed the hydrocodone only without documenting any explanation for changing the medication protocol, which was beneath the California standard of care for documentation. Tr. 198-201; GX 20 at 61. [Dr. Munzing testified that Respondent did not establish a legitimate medical purpose for issuing to S.B. any of the controlled substances at issue. Tr. 201.] Dr. Munzing noted that S.B. was prescribed a dangerous, highly addictive combination of medications that was popular for abuse and diversion; namely hydrocodone and Soma, which are respiratory depressants, and Adderall. Tr. 202.

Another dangerous combination, hydrocodone, Adderall and Xanax was prescribed March 1, 2017, April 2017, and June 2017. Tr. 203; GX 1. Dr. Munzing noted this combination is referred to by drug abusers as the "new Holy Trinity." Tr. 204. It includes the depressants, hydrocodone and Soma, and is followed by the stimulant, Adderall, to counteract the effects of the depressants. Again, the combination of hydrocodone and Soma are the subject of the FDA "black box" warning. Tr. 205. The high dosage of Xanax, 6 mg per day, heightens the risk of this already dangerous combination. With Xanax and Adderall prescribed at their highest commercially available dosage units, the danger and risk of addiction are further increased. Tr. 205. Additionally, two mg tablets of Xanax are popular for abuse and diversion. Tr. 217-18. On September 29, 2017, and monthly from July 2018, to July

2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee any medical condition in which this combination would be appropriate. Tr. 211-12.

Dr. Munzing noted that the medical records failed to disclose any indication that the Respondent warned S.B. regarding the risks associated with these dangerous combinations of controlled substances. This failure precludes any informed consent by S.B. Tr. 207. The Declaration of Pain Medication Use document in the file, dated August 3, 2016, which requires the patient to alert the Respondent if the patient takes additional medications [(other than those prescribed by Respondent)] because they could result in drug interactions, does not put the patient on notice of the dangerous combinations prescribed by the Respondent. Tr. 207-10; GX 1 at 67. Similarly, Dr. Munzing noted the repeated notation within the patient records of "SED," which Dr. Munzing assumed meant, "side effects discussed," was insufficient documentation within the standard of care to establish that Respondent discussed the various risks of these medication combinations. Tr. 210-11; GX 1 at 59.

In March, April and June of 2017, the Respondent prescribed S.B. Xanax at 6 mg per day, in excess of the FDA recommended daily limit of 4 mg per day. Tr. 212-15; GX 1 at 57, 58, 59. GX 22 at 40, 59-61. In May of 2017, the Xanax was abruptly stopped. Tr. 216-17; GDX 1. And abruptly restarted in June of 2017,

and again stopped. Tr. 217. This is very dangerous as the abrupt stoppage of Xanax without titration, especially at this high dosage, can cause seizures, and restarting at this high dosage can trigger an overdose, especially in conjunction with the prescribed opioid. Tr. 212-18.

Dr. Munzing testified that regarding the monitoring of S.B., there were no urine drug screens evident in the records, which the standard of care would have required at least quarterly. Tr. 218-21; GX 1 at 44. In the progress notes for February, March, April 2017, all the way to January 30, 2019, the Respondent noted "refusal to detox." Tr. 220-21, 227-29; GX 1 at 58, 59. This is a huge red flag for opioid use disorder and for diversion. However, the chart reflects the Respondent did not take any necessary action, such as CURES monitoring, random pill count, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 222-23. The Respondent's course of action was outside the California standard of care. Tr. 223, 229. Respondent's medical file for S.B. contained a June 2017 report from Dr. F., an orthopedic surgeon who saw S.B. for reported neck and back pain. According to Dr. F's report, S.B. reported her past medical history as only "anxiety." Tr. 229; GX 1 at 30, 32, 36-42, 56. She did not report Fibromyalgia or ADD. Tr. 229-30. S.B. further reported to Dr. F. that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription evidence. Tr. 231-32. Dr. F.'s report was part of S.B.'s disability application, claiming disability as of June 15, 2017. A report from Chiropractor B.H. is also included in the disability packet. Tr. 235. Dr. B.H. reports the disability was caused by "accident or

trauma," which is inconsistent with what the patient reported to Dr. F. and to the Respondent. Tr. 236. There is no indication within the Respondent's records for S.B. that he ever discussed, with S.B. or with Dr. F., the discrepancies revealed by Dr. F.'s report. Tr. 233-37.

Contemporaneous to the preparation of the disability claim, Dr. Rabadi ordered a series of radiologic tests on S.B., none of which were related to the Respondent's diagnosis of fibromyalgia. The progress notes from August 17, 2017, say that S.B. presented with "overactive thyroid, gait disturbance." Tr. 237-40; GX 1 at 5, 7, 9, 11, 13, 16, 17, 56. Dr. Rabadi ordered an MRI of the brain to rule out MS, a thyroid ultrasound to rule out hyperthyroidism, an MRI of the lumbar spine, and an MRI of the thoracic spine. The MRI of the cervical spine was ordered by Dr. F. Tr. 241.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for S.B., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for S.B.'s relevant diagnoses, never made an appropriately supported diagnosis, never recorded S.B.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with S.B., never appropriately monitored S.B. and failed to appropriately respond to red flags of diversion. Tr. 241-44. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to S.B. were issued without a legitimate medical purpose, outside the usual course of

professional practice and beneath the standard of care in California. Tr. 244.]

Patient M.B.

After a review of M.B.'s patient file, CURES report and related prescriptions, Dr. Munzing observed that between January 5, 2018, and November 20, 2019, the Respondent prescribed hydrocodone and Adderall. Tr. 245. As with patient S.B., Dr. Munzing characterized the patient file as containing "very little" information. Tr. 245-47. The Respondent never obtained prior medical records of M.B. Tr. 288. Dr. Munzing observed that none of the subject prescriptions were within the California standard of care. Tr. 248, 289.

On April 19, 2006, M.B. presented for his first visit. Tr. 248-49; GX 3, p. 88, 91. In his "Comprehensive History and Physical Examination," the Respondent reported that M.B. presented with symptoms of "chronic back pain, left knee pain, dyslipidemia." Tr. 249-50. However, there are no appropriate diagnoses relating to the back and knee pain and therefore no legitimate medical purpose for prescribing hydrocodone.[*E]

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*E Dr. Munzing clarified that "knee pain and back pain are really symptoms, and chronic back pain is essentially, you have a symptom that's there ongoing." Tr. 250. He further testified that these symptoms are not diagnoses, though Respondent treated them as such, and that the distinction is important because the way knee and back pain are treated differs "depending on the more specific diagnoses or diagnosis causing the symptoms." Tr. 251.

The Government's attorney and Dr. Munzing agreed about the importance of this distinction and the Government's attorney apologized in advance that he might refer to certain symptoms

Tr. 250-51, 258. To address the reported pain, the Respondent prescribed hydrocodone. Tr. 252. The file fails to evidence sufficient history to justify the pain prescriptions under the standard of care. Tr. 252-54. The file fails to evidence any physical exam to justify the pain prescriptions under the standard of care.[*F] Tr. 254-55, 258, 287. The file fails to evidence any treatment plan or goals, or past drug abuse to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287.

Although M.B. declared on a "Declaration of Pain Medication Use" form that he had no prior drug abuse in August 2009, which was three years after his first visit, such static declaration does not satisfy the physician's ongoing responsibility under the standard of care to monitor this issue [to determine whether the patient is "currently using drugs."] Tr. 259-61; GX 3 at 93.

On July 9, 2013, M.B. presented with ADD and neck pain. Tr. 261-62; GX 3 at 46. He was prescribed Adderall for the ADD. Tr. 262. Again, the records reveal there was no history taken to support the diagnosis or justify the prescriptions for Adderall. Tr. 262. There was no evident evaluation done by the Respondent. Tr. 287. There was no treatment plan. Tr. 263. Although there was a diagnosis related to the neck pain, there was no history or physical exam

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as diagnoses as "shorthand," even though they both understood what he meant. *Id.*

*F Dr. Munzing testified, "there was no back exam. There was no knee exam. Again, heart, lung, abdomen. There is a head, ear, eyes exam. . . . He, once again, did a testicular and a rectal exam. But there is no back and knee exam evident." Tr. 256.

evident in the file. Tr. 263-64. The Respondent never established a legitimate medical purpose for hydrocodone. Tr. 264. On September 6, 2013, M.B. presented with ADD. Tr. 264-65; GX 3 at 46. He was prescribed Adderall for the ADD, but at double the dosage of the previous visit without any reported justification. Tr. 264-65.

Dr. Munzing testified that on January 5, 2018, M.B. presented to the clinic. Tr. 265-66; GX 3 at 37. He was prescribed hydrocodone and Adderall. There was no medical history, assessment of M.B.'s response to treatment, evaluation of pain or functioning, substance abuse history, diagnoses, rationale for establishing a legitimate medical purpose for prescribing or to justify continuing the medication regimen. Tr. 265-66. On March 6, 2018, M.B. presented to the clinic with "ADD and opioid dependency." Tr. 266-67; GX 3 at 36. Absent was any report of pain. He was diagnosed with "Opioid dependency, refusing detox." Tr. 267. Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 268. He was prescribed hydrocodone, which not only is outside the standard of care, but is illegal in California.[*G]

*G As written, this language suggests that there is a specific California law prohibiting hydrocodone prescriptions for individuals who are opioid dependent and refusing detox. The Government did not introduce specific evidence of any such law. However, the Government, through Dr. Munzing's testimony, has established that opioid dependency is not a legitimate medical purpose for prescribing hydrocodone and that such prescriptions are outside the usual course of professional practice. Furthermore, the Government has established that prescribing without a legitimate medical purpose and outside of the usual course of professional practice is a violation of Cal. Health & Safety Code

Tr. 267-68. Dr. Munzing observed that the Respondent prescribed hydrocodone repeatedly to address his diagnosis of opioid dependency until November 20, 2019. Tr. 268-69. On November 20, 2019, M.B. presented with ADD and back pain. Tr. 269; GX 3 at 27. He was prescribed Adderall, and his hydrocodone was increased. Tr. 270. No medical history was taken or updated. No response to treatment or patient functionality was included. Although vital signs were taken, no physical or mental exam was performed. Tr. 270-71. There was no appropriate diagnosis for the back pain. Tr. 272. There was no evaluation for ADD, such as mental functioning. Tr. 271, 274, 287-88. The Respondent never obtained a sufficient history to support the diagnosis for ADD. Tr. 273. There was no appropriate diagnosis for ADD. Tr. 272.

[Dr. Munzing, in summary, testified that Respondent never took a proper medical or mental health history and never conducted a sufficient physical or mental health examination for M.B.'s relevant diagnoses; therefore, he never made an appropriately supported diagnosis. Tr. 273-74. Accordingly,] the Respondent never established a legitimate medical purpose to prescribe either hydrocodone or Adderall to M.B. throughout the reported treatment. Tr. 274. Dr. Munzing opined that such prescriptions were not issued in the usual course of professional practice, were not for a legitimate medical purpose, and were outside the standard of care. Tr. 274-75.

Dr. Munzing noted the inconsistency of the various diagnoses. Diagnoses would come and go

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§ 11153(a). Accordingly, I agree that the conduct is illegal and have moved the sentence for clarity.

within the records. Tr. 275-278; GX 3 at 35, 37, 43, 67. Although the recorded diagnoses were always treated with hydrocodone, the diagnoses varied greatly; [in 2009, it was prescribed for shoulder pain, in 2013, it was prescribed for neck pain, in 2014, it was prescribed for back pain, in 2018, it was prescribed for opioid dependency, and sometimes there was no diagnosis whatsoever given for the hydrocodone prescribed. Tr. 275-78.] Yet no explanation for the changing diagnoses is included in the file, as required by the standard of care. Tr. 278-80.

Dr. Munzing noted the serious dangers occasioned by the combination of Adderall and hydrocodone by reference to his testimony regarding S.B.'s similar prescriptions.[7] Tr. 281. Dr. Munzing deemed this combination of medications for over ten years inappropriate and unsafe. Tr. 284. The only semblance of a warning to M.B. regarding these dangerous combinations appeared in a 2009 "Controlled Substance Therapy Agreement." For the same reasons as Patient S.B., Dr. Munzing deemed the signed form wholly insufficient to satisfy the California standard of care in this regard. Tr. 281-82; GX 3 at 92. Similarly, the notation within the file, "SED" was insufficient to satisfy the standard of care. Tr. 283. Dr. Munzing also

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7 On September 29, 2017, and monthly from July 2018, to July, 2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition in which this combination would be appropriate. Tr. 211-12.

testified that there was never a UDS ordered for M.B., which was necessary under the standard of care for any patient receiving opioids, but especially for a patient who has refused opioid detox. Tr. 284-85. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not appropriately addressed by the Respondent repeatedly as to M.B. Tr. 285-87; GX 3 at 36.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for M.B., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for M.B.'s relevant diagnoses, never made an appropriately supported diagnosis, never recorded M.B.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with M.B., never appropriately monitored M.B. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 287-89. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to M.B. were issued without a legitimate medical purpose, outside the usual course of professional practice and beneath the standard of care in California. Tr. 289-90.]

Patient B.C.

Dr. Munzing reviewed the subject prescriptions, patient file and CURES report for Patient B.C., which he described as containing "very little." Tr. 290-92; GDX 3. He opined that the subject controlled substance prescriptions issued for hydrocodone, Xanax and

Adderall, from January 25, 2017, to December 19, 2019, were all issued outside the California standard of care. Tr. 290-92, 335-38. B.C. presented on March 27, 2014, with GAD and back pain. Tr. 293-94; GX 5 at 48, 55. B.C. was diagnosed with GAD and back pain, refusing detox. He was prescribed Xanax (6 mg per day) for the GAD, and hydrocodone for the back pain, refusing detox. Tr. 294. Dr. Munzing reiterated the risks involved in prescribing 6 mg of Xanax per day. Tr. 295.

The records failed to disclose the minimum history necessary under the standard of care to appropriately diagnose "back pain" and GAD [or to prescribe controlled substances to treat those conditions.] Tr. 295-96. Other than limited vital signs, the records failed to disclose the minimum physical examination necessary under the standard of care to appropriately diagnose "back pain," or to justify a hydrocodone prescription. Tr. 296-97. Dr. Munzing could not remember seeing any prior medical records in the Respondent's subject files. Tr. 297. There were no entries in B.C.'s file indicating physical or mental functioning. Tr. 298, 335-38. There was no treatment plan indicated. The Declaration of Pain Medication Use, signed by B.C. at his first visit, as discussed previously, is insufficient to evaluate B.C. and to establish informed consent for the controlled substances prescribed. Tr. 299-300. There was insufficient medical evidence to support either diagnosis. Tr. 298, 335-38. Accordingly, there was no legitimate medical purpose for either controlled substance prescription. Tr. 299, 335-38.

B.C. presented on May 20, 2014, with ADD and was prescribed Adderall. Tr. 301-02; GX 5 at 47. The ADD diagnosis was deficient, as no history was devel-

oped, no mental functioning was assessed, the medical evidence was deficient, and a treatment plan was lacking. The Respondent failed to establish a legitimate medical purpose for prescribing Adderall. Tr. 302. Additionally, starting B.C. on 30 mg of Adderall twice daily is a very high dosage, and extremely inappropriate to an Adderall naive patient, which is not developed within the patient file. Tr. 302-03.

According to Dr. Munzing, B.C. presented on January 25, 2017, with ADD, opioid dependency and GAD. Tr. 303; GX 5 at 33. He was diagnosed with ADD for which he was prescribed Adderall, and GAD for which he was prescribed Xanax (6 mg per day). Tr. 304. Pain levels were not reported at this visit. The diagnoses were unsupported by sufficient medical history, medical evaluation, response to treatment, patient functionality, and medical evidence. Tr. 304-06. He failed to establish a legitimate medical purpose for both Adderall and Xanax. Tr. 306, 335-38. The Respondent further diagnosed, "Opioid dependency, refusing detox" for which the Respondent again prescribed hydrocodone. Tr. 306. Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 307. Prescribing hydrocodone for opioid dependence is not only outside the standard of care, but it is illegal in California. Tr. 307. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not addressed by the Respondent repeatedly as to B.C. Tr. 306-07; GX 5, at 33.

On July 31, 2018, B.C. presented with ADD, back pain and GAD. Tr. 308; GX 5 at 28. He was diagnosed with ADD for which he was prescribed Adderall (60 mg

per day), "back pain, opiate dependent, refusing detox" for which he was prescribed hydrocodone, and GAD for which he was prescribed Xanax (6 mg per day). Tr. 308. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment and no indication that a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 308-09, 335-38. There was no reference to pain levels or physical functionality. Tr. 309-10. There was no reference to mental functioning with respect to the ADD and GAD diagnoses. Though three diagnoses were recorded, Dr. Munzing testified that none of them were appropriate. Tr. 309-10. Neither did Respondent establish a legitimate medical purpose for the three controlled substance prescriptions. Tr. 311.

B.C. presented on December 19, 2019, with ADD and back pain, which were also his diagnoses, and for which he was prescribed Adderall (60 mg per day) and hydrocodone. Tr. 311-12; GX 5 at 20. The record is lacking documentation of a medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. Tr. 312-13, 335-38. As a result, the three diagnoses are without sufficient medical evidence. Tr. 313. Dr. Munzing testified that each of the controlled substance prescriptions were issued without a legitimate medical purpose, outside the usual course of professional practice, and beneath the standard of care. Tr. 313-16, 335-38.

Dr. Munzing noted the inconsistency of diagnoses throughout B.C.'s records and the dual prescribing of

hydrocodone, sometimes for opioid abuse, sometimes for skeletal pain, and sometimes for both, without explanation in the record. Tr. 316-19; GX 5 at 31, 32, 33. [Dr. Munzing explained that it "would be important to document [what is] going on here." Tr. 318.] Dr. Munzing noted the GAD and ADD diagnoses appear and disappear within the record, as do their treatment medications without explanation. Tr. 319-24; GX 5 at 27, 31, 32, 33. Dr. Munzing deemed it highly unlikely that ADD and GAD were appropriate diagnoses.[*H] Tr. 322, 324.

Dr. Munzing also testified that the Respondent prescribed B.C. a combination of hydrocodone, Adderall and Xanax. Tr. 327; GDX 3. Dr. Munzing could not conceive of a medical condition warranting this dosage, duration, and combination of medications, noting Adderall is counter-indicated for GAD, and combining Xanax with an opioid represents a dangerous combination that is contrary to an FDA black box warning and CDC guidance. Tr. 327-29, 332-33; GDX 3. A further concern, as detailed earlier in his testimony, is reflected by the repeated combination of hydrocodone and Adderall by the Respondent. Tr. 329-30; GDX 3.

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*H Dr. Munzing's opinion regarding the credibility of any assigned diagnosis is not particularly relevant to my analysis. Here, the standard of care requires that a diagnosis be based on a patient's history and physical examination. *See infra*, The Standard of Care for Prescribing. Accordingly, where, as here, Dr. Munzing has testified that the diagnosis was not adequately supported by the patient's history and physical examination, then I find that, based on his expert testimony, the diagnosis is inadequate to serve as the basis for the prescribed prescriptions. This is true whether or not a practitioner acting in the usual course of professional practice could have properly reached the same diagnosis for that individual.

These dangerous combinations were prescribed without an established legitimate medical purpose, outside the usual course of professional practice, without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 330-35.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for B.C., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for B.C.'s relevant diagnoses, never made an appropriately supported diagnosis, never recorded B.C.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with B.C., never appropriately monitored B.C. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 335-37. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to B.C. were issued without a legitimate medical purpose, Tr. 330, outside the usual course of professional practice and beneath the standard of care in California. Tr. 330, 338.]

Patient J.C.

Dr. Munzing reviewed the subject prescriptions issued from January 16, 2018, to December 30, 2019, patient records and CURES data relating to Patient J.C. Tr. 381-82; GDX 4. Dr. Munzing opined that none of the subject prescriptions issued to J.C. were issued within the California standard of care. Tr. 382. J.C. presented to the Respondent's clinic on May 18, 2009,

with a headache and GAD. Tr. 383-384; GX 7, at 216, 233. He was prescribed hydrocodone for migraine and Xanax for GAD and remained on this medication regimen for a long period. As to the migraine diagnosis, insufficient medical history was obtained, symptom evaluation was absent, no neurological exam was conducted, no evaluation of functioning level was made, no treatment plan was evident, and no evaluation of possible drug abuse was provided. Tr. 384-90. In short, there was insufficient medical evidence to support the diagnoses of migraines and GAD, nor was there a legitimate medical purpose to prescribe hydrocodone and Xanax. Tr. 386-88.

[On August 17, 2009, J.C. signed a "Declaration of Pain Medication Use" form indicating that he had no prior drug abuse, and Dr. Munzing testified that there is no record of J.C. ever being asked about illicit substance abuse again. Tr. 389-90. Dr. Munzing testified that the 2009 Declaration was an insufficient inquiry to cover Respondent's prescribing during the relevant period. *Id.*]

J.C. presented on July 21, 2016, with "GAD, chronic back pain, consented for H&P." Tr. 390; GX 7 at 189. He was diagnosed with GAD and back pain—refusing detox for which he was prescribed Xanax and hydrocodone, respectively. Tr. 390-91. There was no updated history taken for either diagnosis, no physical exam, no treatment plan, no response to treatment, no pain or functioning level evaluations, no discussion regarding drug abuse, and no rationale for continued treatment, as required by the standard of care. Tr. 390-94. There was deficient medical evidence to support either diagnosis. The Respondent did not establish a legitimate medical purpose to prescribe the controlled

substances. Tr. 393-94. J.C. presented on January 16, 2018, with GAD and back pain for which he was diagnosed with GAD and back pain, opiate dependent, refused detox. Tr. 394-95; GX 7 at 180. He was prescribed Valium for the GAD (Klonopin was discontinued), and hydrocodone for back pain, although no explanation was given for substituting the Valium for the Klonopin. Tr. 395. There was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no drug abuse history, rendering each diagnosis inappropriate. Tr. 395-97. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 396-98. J.C. presented on February 16, 2018, with "opioid dependency, GAD," yet without the previously noted back pain. Tr. 398; GX 7, 9. There was no reference to pain. He was diagnosed with "Opioid dependency, refusing detox" for which he was prescribed hydrocodone, which again, is outside the usual course of professional practice and illegal in California. Tr. 398-400. The diagnosis for opioid dependency that was treated with hydrocodone appeared repeatedly in the records. Tr. 399. J.C. presented on May 6, 2019, however no treatment notes for this visit are evident in the file. Tr. 401; GX 4, GX 7 at 168.

On April 9, 2019, J.C. presented with GERD and back pain for which he was prescribed hydrocodone. Tr. 402. However, there was no medical history included in the records, no response to treatment, no adequate physical exam, no pain or functioning evaluation, no mental health history, and no drug abuse history, which rendered the back pain diagnosis inappropriate. Tr. 402-04. Without a legitimate medical purpose, there was no appropriate rationale for continued

treatment with controlled substances. Tr. 402-04. On December 30, 2019, J.C. presented with GERD and GAD. Tr. 404; GX 7, p. 171. He was prescribed Valium for the GAD. However, there was no appropriate medical history included in the records, no response to treatment, no documented evaluation for GAD or functioning evaluation, no mental health history, and no drug abuse history, rendering the GAD diagnosis inappropriate from January 16, 2018, to December 30, 2019. Tr. 404-08, 425-28. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 408, 425-28. Such prescriptions, from January 16, 2018, to December 30, 2019, were issued outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice. Tr. 408, 425-28.

Dr. Munzing noted the inconsistency of diagnoses throughout J.C.'s records, and the dual prescribing of hydrocodone for opioid abuse, migraines, and for skeletal (sometimes neck, sometimes back) pain, without documenting an explanation for the changes in the record. Tr. 410-14; GX 7 at 188, 189, 205, 214, 215. [There was never any discussion regarding "where one condition was going and another was coming from" as Dr. Munzing agreed "would be important for a practitioner acting within the standard of care to understand" and to document. Tr. 414.] Dr. Munzing noted the skeletal pain diagnoses appears and disappears within the record. Tr. 414-15. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 415; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the Respondent had prescribed a combination of hydrocodone and Valium monthly

between January 2018 and January 2019 without a legitimate medical purpose. Tr. 416-17; GX 4. Combining Valium with an opioid represents a dangerous combination and is contrary to an FDA black box warning and to CDC guidance, especially with the Valium at its highest available strength. Tr. 417. Dr. Munzing could not envision a condition for which this medication regimen would be appropriate treatment. Tr. 418. These dangerous combinations were prescribed without an established legitimate medical purpose, outside the usual course of professional practice, without sufficient warnings and informed consent, without sufficient patient monitoring,[*I] and without addressing obvious red flags. Tr. 418-23; GX 7 at 19, 25, 27, 180, 225.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for J.C., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for J.C.'s relevant diagnoses, never made an appropriately supported diagnosis, never recorded J.C.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with J.C., never appropriately monitored J.C. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 424-27. Accordingly, Dr. Munzing opined that each of the relevant

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*I Dr. Munzing testified that given the prescribed combination of medications and how "highly sought after [they are] in the drug abusing community," it would have been "[v]itally important" to conduct appropriate ongoing monitoring, which was not done and was therefore outside the standard of care here. Tr. 421.

prescriptions Respondent issued to J.C. were issued without a legitimate medical purpose, outside the usual course of professional practice and beneath the standard of care in California. Tr. 428.]

Patient D.D.

Dr. Munzing reviewed the subject prescriptions issued from January 4, 2018, to February 12, 2019, patient records and CURES data relating to Patient D.D. Tr. 428-29; GDX 5. Dr. Munzing opined that none of the subject prescriptions issued to D.D., which were for hydrocodone, Soma, and Xanax, were within the California standard of care. Tr. 430. Again, the records contained "very little information." Tr. 429. D.D. presented on July 9, 2008, with GAD and back pain. Tr. 430-31 GX 9 at 74. For the GAD, he was prescribed Valium. For back pain, he was prescribed hydrocodone and Soma. Tr. 431. The medical records reflect that D.D. refused an MRI and refused referral to orthopedist or a pain specialist. Tr. 431. According to Dr. Munzing, each refusal is a red flag, and suggestive of drug-seeking behavior. Tr. 432. ["Those are huge red flags. [For] someone who truly wants to be treated for back pain to be refusing kind of ways to try to improve that or to better diagnose it through an MRI or an evaluation from a subspecialist are just enormous red flags and certainly brings in the distinct possibility [he] is here seeking drugs rather than really trying to get his pain managed." Tr. 432.] Instead of addressing the red flags, the Respondent prescribed opioids. Tr. 432. The Respondent's response was the same throughout the subject treatment of D.D., a total of nine and a half years. Tr. 433.

According to Dr. Munzing, there was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, no functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from July 9, 2008, to January 4, 2019. Tr. 433-38; GX 9 at 37, 39, 41, 43, 44. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 434-48. Such prescriptions, from July 9, 2008, to January 4, 2019,[*J] were issued outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice. Tr. 434-48.

[On January 11, 2019, D.D. was diagnosed with GERD and "back pain—opiate dependent refusing detox." Tr. 439. This is the last time Respondent prescribed D.D. both hydrocodone and Soma, but the medical records again reflected a lack of appropriate medical history, response to treatment, an appropriate physical examination, assessment of pain or physical functionality, an appropriate diagnosis, or an established legitimate medical purpose for the prescriptions. Tr. 439-40. On February 12, 2019, Respondent prescribed D.D. hydrocodone to treat opioid dependency—refusing detox without there being any mention of pain. Dr. Munzing testified that this was outside the standard of care for all of the reasons he had previously testi-

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[*J] Only the prescriptions issued between January 4, 2018, and February 12, 2019, were alleged in the OSC and are relevant to my decision.

fied. Tr. 441-42. Dr. Munzing testified that at no point during the treatment period did Respondent ever obtain a sufficient history to establish a diagnosis for back pain or support prescribing of hydrocodone and that the prescriptions for hydrocodone and Soma were not issued within the usual course of professional practice and were outside the standard of care. Tr. 443-44.

Dr. Munzing noted a period of over a year when no diagnosis for GAD appeared in D.D.'s records, from May 10, 2017, to September 19, 2018, and the 30 mg daily dose of Valium was stopped. Tr. 447-48. Then on September 19, 2018, the Respondent was placed on 6 mg of Xanax, which is a very high dosage especially for the beginning dosage. [Dr. Munzing testified that Respondent failed to obtain sufficient medical evidence upon which to base a GAD diagnosis. Tr. 446.] Compounding this dangerous dosage of Xanax, D.D. was prescribed hydrocodone in combination, which heightened the risk of overdose [without any warning from Respondent regarding the dangers of the controlled substances being prescribed.] Tr. 446, 448-50, 458. [Dr. Munzing testified that there was no established legitimate medical purpose for prescribing Xanax to D.D. Tr. 446.]

Dr. Munzing noted the inconsistency of diagnoses throughout D.D.'s records and the dual prescribing of hydrocodone and Soma for fibromyalgia, opioid abuse, and skeletal pain (namely back pain or neck pain), without a documented explanation in the record. Tr. 450-56; GX 9 at 43, 51, 64, 70; GDX 5. Dr. Munzing noted the skeletal pain diagnoses appear and disappear within the record. Tr. 450-56. Dr. Munzing suspected the skeletal pain complaints were not legitimate.

Tr. 456; GX 9 at 43, 51, 64, 70. Prescribing Soma with hydrocodone presents considerable risks to the patient. Each are respiratory depressants, which presents a significant risk of overdose, [and each is highly abused.] Tr. 458. [Dr. Munzing also reiterated the risks of prescribing both hydrocodone and Xanax together. Tr. 458. Dr. Munzing testified that in 2009, D.D. signed "the same controlled substance therapy agreement we've seen with the previous four patients," and it was insufficient notice of the risks of using controlled substances for the reasons already discussed. Tr. 458-59. Dr. Munzing further testified that the record is lacking any documentation that Respondent adequately warned D.D. of the risks of the controlled substances he was taking, particularly in light of the various combinations and high dosages. Tr. 459-60.]

D.D. presented on March 23, 2019, with opioid dependency, refusing detox, which is a red flag. He was again prescribed hydrocodone and Soma. Tr. 463; GX 9 at 42, 43. [Dr. Munzing reiterated his testimony that hydrocodone is not an appropriate treatment for opioid dependency and added that neither is Soma. Tr. 454-55. Accordingly, Dr. Munzing testified, every relevant prescription for hydrocodone and/or Soma that was issued to treat opioid dependency was issued outside the standard of care. Tr. 455.] The Respondent failed to address this red flag repeatedly, instead prescribing Soma and hydrocodone. Tr. 465.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for D.D., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for D.D.'s relevant diagnoses, never made an appropriately supported diagnosis,

never recorded D.D.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with D.D., never appropriately monitored D.D. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 465-68. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to D.D. were issued without a legitimate medical purpose, outside the usual course of professional practice and beneath the standard of care in California. Tr. 468.]

Patient J.M.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 10, 2017, to December 31, 2019, patient records and CURES data relating to Patient J.M. Tr. 469-70; GDX 6. [Again Dr. Munzing testified there was "very little information" in the patient's medical records. Tr. 470.] Dr. Munzing opined that none of the subject prescriptions issued to J.C., namely for hydrocodone, Xanax and Soma, were issued within the California standard of care. Tr. 470-71.

On May 13, 2007, J.M. presented with hypertension, back pain, GAD, dyslipidemia and insomnia. Tr. 470-72; GX 7 at 104, 111. He was diagnosed with hypertension, back pain, GAD, dyslipidemia and insomnia. He was prescribed hydrocodone for back pain and Xanax (6 mg per day) for GAD. Tr. 472. Xanax and hydrocodone were recurring prescriptions. As discussed, the high dosage of Xanax was a concern to Dr. Munzing, as well as its combination with an opioid. Tr. 473.

According to Dr. Munzing, there was no appropriate medical history included in the records, no response to treatment, no physical exam of the back or other areas of issue, insufficient patient monitoring, no evaluation for GAD, no treatment plan, no pain or functioning evaluation, no mental health history, no ongoing drug abuse history or monitoring, no discussion of risk factors and informed consent, and no patient monitoring, which rendered the GAD and back pain diagnoses inappropriate from May 13, 2007, to January 13, 2017. Tr. 473-76, 478, 481-83, 485-500. The MRI dated May 30, 2007, and its "mild" findings, did not independently satisfy the Respondent's obligations or justify the subject prescriptions. Tr. 479-80, 485-87; GX 11 at 14, 16, 17, 22, 26, 31, 37, 41, 42, 115. [Dr. Munzing testified that for the five visits between January 10, 2017, through March 27, 2017, there is so little documentation that Dr. Munzing cannot tell whether the records reflect "actual visits" or just "documentation of a refill of the medication." Tr. 482-85. This is because, according to Dr. Munzing, the records lack examination or history notations, documentation of the dose or strength prescribed, diagnoses, nothing to meet the standard of care for prescribing hydrocodone and Xanax for that period. Tr. 482-85.

The first prescription for Soma during the relevant time period was on April 13, 2017, and according to Dr. Munzing, the medical note said "Xanax number 90, Soma number 50SED, and then a signature" with absolutely nothing else recorded and none of the elements of the standard of care met. Tr. 485-86. Dr. Munzing testified specifically about selected office visits. On April 25, 2018, Respondent's records for J.M. contain information suggesting an office visit

occurred, but they continue to have the same deficiencies. That day, J.M. was not diagnosed with pain, but with GAD and opioid dependence-refusing detox, which was treated with hydrocodone. Tr. 487. Dr. Munzing reiterated his concern that hydrocodone is not appropriate treatment for opioid dependence and was inappropriate each time it was prescribed for that purpose. Tr. 488. Dr. Munzing testified about the November 19, 2018 visit during which J.M. was prescribed Xanax for GAD and Soma for back pain; the February 20, 2019 visit during which he was prescribed Xanax for GAD and hydrocodone for back pain; and the December 31, 2019 visit during which he was prescribed Xanax for GAD and was not diagnosed with back pain. Tr. 489, 492-93, 495. Dr. Munzing again testified, amongst other things, that for each of these visits, there was an insufficient medical history or physical examination to make the diagnoses, there was no information regarding the response to treatment, pain level, or functionality, and there was no legitimate medical purpose established for the prescriptions at issue. Tr. 489-91, 493-97.] Without a legitimate medical purpose, there was no appropriate rationale for the controlled substance prescriptions, or to continue treatment with controlled substances. Tr. 473-76, 478, 485-500, 505; GDX 7.

There were also red flags left unaddressed by the Respondent. J.M. refused to see a pain specialist, which gives rise to the suspicion that he is not concerned about getting better, but just getting medicated. Tr. 476-77.*K Dr. Munzing noted that there were gaps in prescribing hydrocodone and Soma

*K Omitted for relevance.

without any required explanation for changes to the medication regimen. Tr. 500-04; GX 11 at 36, 37, 40, 41, 42, 76. He observed that the hydrocodone was prescribed either for back pain or for opioid dependence. Tr. 504. However, as with the other patients, the required evaluation for the diagnoses coming and going and explanation for treatment is lacking. This further diminishes any medical legitimacy for prescribing hydrocodone. Tr. 504.

Additionally, on multiple occasions the Respondent prescribed a very addictive and dangerous combination of medications including an opioid and a benzodiazepine. Tr. 558-60. Even more concerning, he added a muscle relaxant, to this already dangerous combination to form the "Holy Trinity," which is a favorite drug combination for abuse. Tr. 505-10. Dr. Munzing could not conceive of a medical condition in which the trinity combination would represent appropriate treatment. Tr. 512. This trinity of medications was prescribed to J.M. repeatedly. GDX 6. The file fails to reveal whether appropriate warnings were given to J.M. in connection with this dangerous combination. Tr. 511; GX 11 at 113. The CURES report reveals that 40 Xanax prescriptions (totaling 3600 dosage units and 7200 mgs) were issued to J.M. over a period of 22 months between January 2017 and November 2018. This means that Respondent was issuing a Xanax prescription to Respondent every 16 days on average for an average total of 10.5 mgs per day. Tr. 512-17, 527-28; GX 7, 17, 18. Ten and a half mgs per day is considerably greater than the maximum 4 mg per day recommended for treatment of anxiety. The CURES report lists two different dates of birth for J.M., as well as two different spellings of his first name. Tr. 517-18, 547-

49; GX 18. A CURES search would be name and date of birth specific, so a search by one name and date of birth would not reveal prescriptions filed under the alternate name and date of birth. Tr. 526. The main sources of the CURES report information are two pharmacies, Reliable Rexall and Northridge Pharmacy. Tr. 518-19. Despite the fact that J.M. was using different names and dates of birth at different pharmacies, which was a considerable red flag suggesting abuse or diversion, the Respondent did not address these issues. Tr. 519-20, 525-26. Even if J.M. or the pharmacies were the source of the alternate dates of birth and alternate first names, with due diligence, the Respondent would have discovered that a search by a single name and date of birth would only include half of the Xanax prescriptions the Respondent issued to J.M. Tr. 521-26, 549-50. [Dr. Munzing testified that there is "nothing in the notes" addressing this red flag." Tr. 550.] Additionally, two prescriptions, one written by the Respondent and one called in by the Respondent on the same day, contain two different dates of birth. Tr. 533-34.

The CURES report also reveals J.M. was alternating the filling of the Xanax prescriptions between the two pharmacies-which could indicate that he was trying to hide the bi-monthly frequency of the prescriptions. Tr. 520; GX 17, 18. Dr. Munzing noted this was a suspicious prescribing practice by the Respondent. Tr. 530; GX 17, # 425 & 575.[8] He would issue two prescriptions on the same day to J.M., one for hydrocodone and one for Xanax. He would issue a written prescription for hydrocodone, which J.M.

8 These are prescription numbers.

would invariably fill at Northridge Pharmacy, but would call in the Xanax prescription to Reliable pharmacy. Tr. 531-33, 535-45, 550-58; GX 11 at 32, 33, 35, 36, 38, 40, 41, GX 12 at 5, 6, 10, 11, 14, 22, 24, 27, 33, 34; GX 13, at 20, 25, 27, 32, 34; GX 17, 18 #473, #474, #994, #1120, #1228, #1386, #1472, #1553, #2102, #2229, #2341, #2342. Dr. Munzing testified that this could have been an attempt to avoid the suspicion generated by the opioid/benzodiazepine combination if filled at a single pharmacy. Tr. 532-33, 557-60. There was an additional suspicious circumstance related to a Xanax prescription. The Respondent wrote in his medical notes that the medication should be taken once every eight hours, but the call-in information to the pharmacy was once every six hours. Tr. 543-45, 554, 556-57. [Dr. Munzing testified "[there is] not consistency between what [Respondent is] telling the pharmacist and what [he is] documenting in the progress note." Tr. 545.]

The red flag of refusing to detox was repeatedly evident within J.M.'s patient file. Tr. 562; GX 11 at 37. He was diagnosed with "Opioid dependency, refusing detox" for which he was prescribed hydrocodone, which again, is outside the usual course of professional practice and illegal in California. Tr. 563-64. The diagnosis for opioid dependency being treated with hydrocodone appeared repeatedly in the records. The Respondent never addressed this red flag. Tr. 564.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for J.M., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for J.M.'s relevant diagnoses, never made an appropriately supported diagnosis,

never recorded J.M.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with J.M., never appropriately monitored J.M. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 564-67. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to J.M. were issued without a legitimate medical purpose, outside the usual course of professional practice and beneath the standard of care in California. Tr. 567-68.]*L

Patient K.S.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 19, 2018, to January 31, 2019, patient records and CURES data relating to Patient K.S. Tr. 469-70; GDX 8. [Again Dr. Munzing testified there was "very little" information in the medical records. Tr. 569.] Dr. Munzing opined that none of the subject prescriptions issued to K.S., namely hydrocodone, Xanax and Adderall, were issued within the California standard of care. Tr. 568-70. K.S. presented on June 21, 2007, with "back pain" for which he was prescribed hydrocodone and Soma. Tr. 570; GX 13 at 117. Although the Respondent noted he would get an MRI for the lumbar spine, no such MRI appears in the records. Tr. 571. There was no medical history included in this record regarding back pain, no treatment plan, no response to treatment, no physical exam of the back or musculoskeletal area, no

*L This text replaces the ALJ's summary paragraph for consistency.

pain or functioning evaluation, no ongoing drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 570-74. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances for back pain. Tr. 571-74.

[On August 5, 2009, K.S. signed a "Declaration of Pain Medication Use" form indicating that he had no prior drug abuse, and Dr. Munzing testified that there is no record of K.S. ever being asked about illicit substance abuse again. Tr. 575. Dr. Munzing testified that the 2009 Declaration was an insufficient inquiry to cover prescribing at any point in time when Respondent was treating K.S. Tr. 576.]

On May 1, 2012, K.S. presented with GAD and neck pain. Tr. 576; GX 14 at 80. He was diagnosed with GAD and neck pain, and prescribed Xanax for GAD and hydrocodone for the neck pain, refusing detox. Tr. 577. K.S. was prescribed a combination of hydrocodone and Xanax frequently throughout his treatment. This combination of an opioid and a benzodiazepine is dangerous, beneath the standard of care and represents a red flag unresolved by the Respondent throughout the records. Tr. 578-79. There was no medical history supporting the prescriptions. There was no indication of how the patient was responding to treatment. There was no treatment plan and no indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 579-81. There was no reference to pain levels or physical functionality. There was no reference to mental functioning with respect to the GAD diagnosis. There was no appropriate diagnosis for the GAD and neck pain. Respondent did not establish a legitimate medical

purpose for the controlled substance prescriptions. Tr. 580-81.

According to Dr. Munzing, K.S. presented on November 18, 2013, and was prescribed Adderall (60 mg per day) with no documented evaluation for or diagnosis of any condition that Adderall may treat. Tr. 581-82; GX 14 at 70. There is also no medical history, physical exam, or treatment plan, and accordingly, the subject prescription is without a legitimate medical purpose.[*M] Tr. 582.

On January 19, 2018, K.S. presented with GAD, back pain and ADD.[*N] Tr. 583, 599; GX 14 at 41. For GAD, the Respondent prescribed Xanax. For back pain—opioid dependent, refusing detox, the Respondent prescribed hydrocodone; and for ADD, Adderall. Tr. 584. The record is missing any medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning assessment, appropriate rationale for continued treatment, and information relating to drug abuse. Tr. 583-86. As a result, the treatment is without sufficient medical evidence. Tr. 584-86. Accordingly, the subject charged prescriptions are without a legitimate medical purpose. Tr. 586.

On February 27, 2018, K.S. presented with ADD, opioid dependency and GAD. Tr. 586-87, 599-600; GX

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*M This sentence was modified for clarity.

*N Dr. Munzing testified that Respondent did not obtain sufficient medical evidence to diagnose K.S. with ADD at any point between the November 2013 visit and the January 2018 visit. Tr. 583.

14 at 39, 40. He was diagnosed with ADD, opioid dependency-refusing detox, and GAD. Back pain was not reported, nor was any report of pain made. At the April 30, 2018 visit, again, back pain was not reported, nor was any report of pain made. Tr. 601. Throughout the records, the Respondent failed to explain the appearance and disappearance of back pain. Tr. 601-02. Again, beneath the standard of care and against the law in California, K.S. was prescribed hydrocodone for opioid dependency, which Dr. Munzing testified was neither appropriate nor legal. Tr. 587-88. On November 28, 2018, K.S. presented with opioid dependency and GAD for which he was diagnosed with opioid dependency-refusing detox and GAD, and for which he was prescribed hydrocodone and Xanax respectively. Tr. 588-589; GX 14 at 33; GDX 8. Again, beneath the standard of care and contrary to the law in California, K.S. was prescribed hydrocodone for opioid dependency. Tr. 588-89. And again, the medication regimen included the dangerous combination of an opioid and benzodiazepine. The record is missing any medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 588-89. Accordingly, the subject charged prescriptions were issued without a legitimate medical purpose, outside the usual course of professional practice, and beneath the standard of care. Tr. 590.

On December 11, 2018, K.S. presented with ADD and eczema for which he was diagnosed with ADD and eczema. Tr. 591; GX 14 at 33. For ADD, he was pre-

scribed Adderall. [Dr. Munzing testified that the Adderall prescription lacked a legitimate medical purpose for the same reasons as the prior prescriptions he had just discussed. Tr. 591-93.] On January 31, 2019, K.S. presented with and was diagnosed with back pain and stomatitis. Tr. 593-94; GX 14 at 31. For the back pain he was prescribed hydrocodone. [Again, Dr. Munzing testified that the hydrocodone prescription lacked a legitimate medical purpose for the same reasons as the prior prescriptions he had just discussed. Tr. 594-95.]

A review of the entirety of K.S.'s subject medical records reveals that the Respondent never obtained any prior medical records. Tr. 596, 619. The record is missing an adequate prior medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 598-99, 620. Accordingly, the subject charged prescriptions were issued without a legitimate medical purpose, outside the usual course of professional practice, and beneath the standard of care. Tr. 597-98, 619-20.

[Dr. Munzing testified that, similar to the other patients, Respondent prescribed hydrocodone to K.S. for back pain, then neck pain, then for opioid dependency, and sometimes for a combination of these reasons, without any documentation regarding these changes or the coming and going of the pain issues as would be required by the standard of care. Tr. 598-602.] Dr. Munzing also noted the inconsistency of the GAD diagnoses throughout the records. Tr. 602-05; GX

14 at 31, 42, 47, 48. With the GAD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 605-09; GX 8. Similarly, ADD was inconsistently diagnosed with Adderall inconsistently prescribed. Tr. 605-06; GX 14 at 34, 35; GX 8. With the ADD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 609.

Dr. Munzing noted the Respondent prescribed a dangerous combination of medications, including hydrocodone, Adderall and Xanax, which was prescribed from January 2018, through August 2018. Tr. 609-10. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity." Tr. 610. Additionally, the combination of an opioid and a benzodiazepine is present in August, October and November 2018. Tr. 610-11. The records fail to reveal that the appropriate warnings were conveyed to K.S., or that informed consent was obtained. Tr. 611-13; GX 8. Dr. Munzing could not conceive of a medical condition warranting the dangerous combinations of medications prescribed. Tr. 614. [Dr. Munzing also noted that Respondent failed to properly monitor medication compliance, and conducted no urine drug screens, as was required by the standard of care in California. Tr. 614.]

Dr. Munzing noted the Respondent's failure to resolve red flags, including K.S.'s diagnosis of opiate dependency with refusal to detox, the dangerous combinations of medications, and high dosages of controlled medications. Tr. 615-18, 620; GX 14 at 39, 40, 41. The refusal to detox is a major red flag for opioid

use disorder and for diversion. However, the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 615-17. The Respondent's course of action was outside the California standard of care.

[Dr. Munzing, summarizing his opinions based on his review of the entire file for K.S., testified that Respondent never took a proper medical or mental health history, never conducted a sufficient physical or mental health examination for K.S.'s relevant diagnoses, never made an appropriately supported diagnosis, never recorded K.S.'s pain and functionality level, never documented an appropriate treatment plan with goals or objectives, never appropriately documented discussion of the risks of the prescribed controlled substances with K.S., never appropriately monitored K.S. for medication compliance and failed to appropriately respond to red flags of diversion. Tr. 617-20. Accordingly, Dr. Munzing opined that each of the relevant prescriptions Respondent issued to K.S. were issued without a legitimate medical purpose, outside the usual course of professional practice and beneath the standard of care in California. Tr. 620.

In summarizing the entire body of evidence he reviewed in this matter, Dr. Munzing opined that each of the controlled substance prescriptions at issue in this matter were issued "outside the standard of care" and that Respondent's prescribing of high dosages of these controlled substances "absolutely" constituted clear excessive prescribing. Tr. 621.

Respondent's Case-in-Chief

The Respondent presented his case-in-chief through the testimony of one witness, the Respondent, Fares Rabadi, M.D.

Fares Rabadi, M.D.

Dr. Rabadi attended medical school in the former Soviet Union. Tr. 626. He underwent a three-year residency training in internal medicine at State University of New York School of Medicine and Biomedical Science in Buffalo, New York. Tr. 627. According to Respondent, he is currently licensed to practice medicine in New York (inactive), California, and Indiana. Tr. 627. He has been licensed in California since September 25, 1998. His first two years practicing in California were spent working at another medical group. For the past twenty-years he has had his own practice. Tr. 628. He is a member of the American Medical Association (AMA), the American College of Physicians, a Master of the College of Physicians, the American Society of Internal Medicine, the Los Angeles Medical Association and Arab American Medical Association. Tr. 628. He is affiliated with the U.S.C. Keck School of Medicine, and is on the volunteer faculty with the UCLA's David Geffen School of Medicine. He teaches family medicine residents at the Northridge Hospital. Tr. 628-29.

Dr. Rabadi was familiar with the federal regulations, the California Health and Safety Code, and the California Business and Professional Code cited in the Order to Show Cause. Tr. 630. Dr. Rabadi was familiar with the Government Exhibits 1-19 (records relating to the prescribing to the charged patients), and 20 (The [California] Guide to the Laws Governing the

Practice of Medicine by Physicians and Surgeons). Tr. 630. He was specifically familiar with pages 59-60 relating to pain management. Tr. 630; GX 20. He was also familiar with the Guidelines for Prescribing Controlled Substances. Tr. 630; GX 21.

In his medical career Dr. Rabadi has treated thousands of patients, including hundreds of pain patients. At the time of the issuance of the Order to Show Cause, Dr. Rabadi had 300-400 patients of which 175-200 were pain management patients. Tr. 631, 792. In both 2017 and 2018, he estimated he treated 400 to 500 patients. Tr. 803. In 2019, he estimated he saw 400 patients, and less than 200 in 2020.[9] Tr. 804.

Dr. Rabadi described his protocol upon a patient's first visit to his clinic prior to the issuance of a prescription. Tr. 631. The patient initially fills out paperwork. His office verifies insurance coverage. The patient is weighed and then sent to an examination room. Dr. Rabadi enters the room, greets the patient and sits on a stool "so [his] eyes are with the same

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9 There was some confusion in the transcript as to the total number of patients in 2019. The Respondent estimated 400 total patients for 2019, but later agreed it was approximately 200 total patients in 2019. Tr. 804. [Respondent also testified at the hearing that "I have close to 550-600 patients" suggesting that was his total number of patients at the time of the hearing in September 2020. Tr. 792. He testified that he had 175-200 patients who were specifically pain patients up until the time of the OSC which was dated March 2020. I note that the exact number of patients that Respondent was treating at any given time has little relevance to my decision in this matter, other than as it relates to his ability to accurately recall the undocumented details of each medical visit to which he testified.]

level as the patient's eyes."*O Tr. 632. Dr. Rabadi determines how the patient was referred to him. Dr. Rabadi then takes the patient's history, which begins with the patient's main complaint. Dr. Rabadi disagreed with Dr. Munzing's estimate that a diagnosis is 85% based on the patient's history. Dr. Rabadi believed it was upwards of 95% based on history. Tr. 635-36. The Respondent conceded history is critical to understanding the patient's condition and how to treat the patient. Tr. 804. He inquires about family history and their medical issues. Dr. Rabadi then inquires regarding social history, surgeries and present pain. He inquires into habits, such as smoking, and past and present use of illegal drugs. He then probes any allergies, including allergies to medications. If a patient has no allergies, he reports NKDA. Tr. 635. Following history, Dr. Rabadi testified he "starts going in depth about the main complaint," with an eye toward isolating the ultimate medical source of the malady, and whether the symptoms are resolved with medication. Tr. 635-37. Regarding complaints of "back pain," for example, Dr. Rabadi testified that he will review previous diagnoses, probe the source and triggers for the pain, explore any nerve restrictions, and discuss the success of different past treatment methods. Tr. 638-40. If pain medication management was the only treatment that alleviated the pain, Dr. Rabadi would explore the history of that treatment and its efficacy. [Respondent testified that "after [he] complete[s] the history in general, and organ-specific where the complaint is, then [he does the] physical examination." Tr. 641.]

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*O Modified for clarity.

Dr. Rabadi testified that the physical exam he performs for all patients starts with the head. He examines the skull. He explores headaches, noted in the records as, "HEENT." Tr. 641. He then checks the eyes, the ears, and the mouth. Tr. 642. He moves down to the neck, checking for issues with the veins of the neck. He then checks the efficiency of the heart's pumping and its rhythm. Next, he checks the lungs. Moving down to the abdominal cavity, he palpates the liver and spleen for abnormal size. Tr. 643. He then checks the remaining organs of the abdomen and the bowel for irregularities. Tr. 643. He then checks the extremities for circulation issues, often noting in the records, "No ECC" (edema, clubbing or cyanosis). He then checks for skin issues. Finally, he performs a neurological examination, including a mini mental-state exam and their orientation as to time and space. Tr. 643-45. He checks their reflexes, their cranial nerves. Tr. 645. He decides if further radiologic testing is necessary. Tr. 651-52. For men aged 17-35, he offers a testicular exam to check for cancer. For men over 50, he offers a rectal exam to determine indications of prostate and colorectal cancer. The complete exam takes from 30-40 minutes. Then, Dr. Rabadi formulates his diagnosis, [though he noted that "the patient many times comes with a diagnosis already."][*P] Tr. 647. He

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[*P] At this point in his testimony, Respondent stated, "[T]he Government seized more than 223 charts . . . they returned more than 200. . . . And now, they are focusing and fixating on these seven charts. So, they're just looking at the charts and some notes and immediately demonizing an astute clinician who's been in the medical field for 41 years without a blemish to my reputation and career. And now, I'm just portrayed as I'm just feeding the addicts; I'm just distributing his medications." Tr. 648-49. I note that for the purposes of this Decision, I pre-

then establishes a treatment plan. Tr. 649. He discusses the treatment plan with the patient and obtains informed consent. Tr. 658. For patients experiencing pain, he explains the mechanism of pain, the modalities of pain and the type of pain; chronic pain, acute pain, malignant pain, post-traumatic pain, rheumatological pain, psychogenic pain, and neuropathic pain.[10] Tr. 668. For patients receiving pain medication prescriptions, Dr. Rabadi explains the medications, their side effects, including addiction, overdose and death, and cautions patients not to operate machinery or use heavy equipment. Tr. 668-70. [When asked whether he had ever prescribed a controlled substance for a patient without having this discussion about the dangers, he responded, "Absolutely not. Absolutely not. Absolutely not." Tr. 669.] Dr. Rabadi assures his patients that if they take the medication as prescribed, they will not overdose. Tr. 670.[11] He typically sees his pain patients monthly. Tr. 672.

For return visits, Dr. Rabadi is focused on the specific reason for their visit. Tr. 673. This explains why Dr. Munzing's noted diagnoses would appear and disappear from month to month. Tr. 673. Dr. Rabadi

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sume that all prescriptions issued by Respondent that are not at issue in this cases were legitimate.

[10] Dr. Rabadi contrasted these classifications with those he indicated were described by Dr. Munzing mild moderate and severe. Tr. 667-68.

[11] As I understand Dr. Rabadi's testimony, Dr. Rabadi noted that an unnamed study found that dosages 5-6 times higher than that recommended by the FDA were safe. This highly specific evidence was not noticed prehearing, was not reasonably anticipated by the Government, and will not be considered.

does not make note each month of long-term chronic conditions. Tr. 673. If a patient has new symptoms, Dr. Rabadi will focus on these new symptoms and tailor his examination to these symptoms, although at least two organ systems are always examined. Tr. 674. At least every three months blood pressure is checked. Tr. 675. Dr. Rabadi explained that much depends on the physician's judgment. Guidelines are essentially recommendations. Following the guidelines does not make the Respondent a good doctor. The most important thing is to perform with knowledge, with care and in good faith, placing the interest of the patient as the Respondent's top priority. Tr. 676.

If patients' symptoms subsided and they did not finish their medication, Dr. Rabadi would not prescribe more medication. He would wait until the medication was finished. This explains why prescriptions would sometimes stop and restart from month to month. Tr. 673.

For patients on pain medication and desiring to continue on pain medication, he discusses the options of detox and referral to a pain specialist. Tr. 650. All of his patients on pain medications are required to sign a "Controlled Substance Agreement." Tr. 658. Dr. Rabadi also verbally tells patients that they cannot obtain pain medication from different physicians, and they cannot go to different pharmacies for refills. Tr. 660. If a patient overdoses, or is arrested selling medications, he is banned from further treatment. Tr. 660. Dr. Rabadi has little sympathy for reports of lost or stolen medication. Tr. 661.

In the United States, the patient "is in the driver's seat." The patient's wishes are granted unless they are asking for something illegal or abnormal.

Treatment cannot be forced on them. Tr. 650. When a patient reports that he has received extensive radiologic testing and has exhausted medical treatment and surgeries for his injury and wishes to remain on pain medications, the only option is to prescribe those medications or to drop the patient, which Dr. Rabadi did not view as an ethical option.*Q Tr. 651. No one deserves to be in pain. Tr. 664-65, 670. If chronic pain patients were dropped from the practice, they may turn to buying illegal drugs off the street. Tr. 663. Dr. Rabadi was realistic as to most of his pain patients. Some had been on pain medications for 10, 15 and 20 years and were chemically dependent on them. Tr. 662. The goal was not to make them pain free, which would be impossible. It was to minimize the pain, and maximize their functionality without making them a slave to the medications. Tr. 662, 664. For acute pain, Dr. Rabadi typically restricted pain medication to one week. Tr. 662.

Dr. Rabadi noted that almost all of his patients work full time in the motion picture industry doing hard labor and suffer serious and sometimes recurring injuries. Tr. 647, 663. They have had long term injuries with surgeries, and have been on pain medication for a long period of time prior to coming to see him, and are still able to function. Tr. 647-48, 663.

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*Q Respondent testified, "[i]f the patient tells me, 'Look, I've already been with pain specialists; I've already seen a couple of specialists; I already had three-four MRIs; I already had surgery; I'm on this medication for years, and it's working for me,' then it comes down to one of two options. Either I tell him I will fill his prescription or I kick him out of my office. And I don't think it is ethical to do that latter approach." Tr. 651.

Regarding the use of pain scales in diagnosing, Dr. Rabadi noted their limitations—it is purely subjective to each patient. Tr. 658-59. Regarding the high doses of medications he prescribed, Dr. Rabadi agreed with Dr. Munzing that starting patients on such high doses was dangerous. Tr. 640. However, if the patients were acclimated to such high doses, prescribing lower doses would be ineffectual and potentially dangerous. Tr. 656-58. If Dr. Rabadi was just starting treatment for ADD, for example, he would start the patient on .25 mg of Xanax per day. Tr. 657.

Patient S.B.

Patient S.B. remained a patient of Dr. Rabadi's. Tr. 708-09. She was prescribed hydrocodone, Xanax and Adderall. Tr. 709. Dr. Rabadi believed his prescription practice concerning S.B. was within the California standard of care. Tr. 709. Dr. Rabadi began his treatment of S.B. on August 3, 2016. Tr. 718. She presented as a 29 year-old female to establish care for the treatment of ongoing conditions of GAD, fibromyalgia, and ADD. Tr. 719. As per Dr. Rabadi's policy, as detailed in his earlier testimony, he took a complete history.*R Tr. 719-20. He performed a complete physical examination ["head to toe including every organ and system,"] reviewed her existing diagnoses of GAD and ADD, and her medication history in general and specifically for those diagnoses. Tr. 720, 722-24. He obtained her pain level with and without medication. Without medication her subjective pain level was eight. With

*R Respondent testified both generally and specifically to S.B. that he "take[s] personally a very lengthy history. [He] spend[s] close to 60 minutes in the first visit the patient comes." Tr. 719, 721.

medication, it was one to two, which permitted her to function and perform daily activities. Tr. 721. The Respondent conceded that the detailed findings of the complete physical exam are not reflected in his chart, but noted he was a clinician with 41-years of experience, and not a medical student. Tr. 810. Tr. 810. [He testified that he inquired regarding any behavioral and psychological issued S.B. might have. Tr. 722.] Dr. Rabadi noted that patients with ADD are six times more likely to have other psychiatric conditions as people without ADD. Tr. 722. Ultimately, Dr. Rabadi concurred with the previous physician's diagnoses of ADD, GAD, and fibromyalgia. Tr. 724, 728. To obtain informed consent to prescribe controlled substances to S.B., the Respondent executed the "pain management contract." Tr. 728-29. The patient reads it and signs it. The Respondent then goes over the contract in detail with the patient. The Respondent then explains that the medications are meant to help the patient, not to cause side effects or addiction, although they tend to cause chemical dependence. Tr. 729. The Respondent then goes over all the alternative treatments, but in the end, it is the patient's decision as to the treatment she will receive. Tr. 729. If the Respondent objected to every patient's choice of treatment, there would no medical care. If a patient says she is on medication and it permits her to function, the Respondent will continue that treatment. Tr. 729-30. S.B. indicated she had been through several alternate treatments, including, occupational therapy, physical therapy, hydrotherapy, yoga and meditation. Tr. 731, 805.

The Respondent conceded the list of prior therapies was not in his progress notes. Tr. 805-06, 808. The Respondent explained its absence as maybe he "did

not feel it was crucial to be documented," as he memorizes what the patient tells him.*S Tr. 806. Respondent testified that including references to prior, concluded treatment was irrelevant as the prior treatment was concluded and the patient had moved on to the new treatment. Tr. 807-08. The Respondent testified to S.B.'s prior treatment from memory. Tr. 808. The Respondent explained that, as he still maintained handwritten records and saw up to 20 patients a day, with new patients taking an hour and returning patients taking up to 20 minutes each, he did not have the luxury of documenting in detail. Tr. 807, 849. So, the basic information is reflected in his written notes, while the rest he remembers; "I rely on my photographic memory." Tr. 808-09. The Respondent conceded that "maybe" it was "inappropriate" of him not to more thoroughly detail this information in the charts. Tr. 809. But with handwritten charts he was only able to include the "main ideas." His notes are simply to remind him of the matters. Tr. 810-11. He keeps his notes as brief as possible to remind him in the future. Tr. 815.

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*S Respondent testified that, "the record is probably missing these things, because maybe at the time of the documentation I did not feel that was crucial to be documented. As soon as the patient disclosed that to me, I memorize it. I remember it. You've seen how several years later I still remember it. . . . I did not feel I have to clutter my charts with, you know, this information." Tr. 806-07. Respondent further testified that he does not have electronic medical records, he is "still writing . . . And when I see 15, 20 patients a day . . . There [are] only 24 hours a day. I don't have the luxury to write ten pages on each patient. . . . [W]hat's pertinent, what's your diagnosis, what's your main exam, and what's your treatment is reflected there. The rest I remember. I don't need to write it." Tr. 807-08.

Respondent testified that S.B. further reported that she had been on the same dosage of medications for several years to good effect. Tr. 731-32. [Respondent testified that "medically it is very inappropriate when a patient is stable at [a] certain dose, to start cutting the dose because [the] patient will regress" and either] suffer withdrawal symptoms or have severe pain.*T Tr. 732. Prior to each prescription, the Respondent discussed side effects, and changes in status. Tr. 733.

The Government sought to test the Respondent's "photographic memory" by asking to confirm that, consistent with his direct testimony, he only treated S.B. with hydrocodone, Xanax and Adderall. Tr. 810-13. The Respondent confirmed his direct testimony. Tr. 812. The Government reminded the Respondent that he prescribed Soma as well, [but Respondent testified that he did not mention it on direct because it "was not [an] ongoing prescription. Maybe the patient got it once or twice over the course of the years."] Tr. 813.

Although the Respondent testified he developed a treatment plan for each of his patients, the Government pointed out, and the Respondent agreed, that S.B.'s treatment plan and objectives were not documented in her chart. Tr. 813-14.

Although the Respondent testified he did not introduce any of his subject patients to controlled substances, the chart reflects he did prescribe Soma to S.B. for the first time. Tr. 816-17; GX 1 at 61, 62. The Respondent remembered during cross-examination

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*T Modified for clarity.

that, although not in the chart, S.B. told him she had been on Soma previously. Tr. 817-19.

Patient J.M.[12]

J.M. has been a patient for thirteen years. Tr. 734. The Respondent has prescribed him Xanax, Soma and hydrocodone. The Respondent believed his treatment of J.M. was within the California standard of care. J.M. first presented on May 14, 2007, with chronic pain syndrome, which sometimes manifests as back pain, and neck pain, and GAD. Tr. 735; GX 11 at 104. The Respondent took a history. J.M. had been involved in a motor vehicle accident injuring his back, neck and lumbar spine. Additionally, he suffered from GAD and hypertension. Tr. 736. The motor vehicle accident as the source of the injury was not documented. Tr. 853. J.M. had seen an orthopedic surgeon, although it was not documented in the chart. Tr. 853. Without medication, J.M. reported severe pain of 10

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[12] In transcript pages 734-43, Patient J.M. is discussed. However, due to some confusion with patient initials, the Respondent described his treatment of J.M. as M.B. within the transcript. Tr. 774. [All of the questions and responses for pages 734-43 referred to this patient as "M.B."; however the factual information that was being discussed was actually applicable to "J.M." The error was not discovered until Respondent was questioned about the patient whose initials were actually M.B. The parties entered "a stipulation that Dr. Rabadi's [prior] testimony as to M.B., the second patient discussed, is actually applied or attributed to Patient J.M." Tr. 774-75. This exchange did not fill me with confidence that Respondent's testimony reflected his true recollection of the specific actions he took with regard to the specific patient being discussed. Rather, Respondent seemed to testify to the policies and procedures he followed in the regular course and assumed that those policies and procedures were followed with regard to all the named patients.]

or 11 of 10. With medication, he reported pain levels of three of ten, which permitted him to function and to work full time; the pain levels were not documented in the chart. Tr. 736, 854-55. J.M. reported prior treatments and medication. He had received physical therapy, occupational therapy, hypnosis and acupuncture to no avail prior to turning to chronic pain management, although these previous therapies were not documented in the chart. Tr. 737, 854. His present medication protocol delivered the best results with the least side effects. Tr. 737. The Respondent probed his psychological history, which included an all-consuming fear.

The Respondent performed a comprehensive physical exam "head to toe." Tr. 739. To obtain informed consent to prescribe J.M. controlled substances, the Respondent went over the pain management contract, which J.M. also read and signed. The Respondent cautioned J.M. about diversion and red flags of doctor shopping and pharmacy hopping, which would result in discharge. Tr. 739-40. The Respondent noted that J.M. is a very well-respected man. He's very well-known in the community. Tr. 740.[13] The Respondent then discussed the beneficial aspects of the pain medication and potential negative effects if abused. Respondent testified that J.M. never gave any indication he represented a risk of diversion. Tr. 741. Prior to seeing the Respondent, J.M. was on a higher MME of opioids. He was able to reduce the dosages to the level he was on when he first saw the Respondent. He remains on

[13] J.M.'s prestigious background will not be considered. It is an unnoticed matter that the government would have no way of checking or countering. [It is also completely irrelevant to my decision in this case.]

that dosage. Again, he is able to function and work full-time on this dosage. Tr. 742. The Respondent noted that J.M. would sometimes try to avoid taking his medication, even if he suffered pain, as explanation for the breaks in prescribing. Tr. 743.

The Respondent denied ever using a different first name for J.M., or using a different birth date for him [and attributed any mistake to the pharmacy.] Tr. 778-82.

Patient B.C.

Patient B.C. has been a patient of the Respondent since March 27, 2014. Tr. 750-51. Patient B.C. has been prescribed hydrocodone, Xanax and Adderall. Tr. 749. The Respondent obtained a complete history, a complete physical exam and then probed the complaint that brought him to the Respondent, which was right shoulder and chronic back pain. Tr. 751. Without medication, B.C. reported pain at seven or eight, and with medication at one or two. Tr. 752. As far as his medication history, B.C. had been on pain medication for years following a neurosurgical procedure to treat a herniated disc with radiculopathy.[14] Tr. 752. To obtain informed consent, the Respondent discussed the pain management contract, which B.C. read and signed. Tr. 752-53. The Respondent then discussed side effects of the medication [including "addiction, overdose, and death." Tr. 753.] B.C. is a married man

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[14] The Government objected to B.C.'s prior treatment history, which was not noticed in the RPHS. I ruled it was reasonably anticipated. The Respondent cited to specific treatment from a prior physician. The contested evidence is reflected in GX 5 at 14, so the Government was certainly not surprised by the evidence.

with three children. He works full time. He gave the Respondent no indication he was a risk for diversion. Tr. 753.

Regarding prior alternate treatment, B.C. reported that he has tried surgery, physical therapy and acupuncture, but that only pain medication therapy alleviates his pain to the extent he can function. Tr. 754. At each visit, the Respondent reviewed B.C.'s progress and believed B.C.'s condition warranted the medication he was prescribed. Tr. 754, 757. Although the Respondent remembered discussing B.C.'s pain levels on March 27, 2014, and that it was one or two on medication, he conceded it was not documented in the chart. Tr. 832-34; GX 5 at 48. Although the Respondent remembered B.C. reporting he had a herniated disc, this report was not documented in the chart. Tr. 836. Neither were B.C.'s reported prior surgery, physical therapy, acupuncture, or occupational therapy documented. Tr. 837.

Patient J.C.

Patient J.C. presented on May 18, 2009, with chronic back pain, ulcerative colitis and GAD. Tr. 759-60, 761-62. He was prescribed hydrocodone, and Xanax, sometimes substituted with Valium. Tr. 759. The Government pointed out to the Respondent that there were visits during which several other controlled substances were prescribed. Tr. 842-46; GX 7 at 181, 214, 215.

He had suffered multiple injuries, and had been immobile for some time. However, the Respondent did not document the injuries or the immobility in the chart, nor did the file contain any prior medical

records.[15] Tr. 839, 842; GX 7 at 216. He had undergone physical therapy, occupational therapy, and finally pain management, which permitted him to resume working full-time. Tr. 760. These alternate treatments and therapies and prior surgeries were not documented within the chart. Tr. 840. The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit.*U Tr. 840. The Respondent performed a full exam on J.C. Tr. 760-61. His GAD resulted from his ulcerative colitis. Tr. 762.

The Respondent obtained informed consent to prescribe controlled substances by explaining the pain contract; afterwards, J.C. read it and signed it. Tr. 763. The Respondent explained the dangers of overdose. Tr. 764. The Respondent had no concerns about J.C. diverting his medication. Tr. 764-65. On the basis of J.C.'s considerable injuries and condition, the Respondent felt J.C.'s medication protocol was fully justified. Tr. 765. The Respondent denied ever intentionally misspelling J.C.'s first name.*V Tr. 765-

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[15] The Respondent again explained the difficulty in obtaining prior medical records. Tr. 842.

*U Respondent testified, "[w]hether he mentioned the surgery the very first visit, that I cannot tell you yes or no at this point because it's not in my notes. So I'm just second guessing myself." Tr. 841.

*V There was no allegation that Respondent misspelled J.C.'s name, but the OSC did allege that Respondent "used a variant spelling of Patient J.M.'s first name." OSC, at 13. Accordingly, Respondent's testimony that he never intentionally misspelled J.C.'s first name is not relevant to this hearing other than it caused me to again question whether Respondent's testimony reflected his true recollection of the specific actions he took with regard to the specific patient being discussed. *See supra* n.12.

66. Although the Respondent remembered J.C. reporting that he had seen two previous doctors, including a pain physician, that report was not reflected in the chart. Tr. 841-42. Although the Respondent remembered performing a complete mental health evaluation on J.C., it is not documented in the chart. Tr. 842.

Patient D.D.

Patient D.D. first presented on July 9, 2008, with GAD and severe back pain, although the source of the back injury was not documented. Tr. 767-68, 850; GX 9 at 74. Over the course of treatment, the Respondent prescribed hydrocodone, Xanax and Soma. Tr. 850.

The Respondent added that he probably prescribed Valium, as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent remembered D.D. was prescribed Valium, hydrocodone and Soma the first visit. Tr. 851-52. The Respondent believes his treatment was within the standard of care in California. The Respondent took a complete medical history, family history, personal history and medication history. Tr. 768. The family history was not documented in the chart. Tr. 848. The Respondent explained that the family history was not documented because it was non-contributory to his assessment. Tr. 848. There were no heart conditions in his family, etc. Tr. 849. The Respondent did document that D.D. was married, which he deemed contributory. Tr. 849. D.D. had a dirt bike accident, which shattered his shoulder and fractured several ribs, although the accident as the source of the injury was not documented.*W Tr. 850. He underwent

*W Respondent testified that, "whether it is specifically dirt bike as opposed to car accident, as opposed to falling off the second story, this has become, there is a good reason for the back pain.

physical therapy and occupational therapy after treatment by an orthopedic surgeon, although neither was documented within the chart. Tr. 769, 771, 850-51. It was several years before he reached the medication regimen he was on when he first reported to the Respondent. The Respondent performed a full physical exam. He established informed consent with the pain contract and discussion of side effects and overdose, as with all his patients. Tr. 770. He verbally cautioned D.D. regarding diversion and other red flags. Again, D.D. gave no indication of diversion. Tr. 771. Respondent testified that alternative treatments were discussed. Tr. 771.

Patient M.B.

Patient M.B. presented on April 19, 2006, with severe back pain, left knee pain and history of dyslipidemia. Tr. 782. The Respondent obtained a full medical history, medication history, pain level, and performed a complete head to toe physical exam. Tr. 783. The Respondent discovered M.B. had chronic back pain related to an injury, a manageable knee injury, and dyslipidemia. Tr. 784. Although the Respondent maintains he obtained a complete medical history as to the back pain and chronic knee pain, he concedes it is not detailed in the chart. Tr. 820-23. [He testified, "[maybe . . . I should have documented more. I'm not going to say anything to that." Tr. 821.] He was already on hydrocodone, previously prescribed, when M.B. first saw the Respondent.

That's the whole thing, why I did not mention specifically dirt bike injury" Tr. 850.

The Respondent obtained informed consent in the same manner as described for his earlier patients. Tr. 784. He discussed alternative forms of treatment with M.B., however M.B. had exhausted those.[*X] M.B.

[*X] Specifically, when asked whether he considered alternative forms of treatment for M.B., Respondent testified: "I do. We do discuss that. However, patient's already been through those. Again, the common denominator in my practice is unique thing . . . because these patients [have] been there, done that. They had surgeries, they had imaging, they had already physical therapy, activation, acupuncture, medication. I told you some of them had hypnosis, water pool or water therapy. Everything was done. But still . . . for the sake of clarity I have to discuss everything. The patient will tell me, Doctor, I've done that, I've been there, and this is what works for me right now" Tr. 785. On cross examination when asked specifically whether M.B. told Respondent that he had tried each of these forms of alternative treatment, Respondent replied "[n]ot necessarily all of this. I always ask questions, what alternative therapy did you discuss." Tr. 825. When directed to identify specifically which forms of alternative treatment M.B. had tried, Respondent testified, "I don't want to misspeak. I'm not sure if he had . . . acupuncture or not. But I know for a fact he had physical therapy." Tr. 827. I find this testimony illustrative of two concerns I have with Respondents testimony. First, it appears that Respondent's testimony does not always reflect an independent recollection of the undocumented events that occurred between him and the specific patients being discussed. Even where Respondent seems to be testifying about a specific patient, it morphs into testimony about his patients collectively rather than as individuals. This sort of collective focus that appears throughout Respondent's testimony causes me to question Respondent's credibility—specifically whether he remembers the events that occurred at each specific visit for each specific patient that he discussed in the absence of medical records documenting these events. Indeed, Respondent testified that "[o]ver [his] career, [he] worked [with] about 5,000 patients." Tr. 792. And at the time of the hearing he had "close to 550-600 patients" and prior to the order to show cause he "had between 175-200 [pain] patients." Id. Secondly, I am concerned that Respondent's "photographic memory" may not be as reliable

had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827. The Respondent conceded he did not document these therapies in the chart. Tr. 828. The Respondent monitored M.B. throughout his treatment. Tr. 785. The Respondent believed his prescribing was justified on the basis of M.B.'s medical conditions, level of chronic pain and present level of functioning, working in a welding factory lifting heavy things.*Y Tr. 786, 832. The Respondent conceded that he did not document M.B.'s degree of pain, but minimized the value of the subjective pain scale. Tr. 823-24. The Respondent conceded there were no imaging reports in M.B.'s chart, but explained that these patients were from the movie business. They were treated by a Health Maintenance Organization (HMO) from which it is almost impossible to obtain records. Tr. 829.

Patient K.S.

Patient K.S. presented on June 21, 2007, with chronic back pain. He was later diagnosed with ADD. He was prescribed hydrocodone, Soma and sometimes Adderall. Tr. 788-89, 861; GX 14 at 110. The Respondent added that he may have also prescribed Xanax, but it is difficult to be sure with hundreds of patients and treatment dating back fifteen years. Tr. 859. Even with a "good memory, sometimes you just miss something." Tr. 859. Additionally, he noted that many

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as he portrays it, particularly where, as here, there is no documentation in support of his memory.

*Y On cross-examination Respondent testified "the patient is in motion picture but he has also something that he does on the side that has to do [with] welding iron or something like that as well." Tr. 832.

times patients do not disclose all of their medications at the initial visit, if they have plenty and do not then need them to be refilled. So, he is not always aware of all of their medications at the initial visit. Tr. 860-62.

The Respondent believed his prescribing was within the standard of care for California. Tr. 788. The Respondent obtained a full medical history, medication history, pain level, and performed a complete head-to-toe physical exam. Tr. 789. The Respondent discovered K.S. had chronic back pain related to a bike accident for which he had been treated by several doctors for several years, although the bike accident as the source of the injury and treatment by other doctors was not documented. Tr. 789, 856-57, 859. Additionally, there were no records from prior treatment in the patient's records. Tr. 857. Although the Respondent explained that he requested the prior medical records, none were provided. The Respondent explained that his request for records is simply faxed to the previous physician's office. Tr. 857-58. Its absence from the file was probably because a staffer forgot to file it. Tr. 858. The Respondent did not contest the Government's observation that no requests for previous medical records were in any of the seven patient files. Tr. 859. K.S. was already on hydrocodone when K.S. first saw the Respondent. The Respondent obtained informed consent [and disclosed the potential side effects including the risk of death] in the same manner as described for his earlier patients.[*Z] Tr. 790. He

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[*Z] Specifically, when asked whether he had a conversation with this patient involving informed consent, Respondent testified: "Yes, I did. And, as usual, he read the entire contract, understood it. Indicated that [he] understood, both verbally and signed it. Then I . . . explain[ed] the potential side effects of these medications

discussed alternative forms of treatment with K.S. K.S. was obtaining physical therapy prior to seeing the Respondent and continued physical therapy after beginning treatment with the Respondent. Tr. 791. The Respondent monitored K.S. throughout his treatment. Tr. 791. K.S. presented no indications of diversion. The Respondent has treated K.S. for thirteen years during which time K.S. got married and had three children. Tr. 790-91.

The Respondent noted that, to the best of his knowledge, none of his thousands of patients have suffered any harm from his medication treatment. Tr. 793. [Respondent testified that a combination of an opiate, muscle relaxant, and benzodiazepine, when "used in the right dosages for the right indications, and used as prescribed by a knowledgeable M.D., . . . are safe to use in combination therapy." Tr. 797.] The Respondent disagreed with Dr. Munzing's assertion that he could perceive of no medical condition justifying the dangerous combinations of medications identified herein. Tr. 794-800. The Respondent conceded the potential danger of individual pain medications, and the potential

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that include from my explaining with sedation and constipation, all the way to addiction, overdose, and possible death. And I indicate always to my patients on the last two, the overdose and the death, is on you, because you can cause it yourself, or you could use this medication indefinitely and never have any problem. . . . " Tr. 790; *see also* Tr. 670-71, 753, 770. Once again, Respondent begins his testimony purporting to have a specific recollection of his 2007 conversation with K.S., but then he turns to general language, which more supports a general assumption that he had the conversation. *See, e.g.*, Respondent's use of "as usual, he," which is ambiguous because, while all of Respondent's patients purportedly receive the contract, K.S. is only purported to have received it once.

increase in risk in combination with other medications. However, according to him, if patients are responsible and take the medications as prescribed for the indications intended, these combinations are fairly safe. Tr. 800.[16]

The Respondent recognized his obligations to follow all federal and state rules concerning the practice of medicine, including the directives of the California Board of Medicine. Tr. 862. California's Compliance with Controlled Substance Laws and Regulations includes a provision on records. Tr. 864; GX 20 at 61. According to Respondent, it mandates that, the physician and surgeon should keep accurate and complete records according to the items above between the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan. Tr. 864-65. The provision further requires, "[a] medical history and physical examination must be accomplished . . . this includes an assessment of the pain, physical and psychological function." Tr. 866; GX 20 at 59. The Respondent assured the tribunal that the necessary assessments were made, but not fully documented. Tr. 866-67. The Respondent, [while again

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[16] Although the government objected to this opinion by the Respondent, I overruled its objection. A general disagreement by the Respondent of the government expert's opinion is certainly reasonably anticipated. The Respondent did not cite to any unnoticed medical practice guide, medical theories or other basis for his contrary opinion. The government was readily able to confront the Respondent's opinion. The Respondent's opinions were not considered expert opinions.

conceding that there was no documentation,] made the same assurances for the requirements as to "Treatment Plan Objectives," "Informed Consent," and "Periodic Review," noting these Guidelines were published in 2013.[17] Tr. 867-72. [As justification for not documenting a treatment plan, Respondent testified that he was "carrying the same treatment [plan] and no change and the patient is stable," but that "[i]f [he] changed the treatment plan" it would be important to document. Tr. 874. Contrary to Respondent's testimony, the treatment plan did change when on February 2, 2017, the Respondent prescribed Soma to S.B. Tr. 875; GX 1 at 59. By March 1, 2017, Soma had been discontinued, yet the chart reflected no rationale for that change in medication regimen. Tr. 876-77. As the Respondent varied his prescribing between Soma and Xanax, he conceded he did document the reason for the variation in medication. Tr. 878-83. The Respondent conceded he did not document the rationale for the change in medication for J.M. or K.S. as well. Tr. 885. Similarly, the Respondent conceded he did not document pain level, function level and quality of life for any of the seven charged patients. Tr. 885-87; GX 20 at 61. The Respondent reiterated that, to his knowledge, none of his patients exhibited red flags or violated the pain agreement. Tr. 888-89.

[Respondent testified somewhat extensively and flippantly regarding his thoughts on California law's documentation requirements. "I am not going to just say, okay, write in the chart I told the patient hello,

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[17] *See* Tr. 950-52. Dr. Munzing testified credibly that the 2013 version was the 7th edition and the basic requirements have not changed over the years.

they said hello, I said, okay, what did you have for breakfast? I am not going to document all that, there is no reason. It is just excessive wrecking [sic.] havoc on the documentation. . . . [E]verything was addressed, everything was talked about, and every exam, every consent, everything was done by the book. I am a perfectionist. I am a perfectionist." Tr. 871.]

Rebuttal Testimony

Diversion Investigator

DI identified a CURES Audit Report for the Respondent's Registration number. Tr. 893-94; GX 24. The audit report shows each time the Respondent accessed CURES to run a query on patients. Tr. 894. This particular audit included data from January 1, 2016, through January 13, 2020. DI also identified GX 25, which was a CURES Audit Report run on the DEA Registration of Dr. B.S., which included the patient M.B., a patient common to the Respondent. Tr. 904. Between October 10, 2018, and September 11, 2020, Dr. B.S. prescribed Suboxone[18] to M.B. Tr. 909; GX 24, 25, 25B. On March 15, 2019, the Respondent accessed CURES and would have observed M.B. was receiving Suboxone from Dr. B.S. Tr. 910; GX 24. DI identified GX 26, an additional CURES Audit Report for Dr. B.S.2, which spanned from January 2017, to September 2020, and which shared a common patient with the Respondent, J.M. Tr. 911-13; GX 26, 26B. Dr. B.S.2 similarly prescribed Suboxone to J.M. from January 2017 to August 2020. Tr. 913. The CURES Audit of the Respondent demonstrated he accessed the

[18] Buprenorphine.

CURES database during the period J.M. was prescribed Suboxone by Dr. B.S.2, which would have been evident by this review. Tr. 914.

Dr. Munzing

Dr. Munzing repeatedly gave his opinion regarding the credibility of the Respondent's testimony. I find that Dr. Munzing's opinion as to the Respondent's credibility is beyond Dr. Munzing's qualified expertise. Accordingly, those opinions will not be considered herein.[19]

Dr. Munzing opined on the importance of documentation within medical records, including medical history and pain levels. Tr. 917, 936-38. He noted that documentation was not just for the then treating physician. It was important for other physicians, perhaps years later, who may treat the patient in an emergency room setting. [Dr. Munzing testified that "[t]rue, and accurate, and thorough documentation is vitally important for patient safety. It's also part of the standard of care." Tr. 917.] He reiterated that the elements identified in the Board of Medicine's Guidelines on documentation are part of the standard of care. Tr. 917-18; GX 20 at 59, 60, 61. He noted the lapse in documentation regarding the history, pain levels, mental health exams, and treatment plans the Respondent testified he performed or obtained for each patient. Tr. 916, 921-22. [Specifically, Dr. Munzing testified that "practically none of the information that Respondent mentioned [during his testimony] was documented." Tr. 916.] Dr. Munzing observed that the examination described by the Respondent for fibro-

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19 [Omitted for brevity.]

myalgia was medically deficient and inconsistent with the standard of care, as it did not include a musculoskeletal exam. Tr. 918-20. Dr. Munzing observed that the standard of care applies equally to electronic records as to written records. It does not matter whether the physician documents electronically or in writing, the standard remains the same. Tr. 922.

Regarding the Respondent's testimony that he would continue patients on medication prescribed by previous physicians if they reported they were doing well on the medication, Dr. Munzing opined that Respondent needed to conduct an "independent evaluation" and "verify what [the patient is] saying"*AA to comply with the standard of care. Tr. 923-27, 928-29. Dr. Munzing observed that the Respondent's warnings regarding the potential for overdose were not consistent with the standard of care. Tr. 927. Dr. Munzing believed the Respondent's undocumented verbal caution that overdose was a potential risk if the patients took the medication other than as directed was misleading, because there were risks even if the medication were taken as prescribed, and it was beneath the standard of care. Tr. 927, 929-31.

Regarding the Respondent's explanation that he only documented the condition of which the patient was complaining, and did not document all the medi-

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*AA For example, Dr. Munzing testified that Respondent could have checked CURES or urine drug tests to verify what the patients were saying or could have asked the patients to bring copies of their prior medical records in with them. Tr. 923-24. Dr. Munzing testified that it is outside the standard of care in California to simply take a patient at their word when they say that they are receiving certain controlled substances in certain doses. Tr. 928-29.

cations the patients were already on when coming to his clinic, Dr. Munzing opined such practice was inconsistent with the standard of care. Tr. 932. Dr. Munzing testified that the documentation was not just to remind the treating physician, but to alert any physician who may treat the patient. Tr. 931-34. Dr. Munzing also criticized the Respondent's handling of situations in which patients reported they still had medication remaining from the previous month. Rather than simply refraining from prescribing additional medication, Dr. Munzing indicated that that situation should trigger a discussion with the patient and evaluation whether the existing level of medication is appropriate, or whether titration is warranted. Tr. 933-36. Dr. Munzing deemed the Respondent's prescribing 10 mg a day of Xanax to J.M. to treat GAD and undocumented panic attacks as excessive and beneath the standard of care. Tr. 938-39. Dr. Munzing deemed the Respondent's reluctance to reduce the opioid dosage lest the patient suffer pain or withdrawal symptoms misguided. Tr. 941. Titration of high opioid dosage of high risk patients or exploration of alternate treatment is consistent with the standard of care. Tr. 941. Dr. Munzing was critical of the Respondent's handling of J.M. and S.B. after discovering they were being prescribed Suboxone by other physicians. Tr. 941-48. Suboxone is typically prescribed for opioid use disorder or addiction. Tr. 943. It directly violates the Respondent's pain contract for these patients, yet the Respondent took no action and continued to prescribe opioids. Tr. 947.

The Facts[20]

Findings of Fact

The factual findings below are based on a preponderance of the evidence, including the detailed, credible, and competent testimony of the aforementioned witnesses, the exhibits entered into evidence, and the record before me.

During the hearing conducted, via video teleconference, from September 28, 2020, to September 30, 2020, the Government established the following facts through evidence, testimony, or stipulation ("Proposed Findings of Fact" or "PFF"):

I. Investigatory Background

1. DI has been employed by DEA as a Diversion Investigator for three years. Tr. 33.

2. DEA began investigating Respondent in April of 2018, after receiving a February 2018 report issued by the Department of Health and Human Services indicating that Respondent's prescribing habits presented a high-risk for overprescribing. Tr. 37-38.

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20 [The contents of the original footnote are omitted due to my omission of the Joint Stipulations. The parties agreed to Joint Stipulations numbered 1-38. *See* ALJX 3, Govt Prehearing, at 1-14 and ALJX 13, Resp Supp. Prehearing, at 1. The RD included many of the stipulated facts between the parties, but appears to have inadvertently left some out. *See* RD, at 54-67. I have omitted the joint stipulations from this decision in the interest of brevity, but I incorporate fully herein by reference Joint Stipulations 1-38. Where there is a reference to the Joint Stipulations herein, the numbering aligns with the numbering in the Government's Prehearing Statement, GX3, at 1-14.]

3. DEA monitored California's prescription drug monitoring program, known as CURES, and identified several red flags regarding Respondent's prescribing. Tr. 35, 38. CURES reports obtained by DEA were admitted into evidence as GX 16, 17, 18, and 19. Tr. 16-18; *see also* Joint Stipulation Nos. 31-34. Among other things, DEA found that; (1) Respondent frequently prescribed opioids at their maximum strength, Tr. 38-39; (2) Respondent frequently prescribed patients a combination of an opioid and a benzodiazepine, Tr. 39; (3) Respondent issued prescriptions for a combination of an opioid, a benzodiazepine, and carisoprodol—a combination that is highly sought after on the illicit market, and is known as "the Holy Trinity," Tr. 40; (4) Respondent prescribed high doses of controlled substances to patients for long periods of time, Tr. 40-41; (5) between November 20, 2015, and November 21, 2018, Respondent issued approximately 9,000 prescriptions for controlled substances, Tr. 39; GX 16; GX 17; GX 18; (6) Over half of those 9,000 prescriptions were for hydrocodone, and approximately 96 percent of these prescriptions were for either hydrocodone, alprazolam, or carisoprodol—which together make up the "Holy Trinity" cocktail. Tr. 39, 42-43; GX 16; GX 17; GX 18.

4. DEA obtained medical files from Respondent, pursuant to a federal search warrant executed at Respondent's medical clinic in February of 2019, and pursuant to an administrative subpoena issued to Respondent in January of 2020. Tr. 46, 49, 49, 55-56. These included medical files for Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. (admitted as GXs 1, 3, 5, 7, 9, 11, and 14; Tr. 16-18).

5. DEA also obtained prescriptions for the above-mentioned patients (see PFF ¶ 4) from its search of Respondent's clinic, and from pharmacies at which these prescriptions were filled (admitted as GXs 2, 4, 6, 8, 10, 12, and 15; Tr. 16:15-18:3). DEA also obtained fill stickers for certain prescriptions issued to Patient J.M. from one of the pharmacies at which Patient J.M. filled prescriptions Respondent issued to Patient J.M. (admitted as GX 13; Tr. 16:15-18:3).

II. The Government Expert's Qualifications

6. Dr. Munzing's curriculum vitae was admitted into evidence as GX 23; Tr. 89. He is a licensed physician in the State of California, who has worked in the field of family medicine for nearly forty years. Tr. 89.

7. Dr. Munzing received his medical degree from the University of California, Los Angeles, in 1982, and did his residency at Kaiser Permanente Medical Center in Los Angeles. Tr. 89. He then began working in the family medicine department of Kaiser Permanente Orange County, where he has been for the last thirty-five years, twice serving as president of the medical staff at the hospital. Tr. 89, 94. He has a DEA COR and an active clinical practice, prescribing, inter alia, opioids, benzodiazepines, and other controlled substances when indicated. Tr. 91-92.

8. In addition to his clinical practice, Dr. Munzing teaches extensively to physicians, serving as the director of the Kaiser Permanente Orange County family medicine residency program. Tr. 90. Further, he is a full clinical professor at University of California, Irvine. Tr. 91. He also sits on the National Accreditation Board for Family Medicine Residency, which accredits all of

the residency programs in the United States of America. Tr. 90-91.

9. Dr. Munzing has been called upon to provide opinions about the prescribing of other medical professionals, and he has been qualified as an expert witness in over 30 cases, including in DEA administrative hearings. Tr. 93-94.

10. As a licensed California physician who has been practicing in California for nearly 40 years, Dr. Munzing is familiar with the standard of care for prescribing controlled substances in California. He also has reviewed publications by the Medical Board of California that inform his understanding of the standard of care, including the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons (7th Edition)" (admitted as GX 20, Tr. 16-18), and the "Guidelines for Prescribing Controlled Substances for Pain," (admitted as GX 21, Tr. 16). In addition, he is familiar with the FDA's black box warning regarding the risks of overdose and death posed by concurrently taking opioids and benzodiazepines, and the FDA labels for benzodiazepines including Klonopin, Valium, and Xanax (admitted as GX 22, Tr. 16-18). Further, Dr. Munzing reviewed several laws and regulations that informed his understanding of the standard of care. Tr. 99.

11. Dr. Munzing was qualified as an expert in California medical practice, including, but not limited to, applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine. Tr. 102.

III. The Standard of Care for Prescribing Controlled Substances in California

12. Dr. Munzing testified that the standard of care in California first requires that, before prescribing controlled substances, a practitioner perform a sufficient evaluation of the patient, including, a medical history and appropriate physical examination. Tr. 103.

a. In the context of treating a patient with controlled substances for pain, the standard of care in the state of California requires the following:

   i. Medical history: The practitioner must obtain detailed information about the pain, including where the pain is, how long a patient has had it, how severe the pain is, the impact of the pain on the patient's functionality and activities of daily living, and any previous diagnoses and treatments the patient has received for the pain. The practitioner must also seek to obtain any relevant prior medical records and imaging. Tr. 114-115.

   ii. Physical examination: The practitioner must look at the area of pain unclothed for any swelling, redness, or mass. Tr. 116-17. The practitioner must palpate the affected area and identify areas of particular tenderness or pain. Tr. 117-18. The practitioner also is required to test a patient's range of motion, as well as the patient's neurological conditions via targeted tests for the area affected by pain (*e.g.,* tendon reflexes, and

strength tests for the affected area). Tr. 118-19.

b. In the context of treating a patient with controlled substances for mental health conditions, the standard of care in the state of California requires the following:

i. Medical history: The practitioner must inquire into the patient's condition, including symptoms the patient is experiencing, when the patient experiences symptoms, how those symptoms impact the patient's functionality and activities of daily living, when the condition began, and if there is a family history of mental health issues. The practitioner must also seek to obtain any relevant prior medical records. Tr. 136-38.

ii. Physical examination: The practitioner must conduct a limited and focused general examination, including heart, lungs, and vital signs, [to rule out other possible medical diagnosis.] Tr. 138-39.

13. As part of the medical history, the practitioner must inquire into the patient's history of, and/or current use or abuse of, tobacco, drugs, or alcohol, as well as into any family history of use or abuse of tobacco, drugs, or alcohol. Tr. 120-21, 142.

14. Based on the history and physical examination, the standard of care requires the practitioner to assign a diagnosis to the patient. Tr. 103. An appropriate history and physical examination are crucial to arriving at an appropriate diagnosis. Tr. 121-22, 141. Without

an appropriate diagnosis, a practitioner cannot establish a legitimate medical purpose to prescribe. Tr. 124, 141. [The standard of care requires the diagnosis to be documented in the record. Tr. 122.]

15. Next, the standard of care requires the practitioner to develop a customized and documented treatment plan for the patient with goals and objectives. Tr. 109-110. The practitioner must relay that plan to the patient, inform the patient of the risks*BB and benefits of treatment with controlled substances, as well as potential alternative treatments, and obtain the patient's informed consent for the treatment. Tr. 103-04, 124-25. When prescribing high dosages of controlled substances, this discussion of risks must include risks of addiction, overdose, and death. Tr. 126-27. "All of [this] needs to be documented" in the medical record. Tr. 135.

a. In the context of treating a patient with controlled substances for pain, the standard of care in the state of California requires that a treatment plan contain goals and objectives for pain management, such as maximizing benefit to function and minimizing pain, while also minimizing the risk to the patient from the controlled substances prescribed. Tr. 131.

b. In the context of treating a patient with controlled substances for mental health condi-

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*BB The practitioner must determine the risk posed to a patient by controlled substances due to the patient's overall health history—as well as the potential for substance abuse or addiction. Tr. 103, 109. This text, which appeared in the RD originally, has been relocated for clarity.

tions, the standard of care in the State of California still requires that the treatment plan contain goals and objectives for the patient. Tr. 143.

c. With respect to risks of medications, Dr. Munzing explained that practitioner should only co-prescribe opioids and benzodiazepines when "absolutely necessary," and should do so for "[n]o longer than absolutely necessary and typically in as low doses as possible to . .. decrease the risk." Tr. 154-55.

16. As treatment progresses, the standard of care requires a physician to monitor the patient. Tr. 104, 132. A practitioner must periodically update the patient's medical history, conduct further physical examinations, and obtain updated information regarding the etiology of a patient's state of health. Tr. 106-08. The practitioner must periodically review the course of treatment, ascertain how the patient is responding thereto, determine if continued treatment is appropriate or if the treatment plan needs to be modified, and document the rationale for any modifications. Tr. 108-09, 206; GX 20 at 61. The practitioner must also periodically re-inquire into the patient's use or abuse of tobacco, drugs, or alcohol. Tr. 259-60.

17. The practitioner must also periodically conduct updated physical examinations, both brief general examinations to ensure that the patient is healthy enough to continue receiving controlled substances, as well as focused examinations of the area for which pain is being treated to help in determining how the patient is responding to treatment. Tr. 111-12.

18. When prescribing controlled substances, the standard of care in California also requires a practitioner to monitor medication compliance, including thorough reviews of CURES, Tr. 132, periodic urine drug screening, Tr. 133, and/or pill counts. *Id.* The practitioner must address any red flags of abuse or diversion. Tr. 112.

19. In addition, the standard of care requires that a practitioner document all of these above steps in detail. *See, e.g.,* Tr. 104, 109, 110, 112, 122, 135, 144. Such documentation is critically important as it: (1) enables the practitioner to recall important facts about the patient's state of health and treatment, Tr. 145, 146; and (2) allows other practitioners who may also see the patient to see these facts. Tr. 145-146.

20. Appropriate documentation is a well-known, fundamental requirement in the medical community. Tr. 146. [According to Dr. Munzing, "[t]he general mantra in medicine [is] . . . if [it is] not documented, it [did not] happen." Tr. 148. Thus, it is not credible that a practitioner who consistently failed to document these basic elements for a patient actually performed them. Tr. 148-50.

21. The practitioner must also comply with all relevant California laws.

IV. Respondent's Improper Prescribing of Controlled Substances

A. Patient S.B.

i. Patient S.B.'s Initial Visit

22. Between February 2, 2017, and January 30, 2019, Respondent issued Patient S.B. the controlled

substance prescriptions listed in Joint Stipulation No. 10. *See* ALJ Ex. 3 at 2-3. During this time, Respondent diagnosed Patient S.B. with fibromyalgia, GAD, and ADD. GX 1 at 47-59.

23. Respondent's initial encounter with Patient S.B. took place on August 3, 2016. GX 1 at 62, 66; Tr. 164-65. At that visit, Respondent diagnosed Patient S.B. with fibromyalgia, GAD, and ADD. GX 1 at 62; Tr. 165. Respondent prescribed Patient S.B. hydrocodone for fibromyalgia, Xanax for GAD, and Adderall for ADD. GX 1 at 62; Tr. 165. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 1 at 62; Tr. 166-68;

b. address Patient S.B.'s pain or functionality levels, GX 1 at 62; Tr. 171;

c. conduct an appropriate physical examination, GX 1 at 62; Tr. 166, 168-71;

d. establish appropriate diagnoses, and therefore to establish legitimate medical purposes for hydrocodone, Xanax, or Adderall, Tr. 171-72; or

e. establish and document a treatment plan with goals and objectives, GX 1 at 62; Tr. 172-73.

ii. Continued Controlled Substance Prescribing Violations

24. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient S.B., never recorded Patient S.B.'s pain or functionality levels, never obtained prior medical records for Patient S.B.—nor does Patient S.B.'s

medical file reflect Respondent requested such records—failed to periodically update Patient S.B.'s medical history as treatment progressed, and never conducted a sufficient physical examination for fibromyalgia. *See generally* GX 1; Tr. 241-43.

25. None of Respondent's diagnoses of Patient S.B. for which he prescribed controlled substances were based on sufficient clinical evidence. Tr. 243.

26. Over the course of his treatment of Patient S.B., Respondent's diagnoses of Patient S.B. for ADD, GAD and fibromyalgia came and went without explanation or comment. *See generally* GX 1; Tr. 188, 193-95. Fibromyalgia and ADD are chronic diagnoses. Tr. 188, 193. These erratic diagnoses were outside of the standard of care, [especially since these diagnoses,] including those made between February 2, 2017, and January 30, 2019, [were not supported by an adequate medical history and physical examination].*CC Tr. 191-92; 195-97.

27. Respondent sometimes prescribed Patient S.B. both hydrocodone and Soma, and sometimes only hydrocodone, for fibromyalgia. *See* GX 1 at 47-59; Tr. 197:3-17. Respondent never documented any rationale for changing Patient S.B.'s course of medication in violation of the California standard of care. *See* GX 1 at 47-59; PFF ¶ 16; Tr. 199-200.

28. Respondent never documented an appropriate treatment plan with goals and objectives for Patient S.B., never documented an appropriate rationale for continued treatment of Patient S.B. with controlled

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*CC I have made this change for S.B. and each of the subsequent patients for legal clarity pursuant to supra n. *HH.

substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient S.B. *See generally* GX 1; Tr. 243.

29. Respondent also prescribed Patient S.B. the following dangerous combinations of controlled substances that put Patient S.B. at serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 203-05:

a. Hydrocodone, Adderall, and Soma on February 2, 2017, May 8, 2017, June 2, 2017, August 1, 2017, August 30, 2017, November 6, 2017, and January 23, 2018. ALJ Ex. 3 at 2-3.

b. Hydrocodone, Adderall, and Xanax on March 1, 2017, April 4, 2017, June 28, 2017. ALJ Ex. 3 at 2-3.

c. Hydrocodone and Adderall on September 29, 2017, July 2018, and in August 2018, September 2018, October 2018, and November 2018. ALJ Ex. 3 at 3.

30. Respondent's prescriptions to Patient S.B. for Xanax between February 2, 2017, and January 30, 2019, were all for 6 mg of Xanax per day. GX 1 at 57-59; Tr. 212-13. The maximum recommended dosage for Xanax for treatment of GAD is 4 mg per day, according to the FDA label for Xanax. GX 22 at 59; Tr. 213. Prescribing such high dosages of Xanax placed Patient S.B. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 217, 218-19. The fact that Respondent prescribed Xanax to Patient S.B. concurrently with opioids, see ALJ Ex. 3 at 2-3, dramatically increased her risk of overdose and death. Tr. 217-18.

31. Respondent noted, on fifteen occasions between February 2, 2017, and December 21, 2018, that Patient S.B. was opioid dependent and refusing detoxification. GX 1 at 49-59. Refusal to detoxify is a significant red flag of abuse or diversion, indicating the prescriber feels the patient needs to detoxify, but the patient refuses. Tr. 221-22. Respondent never addressed this red flag, but simply continued to prescribe the patient opioids on an as-needed basis. GX 1 at 49-59; Tr. 222. Prescribing opioids to the patient on an as-needed basis when a patient is refusing detoxification is particularly inappropriate, because any prescribed opioids must be carefully controlled. Tr. 223.

32. Patient S.B. provided inconsistent information to other providers; she told an orthopedic surgeon during a June 28, 2017 visit that she had only a past medical history of anxiety (with no mention of fibromyalgia or ADD), and she did not disclose taking any medications when she was receiving hydrocodone, Soma, Adderall, and Xanax from Respondent. *See* GX 1 at 30, 57. Patient S.B. also informed the orthopedic surgeon that she had no history of trauma, *see* GX 1 at 30, but reported to the California Employment Development Department that she was disabled as a result of accident or trauma that had occurred on June 15, 2017, *see* GX 1 at 40. These inconsistent reports were significant red flags of abuse or diversion. Tr. 230, 231-32. Respondent, however, never addressed these red flags. Tr. 233, 235-37.

33. Respondent never conducted a urine drug screen on Patient S.B. in violation of the California standard of care. Tr. 219:13-16; PFF ¶ 18; *see generally* GX 1.

34. None of the controlled substance prescriptions Respondent issued to Patient S.B. between February 2, 2017, and January 30, 2018, were issued for a legitimate medical purpose, or by a practitioner acting within the usual course of professional practice. Tr.244. Indeed, according to Dr. Munzing, no patient should receive the drugs that Respondent prescribed to Patient S.B. in the dosages, durations, and combinations that Respondent prescribed. Tr. 211-12.

B. Patient M.B.

35. Between January 5, 2018, and November 20, 2019, Respondent issued to Patient M.B. the controlled substance prescriptions listed in Joint Stipulation No. 13. *See* ALJ Ex. 3 at 4-5. During this time, Respondent diagnosed Patient M.B. with back pain, ADD, and opioid dependency. GX 3 at 24-37.

i. Patient M.B.'s Initial Visit and the First Diagnosis for ADD

36. Respondent's initial encounter with Patient M.B. took place on April 19, 2006. GX 3 at 84, 91; Tr. 248-49. At that visit, Respondent diagnosed Patient M.B. with chronic back pain, chronic left knee pain, and dyslipidemia. GX 3 at 84; Tr. 250-51. Respondent prescribed Patient M.B. hydrocodone for chronic back and left knee pain. GX 3 at 84. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 3 at 84; Tr. 252-54;

b. address Patient M.B.'s pain or functionality levels, GX 3 at 84; Tr. 257;

c. conduct an appropriate physical examination, GX 3 at 84; Tr. 254-56, 257;

d. establish appropriate diagnoses for back pain and knee pain and therefore to establish a legitimate medical purpose to prescribe hydrocodone, Tr. 258; or

e. establish and document a treatment plan with goals and objectives, GX 3 at 84; Tr. 258.

37. Respondent first diagnosed Patient M.B. with ADD on July 9, 2013, and prescribed 30 mg of Adderall per day. GX 3 at 46. No history was taken, nor evaluations performed, for ADD other than a note saying Patient M.B. presented as a "40 yom with ADD, neck[]pain." GX 3 at 46; Tr. 262. Nothing supported Respondent's diagnosis for ADD, and he did not establish a legitimate medical purpose to prescribe Adderall. Tr. 263. Nor did he establish and document a treatment plan with goals and objectives for the Adderall. GX 3 at 46; Tr. 263.

ii. Continued Controlled Substance Violations

38. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient M.B., recorded Patient M.B.'s pain or functionality levels, or obtained prior medical records for Patient M.B.—nor does Patient M.B.'s medical file reflect Respondent requested such records—failed to periodically update Patient M.B.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 3; Tr. 287-88.

39. None of Respondent's diagnoses of Patient M.B. for which he prescribed controlled substances

between January 5, 2018, and November 20, 2019, were based on sufficient medical evidence. Tr. 288.

40. Over the course of his treatment of Patient M.B., Respondent frequently changed without comment the diagnoses for which he prescribed Patient M.B. hydrocodone. *See generally* GX 3; Tr. 275-78. These erratic diagnoses were outside of the standard of care, [especially because these diagnoses], including those made between January 5, 2018, and November 20, 2019, [were not supported by an adequate medical history and physical examination.] Tr. 278-80.

41. Other than inquiring into smoking and alcohol use at Patient M.B.'s initial visit, *see* GX 3 at 84, Respondent did not inquire about current or past substance abuse until over three years later, on August 11, 2009, when he had Patient M.B. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 3 at 94. Patient M.B. was never asked about substance abuse again—something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 261; *see generally* GX 3.

42. Respondent never documented an appropriate treatment plan with goals and objectives for Patient M.B., never documented an appropriate rationale for continued treatment of Patient M.B. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient M.B. *See generally* GX 3; Tr. 288-89.

43. Respondent also prescribed Patient M.B. dangerous combinations of hydrocodone and Adderall approximately monthly from January 2018, until July 2019, and once again on November 20, 2019. ALJ Ex. 3 at 4-5. These combinations put Patient M.B. at

serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 105-06, 281.

44. Respondent noted, on at least 11 occasions between March 6, 2018, and February 4, 2019, that Patient M.B. was opioid dependent, and refusing detoxification. GX 3 at 30, 32-36. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 3 at 30, 32-36; *see also* Tr. 286-87.

45. Indeed, Respondent frequently prescribed Patient M.B. hydrocodone as a treatment for the patient's opioid dependency, including on March 6, 2018, May 1, 2018, August 16, 2018, September 13, 2018, October 11, 2018, November 7, 2018, and January 2, 2019. GX 3 at 30, 32-36.

46. Opioid dependency does not create a legitimate medical purpose to prescribe hydrocodone. To the contrary, treating a patient's opioid dependency with hydrocodone is outside of the standard of care and outside the usual course of professional practice. Tr. 267-69.

47. Respondent never conducted a urine drug screen on Patient M.B., in violation of the California standard of care. Tr. 284; PFF ¶ 18; *see generally* GX 3.

48. None of the controlled substance prescriptions Respondent issued to Patient M.B. between January 5, 2018, and November 20, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 289-90. According to Dr. Munzing, there is nearly no situation in which a patient should receive the drugs that Respondent prescribed to Patient M.B.

from January 5, 2018, to November 20, 2019, in those dosages, durations, and combinations, and Patient M.B. did not present any such situation. Tr. 283-84.

C. Patient B.C.

49. Between January 25, 2017, and December 19, 2019, Respondent issued to Patient B.C. the controlled substance prescriptions listed in Joint Stipulation No. 16. *See* ALJ Ex. 3 at 5-7. During this time, Respondent diagnosed Patient B.C. with back pain, GAD, ADD, and opioid dependency. GX 5 at 17-33.

i. Patient B.C.'s Initial Visit And The First Diagnosis For ADD

50. Respondent's initial encounter with Patient B.C. took place on March 27, 2014. GX 5 at 48, 55; Tr. 293:1-16. At that visit, Respondent diagnosed Patient B.C. with GAD and back pain. GX 5 at 48; Tr. 294. Respondent prescribed Patient B.C. hydrocodone for back pain and 6 mg of Xanax for GAD. GX 5 at 48; Tr. 294. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 5 at 84; Tr. 295:7-296:15;

b. address Patient B.C.'s pain or functionality levels, GX 5 at 84; Tr. 297-98;

c. conduct an appropriate physical examination, GX 5 at 84; Tr. 296:16-297;

d. establish an appropriate diagnosis for back pain or GAD as necessary to establish a legitimate medical purpose to prescribe hydrocodone or Xanax, Tr. 298-99; or

e. establish and document a treatment plan with goals and objectives, GX 5 at 85; Tr. 299.

51. Respondent only inquired about Patient B.C.'s substance abuse on March 27, 2014. *See* GX 5 at 48, 57; Tr. 296, 299. Patient B.C. was never asked about substance abuse again—something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 300; *see generally* GX 5.

52. Respondent first diagnosed Patient B.C. with ADD on May 20, 2014, and prescribed 60 mg of Adderall per day. GX 5 at 47. He took no history, and performed no evaluations, for ADD, other than a note saying "Pt has ADD—give [A]dderall 30mg bid (SED)." *Id.* Respondent's diagnosis for ADD was unsupported; he did not establish a legitimate medical purpose to prescribe Adderall, nor did he establish and document a treatment plan with goals and objectives. GX 5 at 47; Tr. 302.

ii. Continued Controlled Substance Violations

53. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient B.C., never recorded Patient B.C.'s pain or functionality levels, failed to periodically update Patient B.C.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 5; Tr. 335-36.

54. None of Respondent's diagnoses of Patient B.C. for which he prescribed controlled substances between January 25, 2017, and December 19, 2019, were based on sufficient medical evidence. Tr. 336.

55. Over the course of his treatment of Patient B.C., Respondent's diagnoses for pain, GAD, and ADD

frequently came and went without comment or explanation. *See generally* GX 5; Tr. 316-19; 319-21; 322-25. Like chronic pain and GAD, ADD is a chronic condition. Tr. 167:13-16. These erratic diagnoses were outside of the standard of care, [especially since these diagnoses,] including those made between January 25, 2017, and December 19, 2019, [were not supported by an adequate medical history and physical examination.] Tr. 318-19; 321-22; 325-26.

56. Respondent never documented an appropriate treatment plan with goals and objectives for Patient B.C., never documented an appropriate rationale for continued treatment of Patient B.C. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient B.C. *See generally* GX 5; Tr. 337.

57. Respondent also prescribed Patient B.C. the following dangerous combinations of controlled substances, which put Patient B.C. at serious risk of adverse medical consequences, including addiction, overdose and death. Tr. 326-30:

a. Hydrocodone, Adderall, and Xanax on January 25, 2017, April 18, 2017, June 19, 2017, and July 31, 2018. ALJ Ex. 3 at 5-6.

b. Hydrocodone and Xanax on May 19, 2017, and approximately monthly from February 16, 2018, until July 3, 2018. ALJ Ex. 3 at 5-06.

c. Hydrocodone and Adderall on September 25, 2018, December 19, 2018, February 13, 2019, April 9, 2019, June 5, 2019, July 30, 2019, October 25, 2019, and December 19, 2019. ALJ Ex. 3 at 5-7.

58. Respondent's prescriptions to Patient B.C. for Xanax between January 25, 2017, and July 31, 2018, were all for 6 mg of Xanax per day. GX 5 at 28-33. Such high dosages of Xanax placed Patient B.C. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 294-95. The fact that Respondent prescribed Xanax to Patient B.C. concurrently with opioids, *see* ALJ Ex. 3 at 5-6, dramatically increased his risk of overdose and death. Tr. 295.

59. Respondent noted, on 19 occasions between January 25, 2017, and February 13, 2019, that Patient B.C. was opioid dependent, and refusing detoxification. GX 5 at 23, 25-33. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 5 at 23, 25-33; *see also* Tr. 333-34.

60. Indeed, Respondent frequently improperly and illegally prescribed Patient B.C. hydrocodone as a treatment for the patient's opioid dependency, including on January 25, 2017, June 19, 2017, July 17, 2017, March 26, 2018, May 11, 2018, July 3, 2018, August 28, 2018, October 22, 2018, December 19, 2018, and February 13, 2019. GX 5 at 23, 25-33; Tr. 306-07.

61. Respondent never conducted a urine drug screen on Patient B.C., in violation of the California standard of care. Tr. 333; PFF ¶ 18; *see generally* GX 5.

62. None of the controlled substance prescriptions Respondent issued to Patient B.C. between January 25, 2017, and December 19, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 289-90. According to Dr. Munzing, there is nearly

no situation in which a patient should receive the drugs that Respondent prescribed to Patient B.C. from January 25, 2017, to December 19, 2019, in those dosages, durations, and combinations, and Patient B.C. did not present any such situation. Tr. 337-38.

D. Patient J.C.

63. Between January 16, 2018, and December 30, 2019, Respondent issued to Patient J.C. the controlled substance prescriptions listed in Joint Stipulation No. 19. *See* ALJ Ex. 3 at 7-8. During this time, Respondent diagnosed Patient J.C. with back pain, GAD, and opioid dependency. GX 7 at 168-180.

i. Patient J.C.'s Initial Visit And The First Diagnosis For Back Pain

64. Respondent's initial encounter with Patient J.C. took place on May 18, 2009. GX 7 at 216, 233; Tr. 383:1-384:5. At that visit, Respondent diagnosed Patient J.C. with migraine headaches and GAD. GX 7 at 216; Tr. 384. Respondent prescribed Patient J.C. hydrocodone for migraines and Xanax for GAD. GX 7 at 216; Tr. 384. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 7 at 216; Tr. 385-86;

b. address Patient J.C.'s pain or functionality levels, GX 7 at 216; Tr. 387;

c. conduct an appropriate physical examination, GX 7 at 216; Tr. 386:16-387:3;

d. establish appropriate diagnoses for migraines or GAD and so establish a legitimate medical

purpose to prescribe hydrocodone or Xanax, Tr. 387-88; or

e. establish and document a treatment plan with goals and objectives, GX 7 at 216; Tr. 388.

65. Respondent first diagnosed Patient J.C. with back pain on July 21, 2016, and prescribed hydrocodone. GX 7 at 189. There was no history taken, or evaluations performed, for back pain, other than a note saying Patient J.C. presented as a "39 yom with GAD, chronic back pain." *Id.* Respondent's diagnosis for back pain was unsupported; he did not establish a legitimate medical purpose to prescribe hydrocodone, nor did he establish and document a treatment plan with goals and objectives. Tr. 391, 392-93, 393-94.

ii. Continued Controlled Substance Violations

66. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient J.C., never recorded Patient J.C.'s pain or functionality levels, never obtained prior medical records for Patient J.C.—nor does Patient J.C.'s medical file reflect Respondent requested such records—failed to periodically update Patient J.C.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 7; Tr. 424-26.

67. None of Respondent's diagnoses of Patient J.C. for which he prescribed controlled substances between January 16, 2018, and December 30, 2019, were based on sufficient medical evidence. Tr. 426.

68. Over the course of his treatment of Patient J.C., Respondent frequently changed without comment the diagnoses for which he prescribed Patient J.C.

opioids, as well as the opioids prescribed. *See generally* GX 7; Tr. 409-14. These erratic diagnoses were outside of the standard of care, [especially since those diagnoses,] including those made between January 16, 2018, and December 30, 2019, [were not supported by an adequate medical history and physical examination.] Tr. 414-15.

69. Other than inquiring into smoking and alcohol use at Patient J.C.'s initial visit, *see* GX 7 at 216, Respondent did not inquire about current or past substance abuse until August 17, 2009, when he had Patient J.C. sign a form stating, "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 7 at 227. Patient J.C. was never asked about substance abuse again—something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 359-60; *see generally* GX 7.

70. Respondent never documented an appropriate treatment plan with goals and objectives for Patient J.C., never documented an appropriate rationale for continued treatment of Patient J.C. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient J.C. *See generally* GX 7; Tr. 426-27.

71. Respondent also prescribed Patient J.C. dangerous combinations of hydrocodone and Valium approximately monthly from January 16, 2018, until January 18, 2019, and once again on May 6, 2019. ALJ Ex. 3 at 7-8. These combinations put Patient J.C. at serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 417-18.

72. Respondent noted, on 14 occasions between January 16, 2018, and February 19, 2019, that

Patient J.C. was opioid dependent, and refusing detoxification. GX 7 at 173, 175-180. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 7 at 173, 175-80; *see also* Tr. 423-24.

73. Indeed, Respondent frequently improperly and illegally prescribed Patient J.C. hydrocodone as a treatment for the patient's opioid dependency, including on February 16, 2018, April 16, 2018, June 15, 2018, August 15, 2018, October 17, 2018, and December 13, 2018. GX 7 at 175-80; Tr. 398-400.

74. Respondent never conducted a urine drug screen on Patient J.C., in violation of the California standard of care. Tr. 421; PFF¶ 18; *see generally* GX 7.

75. None of the controlled substance prescriptions Respondent issued to Patient J.C. between January 16, 2018, and December 30, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 427-28. According to Dr. Munzing, there is nearly no situation in which a patient should receive the drugs that Respondent prescribed to Patient J.C. from January 16, 2018, to December 30, 2019, in those dosages, durations, and combinations, and Patient J.C. did not present any such situation. Tr. 418-19.

E. Patient D.D.

76. Between January 4, 2018, and February 12, 2019, Respondent issued to Patient D.D. the controlled substance prescriptions listed in Joint Stipulation No. 22. *See* ALJ Ex. 3 at 9. During this time, Respondent

diagnosed Patient D.D. with back pain, GAD, and opioid dependency. GX 9 at 37-43.

i. Patient D.D.'S Initial Visit

77. Respondent's initial encounter with Patient D.D. took place on July 9, 2008. GX 9 at 74, 80; Tr. 430-31. At that visit, Respondent diagnosed Patient D.D. with GAD and back pain. GX 9 at 74; Tr. 431. Respondent prescribed Patient D.D. hydrocodone and Soma for back pain, and Valium for GAD. GX 9 at 74; Tr. 431. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 9 at 74; Tr. 433-34;

b. address Patient D.D.'s pain or functionality levels, GX 9 at 74; Tr. 435-36;

c. conduct an appropriate physical examination, GX 9 at 74; Tr. 434-35;

d. establish appropriate diagnoses for back pain or GAD and so to establish a legitimate medical purpose to prescribe hydrocodone, Soma, or a benzodiazepine, Tr. 436:3-21; or

e. establish and document a treatment plan with goals and objectives, GX 9 at 74; Tr. 436:22-25.

ii. Continued Controlled Substance Violations

78. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient D.D., never recorded Patient D.D.'s pain or functionality levels, never obtained prior medical records for Patient D.D.—nor does Patient D.D.'s medical file reflect Respondent requested such records—

failed to periodically update Patient D.D.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 9; Tr. 465-66.

79. None of Respondent's diagnoses of Patient D.D. for which he prescribed controlled substances between January 4, 2018, and February 12, 2019, were based on sufficient medical evidence. Tr. 467.

80. Over the course of his treatment of Patient D.D., Respondent frequently changed without comment the diagnoses for which he prescribed Patient D.D. opioids. *See generally* GX 9; Tr. 450-56. These erratic diagnoses were outside of the standard of care, [especially since these diagnoses,] including those made between January 4, 2018, [were not supported by an adequate medical history and physical examination.] Tr. 453-56.

81. Other than inquiring into smoking and alcohol use at Patient D.D.'s initial visit, *see* GX 9 at 74, Respondent did not inquire about current or past substance abuse until over one year later, on August 28, 2009, when he had Patient D.D. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 9 at 77. Respondent never asked Patient D.D. about substance abuse again—something the California standard of care required Respondent to do. PFF ¶ 16; *see generally* GX 9.

82. Respondent never documented an appropriate treatment plan with goals and objectives for Patient D.D., never documented an appropriate rationale for continued treatment of Patient D.D. with controlled substances, and failed to properly discuss the risks

and benefits of the controlled substances he prescribed to Patient D.D. *See generally* GX 9; Tr. 467.

83. Respondent also prescribed Patient D.D. the following dangerous combinations of controlled substances, which put Patient D.D. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 457-58:

a. Hydrocodone and Soma approximately monthly from January 4, 2018, through August 10, 2018, and October 16, 2018, through January 11, 2019. ALJ Ex. 3 at 9.

b. Hydrocodone and Xanax on September 19, 2018. ALJ Ex. 3 at 9.

84. Respondent noted, on 10 occasions between January 16, 2018, and February 12, 2019, that Patient D.D. was opioid dependent and refusing detoxification. GX 9 at 37, 39-43. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 9 at 37, 39-43.; *see also* Tr. 463-65.

85. Indeed, Respondent frequently illegally and improperly prescribed Patient D.D. hydrocodone as a treatment for the patient's opioid dependency, including on March 23, 2018, July 6, 2018, August 10, 2018, October 16, 2018, December 13, 2018, and February 12, 2019. GX 9 at 37, 39-43; Tr. 454. Moreover, on all of those occasions except February 12, 2019, Respondent also prescribed Patient D.D. Soma for his opioid dependency. Soma is not indicated as a treatment for opioid dependency, and prescribing it to treat opioid dependency is outside the usual course of professional practice. GX 9 at 39-43; Tr. 454-55.

86. Although Patient D.D. presented a risk of abuse or diversion, Respondent never conducted a urine drug screen on Patient D.D., in violation of the California standard of care. Tr. 461-62; PFF ¶ 18; *see generally* GX 9.

87. None of the controlled substance prescriptions Respondent issued to Patient D.D. between January 4, 2018, and February 12, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 468:4-16. According to Dr. Munzing, there is nearly no situation in which any patient should receive the drugs that Respondent prescribed to Patient D.D. between January 4, 2018, and February 12, 2019, in those dosages, durations, and combinations, and Patient D.D. did not present any such situation. Tr. 460-61.

F. Patient J.M.

88. Between January 10, 2017, and December 31, 2019, Respondent issued to Patient J.M. the controlled substance prescriptions listed in Joint Stipulation No. 25. *See* ALJ Ex. 3 at 10-12. During this time, Respondent diagnosed Patient J.M. with back pain, GAD, and opioid dependency. GX 11 at 18-42.

i. Patient J.M.'s Initial Visit

89. Respondent's initial encounter with Patient J.M. took place on May 14, 2007. GX 11 at 104, 111; Tr. 471. At that visit, Respondent diagnosed Patient J.M. with, inter alia, back pain and GAD. GX 11 at 104; Tr. 472. Respondent prescribed Patient J.M. hydrocodone for back pain and 6 mg of Xanax per day for GAD. GX 11 at 104; 472. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 11 at 104; Tr. 473-74

b. address Patient J.M.'s pain or functionality levels, GX 11 at 104; Tr. 474-75;

c. conduct an appropriate physical examination, GX 11 at 104; Tr. 474;

d. establish an appropriate diagnosis for back pain and so establish a legitimate medical purpose to prescribe hydrocodone or Soma, Tr. 475; or

e. establish and document a treatment plan with goals and objectives, GX 11 at 104; Tr. 475-76.

ii. Controlled Substance Violations

90. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient J.M., never recorded Patient J.M.'s pain or functionality levels, never obtained prior medical records for Patient J.M.—nor does Patient J.M.'s medical file reflect Respondent requested such records—failed to periodically update Patient J.M.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 11; Tr. 564-66.

91. None of Respondent's diagnoses of Patient J.M. for which he prescribed controlled substances between January 10, 2017, and December 31, 2019, were based on sufficient medical evidence. Tr. 566.

92. Over the course of his treatment of Patient J.M., Respondent frequently changed without comment the diagnoses for which he prescribed Patient J.M.

hydrocodone. *See generally* GX 11; Tr. 502-03, 504. These erratic diagnoses were outside of the standard of care, [especially since these diagnoses,] including those made between January 10, 2017, [were not supported by an adequate medical history and physical examination.] Tr. 503-04.

93. Other than inquiring into smoking and alcohol use at Patient J.M.'s initial visit, *see* GX 11 at 104; Tr. 475, Respondent did not inquire about substance abuse until over two years later, on September 21, 2009, when he had Patient J.M. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 11 at 115. Respondent never asked Patient J.M. about substance abuse again as required by the California standard of care. PFF ¶ 16; Tr. 481-82; *see generally* GX 11.

94. Respondent never documented an appropriate treatment plan with goals and objectives for Patient J.M., never documented an appropriate rationale for continued treatment of Patient J.M. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient J.M. *See generally* GX 11; Tr. 566-67.

95. Respondent also prescribed Patient J.M. the following dangerous combinations of controlled substances, which put Patient J.M. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 505-10:

a Hydrocodone, Xanax, and Soma (a combination referred to by illicit users as "the Holy Trinity," Tr. 506) in May of 2018, and November of 2018. ALJ Ex. 3 at 11.

b. Hydrocodone and Xanax on 26 occasions between January 25, 2017, and February 20, 2019. ALJ Ex. 3 at 10-11.

96. These combinations of drugs are highly sought after for abuse and diversion. Tr. ``-06, 510. Indeed, there is almost never any medical justification for prescribing a combination of hydrocodone, Xanax, and Soma. Tr. 507-08. Specifically, this combination was prescribed on January 25, 2017, June 19, 2017, August 14, 2017, September 14, 2017, October 17, 2017, November 6, 2017, November 20, 2017, January 25, 2018, February 7, 2018, February 23, 2018, March of 2018, April 9, 2018, April 25, 2018, May 23, 2018, June 11, 2018, June 27, 2018, July 11, 2018, July 25, 2018, August 29, 2018, September 17, 2018, October 17, 2018, December 5, 2018, December 21, 2018, January of 2019, February 6, 2019, and February 20, 2019.

97. Respondent's prescriptions to Patient J.M. for Xanax between January 10, 2017, and February 20, 2019, were repeatedly for at least 6 mg of Xanax per day. GX 11 at 26-42; ALJ Ex. 3 at 10-11. Prescribing such high dosages of Xanax placed Patient J.M. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 217, 218-19. The fact that Respondent often prescribed Xanax to Patient J.M. concurrently with opioids, *see* ALJ Ex. 3 at 10-11, dramatically increased his risk of overdose and death. Tr. 217-18.

98. Indeed, between January 10, 2017, and November 2, 2018, Respondent repeatedly issued Patient J.M. substantially early prescriptions for Xanax-issuing Patient J.M. 40 prescriptions for 90 units of Xanax 2 mg, or a prescription approximately every 17 days. ALJ Ex. 3 at 10-11. This provided Patient J.M. with over 10.5 mg of Xanax per day, or more than

double the maximum recommended daily dose of 4 mg. *Id.;* Tr. 513-15.

99. Further, between January 10, 2017, and November 2, 2018, Patient J.M. alternated filling his Xanax prescriptions at one of two different pharmacies. Tr. 520-21; GX 17; GX 18. This was a significant red flag or abuse and diversion, indicating that Patient J.M. was seeking to avoid the pharmacies detecting how much Xanax he was being prescribed, but Respondent did nothing to address this. Tr. 521-22.

100. Instead, Respondent actually assisted Patient J.M. in obtaining controlled substances Patient J.M. might not otherwise have been able to have filled.*DD Respondent frequently issued Patient J.M. a written prescription for hydrocodone which Patient J.M. would fill at one pharmacy, and that same day, Respondent would call in a prescription for Xanax to another pharmacy. Tr. 528-547, 550-58. Respondent did this on at least the following dates:

a. January 25, 2017, *see* GX 11 at 42; GX 12 at 1-2; GX 17 at rows 425, 575;

b. June 19, 2017, *see* GX 11 at 41; GX 12 at 5-6; GX 17 at rows 1,746, 1,825; 28

c. November 6, 2017, *see* GX 11 at 40; GX 12 at 10-11; GX 17 at rows 2,764, 2,788;

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*DD Whether or not Respondent was knowingly assisting J.M. in diversion was not material to my decision in this matter as the overwhelming evidence already established that Respondent issued the relevant prescriptions outside the usual course of professional practice and beneath the standard of care in California.

d. February 7, 2018, *see* GX 11 at 38; GX 12 at 14; GX 13 at 20; GX 18 at rows 473, 474;

e. May 11, 2018, *see* GX 11 at 36; GX 12 at 22; GX 13 at 25; GX 18 at rows 994, 1,120;

f. June 11, 2018, *see* GX 11 at 36; GX 12 at 24; GX 13 at 27; GX 18 at rows 1,228, 1,386;

g. July 11, 2018, *see* GX 11 at 35; GX 12 at 26-27; GX 18 at rows 1,472, 1,553;

h. September 17, 2018, *see* GX 11 at 33; GX 12 at 33; GX 13 at 32; GX 18 at rows 2,102, 2,229; and

i. October 17, 2018, *see* GX 11 at 32; GX 12 at 34; GX 13 at 34; GX 18 at rows 2,341, 2,342.

101. This was a "bright red flag" indicating that Patient J.M. was seeking to avoid having a pharmacy potentially refuse to fill concurrent prescriptions for opioids and benzodiazepines. Tr. 558-59.

102. Between November 20, 2017, and February 20, 2019, Respondent noted 17 times in Patient J.M.'s medical file that Patient J.M. was opioid dependent, and refusing detoxification. GX 11 at 26-39. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 11 at 26-39; *see also* Tr. 561-64.

103. Indeed, Respondent frequently improperly and illegally prescribed Patient J.M. hydrocodone as a treatment for the patient's opioid dependency, including on at least April 25, 2018, May 23, 2018, June 27, 2018, August 29, 2018, October 17, 2018, and December 21, 2018. GX 11 at 30, 32, 34-37; Tr. 486-88.

104. Further, Respondent's prescribing of hydrocodone was sporadic. *See*, *e.g.*, GX 11 at 3942; Tr. 500:5-501:13. However, Respondent never documented any rationale for changing Patient J.M.'s course of medication with respect to hydrocodone. *See* GX 1 at 18-42; Tr. 501.

105. Although Patient J.M. presented significant risks of abuse or diversion, Respondent never conducted a urine drug screen on Patient J.M., in violation of the California standard of care. Tr. 560-61:12; PFF ¶ 18; *see generally* GX 11.

106. None of the controlled substance prescriptions Respondent issued to Patient J.M. between January 10, 2017, and December 31, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 567-68. Dr. Munzing testified that there is no situation in which any patient should receive the drugs that Respondent prescribed to Patient J.M. between January 10, 2017, and December 31, 2019, in those dosages, durations, and combinations. Tr. 507-08.

G. Patient K.S.

107. Between January 19, 2018, and January 31, 2019, Respondent issued to Patient K.S. the controlled substance prescriptions listed in Joint Stipulation No. 29. *See* ALJ Ex. 3 at 12-13. During this time period, Respondent diagnosed Patient K.S. with back pain, GAD, ADD, and opioid dependency. GX 14 at 31-41.

i. Patient K.S.'s Initial Visit And The First Prescriptions For Xanax And Adderall

108. Respondent's initial encounter with Patient K.S. took place on June 21, 2007. GX 14 at 110, 117; Tr. 570:8-571:3. At that visit, Respondent diagnosed Patient K.S. with back pain. GX 14 at 110; Tr. 571. Respondent prescribed Patient K.S. hydrocodone and Soma for back pain. GX 14 at 110; Tr. 571. At this initial visit, Respondent failed to:

a. Take an appropriate medical history, GX 14 at 110; Tr. 572:4-23;

b. address Patient K.S.'s pain or functionality levels, GX 14 at 110; Tr. 573:1823;

c. conduct an appropriate physical examination, GX 14 at 110; Tr. 572-73

d. establish an appropriate diagnosis for back pain and so establish a legitimate medical purpose to prescribe hydrocodone or Soma, Tr. 574; or

e. establish and document a treatment plan with goals and objectives, GX 14 at 110; Tr. 574:16-21.

109. Respondent first diagnosed Patient K.S. with GAD on May 1, 2012, and prescribed 6 mg of Xanax per day. GX 14 at 80; Tr. 577. There was no history taken, or evaluations performed for GAD, other than an insufficient note saying Patient K.S. presented as a "28 yom with GAD, neck pain." GX 14 at 80. Respondent's diagnosis for GAD was completely unsupported as he did not establish a legitimate medical purpose to prescribe Xanax, nor did he establish and

document a treatment plan with goals and objectives. *Id.;* Tr. 579-81.

110. Respondent first prescribed Patient K.S. Adderall on November 18, 2013. GX 14 at 70. There was no history taken, evaluations performed, or even any diagnosis made; there was only a note saying "Adderall 30 mg #60, [one] bid (SED)." *Id.;* Tr. 581. Respondent did not establish a legitimate medical purpose to prescribe Adderall, nor did he establish and document a treatment plan with goals and objectives. Tr. 582:16-23. Respondent later diagnosed Patient K.S. with ADD, *see e.g.,* GX 14 at 41, but he had never obtained sufficient medical evidence for such a diagnosis. Tr. 583-84.

ii. Continued Controlled Substance Violations

111. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient K.S., never recorded Patient K.S.'s pain or functionality levels, never obtained prior medical records for Patient K.S.—nor does Patient K.S.'s medical file reflect Respondent requested such records—failed to periodically update Patient K.S.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 14; Tr. 617-19.

112. None of Respondent's diagnoses of Patient K.S. for which he prescribed controlled substances between January 19, 2018, and January 31, 2019, were based on sufficient medical evidence. Tr. 619:6-13.

113. Over the course of his treatment of Patient K.S., Respondent's diagnoses for pain, GAD, and ADD

frequently came and went without comment or explanation. *See generally* GX 14; Tr. 598-601; 602-05; 605-08. These erratic diagnoses were outside of the standard of care, [especially since these diagnoses,] including those made between January 19, 2018, and January 31, 2019, [were not supported by an adequate medical history and physical examination.] Tr. 601-02; 604-05; 608-09.

114. Other than inquiring into smoking and alcohol use at Patient K.S.'s initial visit, *see* GX 14 at 110; Tr. 573-74, Respondent did not inquire about current or past substance abuse until over two years later, on August 5, 2009, when he had Patient K.S. sign a form stating, "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 14 at 119. Respondent never asked Patient K.S. about substance abuse again as required by the California standard of care. PFF ¶ 16; Tr. 574-75; *see generally* GX 14.

115. Respondent never documented an appropriate treatment plan with goals and objectives for Patient K.S., never documented an appropriate rationale for continued treatment of Patient K.S. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient K.S. *See generally* GX 14; Tr. 619-20.

116. Respondent also prescribed Patient K.S. the following dangerous combinations of controlled substances, that put Patient K.S. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 609-11:

a. Hydrocodone, Adderall, and Xanax approximately monthly from January 19, 2018,

through August of 2018, and again in November of 2018. ALJ Ex. 3 at 12-13.

b. Hydrocodone and Xanax on August 29, 2018, October 2, 2018, October 31, 2018, and November 28, 2018. ALJ Ex. 3 at 13.

117. Respondent's prescriptions to Patient K.S. for Xanax between January 19, 2018, and January 31, 2019, were all for 6 mg of Xanax per day. GX 14 at 33-41; ALJ Ex. 3 at 12-13. Prescribing such high dosages of Xanax placed Patient K.S. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 577-78. The fact that Respondent prescribed Xanax to Patient K.S. concurrently with opioids, *see* ALJ Ex. 3 at 12-13, dramatically increased his risk of overdose and death. Tr. 579.

118. Respondent noted on 13 occasions between January 19, 2018, and January 31, 2019, that Patient K.S. was opioid dependent, and refusing detoxification. GX 14 at 31-41. Respondent never addressed this red flag, but simply continued to prescribe the patient hydrocodone on an as-needed basis. GX 14 at 31-41; *see also* Tr. 615-17.

119. Indeed, Respondent frequently improperly and illegally prescribed Patient K.S. hydrocodone as a treatment for the patient's opioid dependency, including on February 27, 2018, April 30, 2018, July 3, 2018, August 3, 2018, October 2, 2018, November 28, 2018, and January 2, 2019. GX 14 at 31, 33, 35-37, 39-40; Tr. 586-88.

120. Although Patient K.S. presented significant risks of abuse or diversion, Respondent never conducted a urine drug screen on Patient K.S. in violation of the

California standard of care. Tr. 614; PFF ¶ 18; *see generally* GX 14.

121. None of the controlled substance prescriptions Respondent issued to Patient K.S. between January 19, 2018, and January 31, 2019, were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 620. According to Dr. Munzing, there is no situation in which a patient should receive the drugs that Respondent prescribed to Patient K.S. between January 19, 2018, and January 31, 2019, in those dosages, durations, and combinations. Tr. 613.

122. Respondent's prescribing of controlled substances to Patients S.B., M.B., B.C., J.C., D.D., J.M., K.S. constituted clearly excessive prescribing. Tr. 621.

Analysis

Findings as to Allegations

The Government alleges that the Respondent's COR should be revoked and any applications should be denied, because the Respondent violated federal and California law, by issuing numerous prescriptions for Schedule II through IV controlled substances outside the usual course of professional practice and not for a legitimate medical purpose to seven individuals as recently as December 31, 2019. [I find that each of the relevant prescriptions were issued outside of the usual course of professional practice and beneath the standard of care in California in violation of both federal and state law.][*EE] In the adjudication of a

[*EE] Text modified for legal clarity.

revocation or suspension of a COR, DEA bears the burden of proving that the requirements for such revocation or suspension are satisfied. 21 CFR 1301.44(e). Where the Government has sustained its burden and established that a respondent has committed acts that render his registration inconsistent with the public interest, to rebut the Government's *prima facie* case, a respondent must both accept responsibility for his actions and demonstrate that he will not engage in future misconduct. *Patrick W. Stodola,* M.D.,74 FR 20727, 20734 (2009).

Acceptance of responsibility and remedial measures are assessed in the context of the "egregiousness of the violations and the [DEA's] interest in deterring similar misconduct by [the] Respondent in the future as well as on the part of others." *David A. Ruben,* M.D.,78 FR 38363, 38364 (2013). Where the Government has sustained its burden and established that a respondent has committed acts inconsistent with the public interest, that respondent must present sufficient mitigating evidence to assure the Administrator that he can be entrusted with the responsibility commensurate with such a registration. *Medicine Shoppe-Jonesborough,73* FR 364, 387 (2008).

The Agency's conclusion that "past performance is the best predictor of future performance" has been sustained on review, *Alra Labs., Inc. v. DEA,* 54 F.3d 450, 452 (7th Cir. 1995), as has the Agency's consistent policy of strongly weighing whether a registrant who has committed acts inconsistent with the public interest has accepted responsibility and demonstrated that he or she will not engage in future misconduct. *Hoxie v. DEA,* 419 F.3d 477, 482-83 (6th Cir. 2005); *see also Ronald Lynch,* M.D.,75 FR 78745, 78754 (2010)

(holding that the Respondent's attempts to minimize misconduct undermined acceptance of responsibility); *George* C. *Aycock, M.D.,74* FR 17529, 17543 (2009). (finding that much of the respondent's testimony undermined his initial acceptance that he was "probably at fault" for some misconduct); *Jayam Krishna-Iyer,* M.D.,74 FR 459, 463 (2009) (noting on remand, that despite the respondent's having undertaken measures to reform her practice, revocation had been appropriate because the respondent had refused to acknowledge her responsibility under the law); *Medicine Shoppe-Jonesborough,* 73 FR at 387 (noting that the respondent did not acknowledge recordkeeping problems, let alone more serious violations of federal law, and concluding that revocation was warranted).*FF

California Law

The applicable California Codes are:*GG

1. Cal. Health & Safety Code § 11153(a), requiring that a "prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice";
2. Cal. Health & Safety Code § 11154(a), directing that "no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person . . . not under

*FF Remaining text omitted for brevity and clarity.

*GG However, *see supra* n. 1.

his or her treatment for a pathology or condition . . .";

3. Cal. Bus. & Prof. Code § 2242, prohibiting the [p]rescribing, dispensing, or furnishing [of controlled substances] . . . without an appropriate prior examination and a medical indication," the violation of which constitutes unprofessional conduct;

4. Cal. Bus. & Prof. Code § 2234, defining unprofessional conduct to include: "[dross negligence"; [r]epeated negligent acts"; "[i]ncompetence"; or "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon"; and

5. Cal. Bus. & Prof. Code § 725, further defining unprofessional conduct to include "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs. . . . "

ALJ Ex. 1.

Allegations Common to Multiple Patients

There were allegations common to many or all of the subject patients. They will be discussed here generally. They may be discussed in detail in the context of the particular patients as well, and as needed.

Failure To Maintain Accurate and Complete Patient Charts

There was a recurring theme throughout the Respondent's patient files that he failed to maintain accurate and complete patient charts. This failing itself is contrary to the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons," Medical Board of California, 7th ed. 2013, which requires the practitioner to "keep accurate and complete records, including but not limited to, records of the patient's medical history, physical examinations of the patient, the treatment plan objectives and the treatments given, and the rationale for any changes in treatment." *Id.* at 59. Not surprisingly, the failure to maintain accurate and complete patient records itself is outside the usual course of professional practice and represents a violation of the California standard of care.

Dr. Munzing also explained that this failure in documentation rendered any resulting treatment or diagnosis unjustified and inappropriate. Tr. 241-44. Without an appropriate diagnosis that is justified by the documentation, there is no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44.

The Respondent conceded repeatedly that matters allegedly discussed with the patients, information gathered from them, evaluation of treatment plans and changes in treatment, and determinations regarding treatment, were not recorded in the patient chart.[21]

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[21] For example, the Respondent conceded he did not document the rationale for the change in medication for J.M. and K.S. Tr. 885. On February 2, 2017, the Respondent prescribed Soma

He gave various reasons for not documenting the missing information, including his 41-years of clinical experience, his busy practice, and his practice of maintaining paper records, which prevents the degree of detail permitted by electronic record-keeping, and results in him keeping his notes as brief as possible and only recording the "main ideas." Tr. 809. The

Respondent conceded that "maybe" it was "inappropriate" of him not to more thoroughly detail this information in the charts. Tr. 809. But with handwritten charts, he claimed that he was only able to include the "main ideas." His notes are simply to remind him of the matters in the future, so he keeps his notes as brief as possible. Tr. 810-11, 815. Finally, he defended his limited documentation by claiming that more was unnecessary due to his photographic memory.[22] Although the Respondent sometimes dis-

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to S.B. Tr. 875; GX 1 at 59. By March 1, 2017, Soma had been discontinued, yet the chart reflected no rationale for that change in medication regimen. Tr. 876-77. As the Respondent varied his prescribing between Soma and Xanax, he conceded he did not document the reason for the variation in medication. Tr. 878-83. Similarly, the Respondent conceded he did not document pain level, function level and quality of life in the seven charged patients. Tr. 885-87; GX 20 at 61. Although the Respondent testified he developed a treatment plan for each of his patients, the Government pointed out S.B.'s treatment plan and objectives were not documented in her chart. Tr. 813-14.

[22] The list of prior therapies was not in his progress notes. Tr. 805-06, 808. The Respondent explained its absence by stating that maybe he did not feel it was crucial to document them, because he memorizes what the patient tells him. Tr. 806. Respondent thought the documentation did not need to include references to prior, concluded treatment, because the patient had moved on to the new treatment. Tr. 807-08. The Respondent testified to S.B.'s prior treatment from memory. Tr. 808. [Some

played a seemingly extraordinary memory,[23] it was not always infallible. [*See infra* Credibility Analysis of the Respondent. Consistent with Dr. Munzing's opinions, the Respondent misperceives the purpose of these medical records. Not only do medical records remind the treating practitioner of the basis and ongoing treatment strategy; they also provide an accurate history of symptoms, ongoing treatment and medication protocol for other practitioners who may treat the patient in the future. Tr. 917.]

Moreover, as the Respondent indicated he was essentially testifying from memory regarding appointments and treatment from sometimes up to fourteen years ago, the Government was permitted to test the Respondent's memory. The Respondent's memory may not be as good as he believes.[24] [*See infra* Credibility

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footnote text was omitted for brevity, and other portions were moved to the body of the discussion or to other footnotes where the information was more pertinent.]

[23] The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit (in 2009). Tr. 840. The Respondent added that he probably prescribed Valium to J.C., as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent added that he may have also prescribed Xanax to K.S., but it is difficult to be sure with hundreds of patients and treatment dating back 15 years. Tr. 859. M.B. had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827. Even with a good memory, Respondent admitted that sometimes the he may just miss something. Tr. 859.

[24] The Government sought to test the Respondent's memory by asking to confirm that, consistent with his direct testimony, he only treated S.B. with hydrocodone, Xanax and Adderall. Tr. 810-13. The Respondent confirmed his direct testimony. Tr. 812. The Government reminded the Respondent that he prescribed Soma as well. Tr. 813. Although the Respondent testified

Analysis of the Respondent.] Of course, even the extraordinary memory of the Respondent will not help another practitioner who may treat one of the Respondent's patients and expect to rely on the Respondent's chart.

Respondent's belief that all of the necessary patient information was accurately kept in his mind is no justification for Respondent's failure to maintain accurate and complete patient files. I find the Respondent violated the California professional standards and standard of care by failing to maintain complete and accurate medical charts as to each of the subject patients.*HH

In his Post-hearing Brief (PHB), the Respondent argues that Dr. Munzing's assertions that the deficient medical charts demonstrate treatment outside the standard of care is faulty, as Dr. Munzing failed to speak with the subject patients to determine if the prescriptions were justified. Only then, he argues, could Dr. Munzing convincingly opine regarding whether the actual treatment was consistent with the standard of care. The Respondent misses the point. Although certainly the extent of Dr. Munzing's review of relevant material is normally critical to the conclusions he draws, the focus of Dr. Munzing's opinions relate to whether the Respondent complied with his

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he did not introduce any of his subject patients to controlled substances, the chart reflects he did prescribe Soma to S.B. for the first time. Tr. 816-17; GX 1 at 61, 62. The Respondent remembered during cross-examination that, although not in the chart, S.B. told him she had been on Soma previously. Tr. 817-19.

*HH Sentence modified for clarity.

obligations under the standard of care prior to prescribing the subject medications, and documentation was part of his obligation. It is neither here nor there that Dr. Munzing could have resolved his own concerns regarding the subject prescriptions by speaking to the patients years later. Nor is it dispositive that Dr. Munzing might have determined, through his own investigation, that the prescriptions were justified at the time they were issued [but for the documentation failures.] The Respondent failed to satisfy his obligations, which include obligations to accurately document, at the time the prescriptions were issued. Accordingly, I do not view the fact that Dr. Munzing did not speak with the subject patients as diminishing the probity of his relevant opinions as to the Respondent's acts or omissions, at all. The instant evaluation relates to whether the Respondent provided appropriate controlled substance prescriptions on the basis of the information developed by the Respondent prior to issuing the prescriptions.

Although the Respondent argues in his PHB that he testified credibly that he fully complied with his obligations under the standard of care, the Respondent was not fully credible as detailed in my credibility analysis of the Respondent. In the Government's Supplemental Pre-hearing Statement (GSPHS), the Government argues that the failure to document procedures or findings within the chart justifies a finding that the procedures, evaluation or findings did not occur. On the basis of the instant record, I concur. I further adopt Dr. Munzing's conclusions that without sufficient documentation of procedures or evaluation required by the standard of care, resulting diagnoses are deemed inappropriate, there is no legitimate med-

ical purpose established for treatment and any resulting controlled substance prescriptions were outside the usual course of professional practice. [I have discussed this further *infra* at Factors Two and Four.]

Patients Were Left on Their Original Medication Protocols Despite Being Prescribed High MME and Dangerous Combinations

Patients were permitted to remain on the medications and dosages they were previously prescribed if the Respondent found them to be doing well, that their pain level was low enough that they could work full time, and they could complete their ADLs. [Respondent testified, "[i]f the patient tells me, "Look, I've already been with pain specialists; I've already seen a couple of specialists; I already had three-four MRIs; I already had surgery; I'm on this medication for years, and it's working for me," then it comes down to one of two options. Either I tell him I will fill his prescription or I kick him out of my office. And I don't think it is ethical to do that latter approach." Tr. 651.] This was the case even with patients at dangerous levels of medication and in dangerous combinations that are known to be popular for abuse and diversion. [Interestingly, despite Dr. Munzing's consistent testimony supported by CDC guidance and a FDA black box warning, Respondent testified that the prescribed combination of an opiate, muscle relaxant, and benzodiazepine, when "used in the right dosages for the right indications, and used as prescribed by a knowledgeable M.D., . . . are safe to use in combination therapy." Tr. 797.]

The Respondent maintained this *laissez faire* attitude despite being confronted with significant red flags suggesting that his patients could have been abusing and/or diverting.[25] Even patients the Respondent acknowledged as opioid dependent and refusing detox were continued on these dangerous medications and combinations without even UDS monitoring.[26] In fact, the Respondent treated opioid dependence with opioids, which is clearly outside the California standard of care. In fact, Dr. Munzing testified that it is illegal in California. Tr. 267-68, 306, 398-400. The Respondent failed to make any attempt at titration, even for patients who attempted to titrate on their own and who skipped pain medication when they could tolerate it. As Dr. Munzing observed, the standard of care would require an attempt at titration.

I find the Respondent's failures to sufficiently monitor, and to attempt titration from dangerous levels of medication and in dangerous combinations were outside the California standard of care.

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[25] For example, S.B. reported to Dr. F that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription evidence. Tr. 231-32. Also, CURES records disclosed his patients were being prescribed Suboxone by another physician.

[26] *See Holloway Distrib.*,72 FR 42118, 42124 (2007) (a policy of "see no evil, hear no evil" is fundamentally inconsistent with the obligations of a DEA registrant). Agency precedent has long recognized that "Illegally, there is absolutely no difference between the sale of an illicit drug on the street and the illicit dispensing of a licit drug by means of a physician's prescription." *EZRX, L.L.C.*,69 FR 63178, 63181 (1988); *Floyd A. Santner*, M.D.,55 FR 37581, (1988); *Michael J. Aruta*, M.D.,76 FR 19420, 19434 (2011).

Discussion as to Patient S.B.*II

As per the parties' stipulations, between February 2, 2017, and January 30, 2019, S.B. was prescribed hydrocodone, carisoprodol, Adderall and alprazolam. Tr. 162-63; GDX 1. Patient S.B. remains a patient of Dr. Rabadi. Tr. 708-09.*JJ. Rabadi believed his prescription practice concerning S.B. was within the California standard of care. Tr. 709. Dr. Rabadi began his treatment of S.B. on August 3, 2016. Tr. 718. She presented as a 29 year-old female with ongoing conditions of GAD, fibromyalgia and ADD. Tr. 719. Dr. Rabadi noted that patients with ADD are six times more likely to have other psychiatric conditions as people without ADD. Ultimately, Dr. Rabadi concurred with the previous physician's diagnoses of ADD, GAD, and fibromyalgia. Tr. 724, 728.

Respondent testified that, as per his policy, he took a complete history. Tr. 719-20. He testified that he performed a complete physical exam, reviewed her existing diagnoses of GAD and ADD, and her medication history in general, and specifically for those diagnoses. Tr. 720, 722-24. He testified, [from memory,] that he obtained her pain level with and without medication. Without medication her subjective pain level was eight. With medication, it was one to two, which permitted her to function and perform daily activities. Tr. 721.

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*II The RD included an extensive write up of the OSC's allegations pertaining to each of the seven individuals at issue prior to discussing each individual. The allegations are set forth clearly in the OSC, *see* ALJX 1, and are summarized above; therefore, for brevity, I have omitted each of the seven sections outlining the allegations pertaining to each of the seven individuals.

*JJ Text omitted for brevity and clarity.

[In summary, Respondent testified that he did everything required by the California standard of care, except "maybe" it was "inappropriate" of him to not more thoroughly document the details in the charts. Tr. 809.]

Dr. Munzing disagreed with Respondent and characterized the controlled substance prescriptions as being issued outside the standard of care. Tr. 163, 207, 241-44. For S.B.'s initial visit on August 3, 2016, she was diagnosed with GAD, ADD, and fibromyalgia. Tr. 16365; GX1 at 62, 66. However, there was no supporting findings or history for the fibromyalgia diagnosis, which typically is reached after a certain number of tender points are determined. Tr. 166. Similarly, there was no supporting findings or history to support the GAD or ADD diagnoses. Tr. 166-71, 241-44. There is no physical functioning level documented nor mental functioning level. Tr. 171. Without sufficient evaluation and supporting documentation for the three diagnoses, Dr. Munzing deemed the diagnoses inappropriate. Tr. 241-44. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44. The Respondent conceded that the detailed findings of the complete physical exam are not reflected in his chart, but noted he was a clinician with 41-years of experience, and not a medical student. Tr. 810.

In accordance with Dr. Munzing's credible and unrebutted expert testimony, the Respondent misperceives the purpose of these medical records. The documentation is necessary without regard to the skill level of the treating practitioner. It reminds the treating practitioner of the basis and ongoing treatment strategy. It also provides an accurate history of

symptoms, ongoing treatment and medication protocol for other practitioners who may treat the patient in the future.

Dr. Munzing highlights that there is no documented treatment plan for this patient. Tr. 24144. On February 2, 2017, S.B. presented to the clinic suffering from fibromyalgia and ADD. Tr. 173; GX 1 at 59. The Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed hydrocodone, carisoprodol, and Adderall. Tr. 173-74. Again, there was no medical history justifying the diagnoses. The physical exam conducted on February 2, 2017, consisted of blood pressure, cardiovascular, heart and lung, which were normal, which is insufficient to justify the fibromyalgia and ADD diagnosis. Tr. 175. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 175-76. For the progress note dated June 28, 2017, the Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed hydrocodone, carisoprodol, and Adderall. Tr. 177. Again, there was no medical history justifying the diagnoses. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 177-78; GX 1 at 57. Again, only blood pressure, heart, and lung exams were performed. Tr. 177. There was insufficient medical evidence to justify the three diagnoses. Tr. 177-78. For the progress note dated December 21, 2018, S.B. presented with eczema and fibromyalgia. Tr. 179; GX 1 at 49. The Respondent diagnosed her with Fibromyalgia-opioid dependent, refusing detox. She was prescribed hydrocodone. No history was recorded. Again, only blood pressure, heart, and lung

exams were performed. Tr. 180. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 180. There was insufficient medical evidence to justify the fibromyalgia diagnosis. Tr. 181. In the progress notes for January 30, 2019, S.B. reported to the clinic with ADD and rhinitis. Tr. 181; GX1 at 47. She was prescribed Adderall for the ADD. No medical history was taken. ADD patient progress was reported as "stable." There was insufficient medical evidence to justify the ADD diagnosis. Tr. 183. Dr. Munzing deemed the ADD diagnoses inappropriate. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescription. Tr. 185-86.

During the subject period of the Respondent's treatment of S.B., he never obtained any prior medical records. Tr. 184. He never recorded a history, which would justify his diagnoses for fibromyalgia, GAD or ADD. He never reported a sufficient physical or mental exam to justify the fibromyalgia, GAD or ADD diagnoses. He never reported a sufficient evaluation to justify his diagnoses for fibromyalgia, GAD or ADD. Tr. 184-85. The controlled substance prescriptions for S.B. were not issued within the California standard of care, nor were they issued within the usual course of professional practice. Tr. 187, 244.

Dr. Munzing observed that the diagnoses would come and go in the records and were inconsistently reported, which is atypical for chronic diagnoses. Tr. 188-97. A chronic disease with symptoms which appear to come and go would question whether the patient had the disease at all. Tr. 192. Even a lessening

of symptoms should cause evaluation of whether tapering of medication was appropriate. Tr. 196.

Dr. Munzing noted that the Respondent prescribed S.B. both hydrocodone and Soma to treat fibromyalgia on numerous occasions. Tr. 197-98. On other occasions he prescribed hydrocodone alone without any explanation for changing the medication protocol, which was beneath the California standard of care for documentation. Tr. 198-201; GX 20 at 61. Dr. Munzing noted that S.B. was on a dangerous, highly addictive, combination of medications that was popular for abuse, namely hydrocodone and Soma, which are respiratory depressants, combined with Adderall. Tr. 202. Another dangerous combination, hydrocodone, Adderall and Xanax, was prescribed on March 1, 2017, in April 2017, and June 2017. Tr. 203; GDX 1. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity." Tr. 204. It includes the depressants, hydrocodone and Soma, and is followed by the stimulant, Adderall, to counteract the effects of the depressants. Again, the combination of hydrocodone and Soma are the subject of the FDA "black box" warning. Tr. 205. The high dosage of Xanax, 6 mg per day, heightens the risk of this already dangerous combination. With Xanax and Adderall prescribed at their highest commercially available dosage units, the danger and risk of addiction are further increased. Tr. 205. Additionally, two mg tablets of Xanax are popular for abuse and diversion. Tr. 217-18. On September 29, 2017, and monthly from July 2018, to July, 2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a high daily dosage of 60 mg MME, which significantly

increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition for which this combination would be appropriate. Tr. 211-12.

The Respondent defended his keeping S.B. on this medication protocol, noting that if the Respondent objected to every patient's choice of treatment, there would be no medical care. If a patient says they are on medication and it permits them to function, the Respondent will continue that treatment. Tr. 729-30. Respondent, [based on his memory alone,] testified that S.B. indicated she had been through several alternate treatments, including, occupational therapy, physical therapy, hydrotherapy, yoga and meditation. Tr. 731, 805.

Respondent, [testifying from memory,] said S.B. further reported that she had been on the same dosage of medications for several years to good effect. Tr. 731-32. To reduce her from those dosages would have to be done gradually, lest the patient have withdrawal symptoms or suffer severe pain. Tr. 732. Prior to each prescription, the Respondent testified that he discussed side effects, and changes in status. Tr. 733. However, the record discloses that the patient was not always taking the medications as prescribed. There were a number of notations that the patient refused detox.

The Respondent misperceives his role as an independent practitioner. In accordance with Dr. Munzing's testimony, Respondent has a responsibility to independently determine the course of treatment, even in patients he inherits from other prescribers. Completely deferring to his patients' wishes in determining appropriate treatment is contrary to his role within the

California standard of care. He concedes titration would have to be done gradually. However, he kept this patient on high levels of dangerous medication, in dangerous combinations, for two years, without attempting titration. This [prescribing] is below the California standard of care. The Respondent's failure to obtain prior medical records and failure to document the patient's history, and to even order a single UDS, is consistent with this relinquishment of his responsibility to independently evaluate and to monitor the patient's condition and to develop an appropriate treatment plan.

The Respondent explained his process to obtain informed consent to prescribe controlled substances to S.B. The Respondent executed the "pain management contract," which is documented in the record. Tr. 728-29. The patient reads it and signs it. The Respondent testified that he then goes over the contract in detail with the patient. The Respondent testified that he then explains that the medications are meant to help the patient, not to cause side effects or addiction, although they tend to cause chemical dependence. Tr. 729. The Respondent testified that he then goes over all the alternative treatments, but in the end, it is the patient's decision as to the treatment he will receive. Tr. 729.

Dr. Munzing noted that the medical records failed to disclose any indication that the Respondent warned S.B. regarding the risks associated with these dangerous combinations of medications. This failure precludes any informed consent by S.B. Tr. 207. The Declaration of Pain Medication Use document in the file, dated August 3, 2016, which requires the patient to alert the Respondent if the patient takes additional

medications that could result in drug interactions, does not put the patient on notice of the dangerous combinations prescribed by the Respondent. Tr. 207-10; GX 1 at 67. Similarly, Dr. Munzing noted the repeated notation within the patient records of "SED," which Dr. Munzing assumed meant, "side effects discussed," was insufficient documentation within the standard of care to document discussion of the various risks of these medication combinations. Tr. 210-11; GX 1 at 59.

I agree with Dr. Munzing's assessment that, on the basis of the above lapses, the Respondent failed to obtain informed consent under the California standard. The Respondent's failure to document the details of his informed consent process itself renders his process below the California standard of care.

In March, April, and June of 2017, the Respondent prescribed S.B. Xanax at 6 mg per day, in excess of the FDA recommended daily limit of 4 mg per day. Tr. 212-15; GX 1 at 57, 58, 59; GX 22 at 40, 59-61. In May of 2017, the Xanax was abruptly stopped, Tr. 216-17; GDX 1, and abruptly restarted in June of 2017, and again stopped, Tr. 217. According to Dr. Munzing, this was very dangerous as the abrupt stoppage of Xanax, especially at this high dosage, can cause seizures, and restarting at this high dosage can trigger an overdose, especially in conjunction with the prescribed opioid. Tr. 212-18.

Regarding the monitoring of S.B., there were no urine drug screens evident in the records, which Dr. Munzing testified the standard of care would have required at least quarterly. Tr. 218-21; GX 1 at 44. In the progress notes for February, March, April 2017, all the way to January 30, 2019, the Respondent noted

"refusal to detox." Tr. 220-21, 227-29; GX 1 at 58, 59. According to Dr. Munzing, this is a huge red flag for opioid use disorder and for diversion. However, the chart suggests the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 222-23. The Respondent's course of action was outside the California standard of care. Tr. 223, 229.

In a June 2017 report from Dr. F., an orthopedic surgeon who saw S.B. for reported neck and back pain, S.B. reported her past medical history as only "anxiety." Tr. 229; GX 1, p. 30, 32, 36-42, 56. She did not report fibromyalgia, ADD or GAD. Tr. 229-30. S.B. further reported to Dr. F. that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription evidence. Tr. 231-32. Dr. F.'s report was part of S.B.'s disability application, claiming disability as of June 15, 2017. A report from Chiropractor, Dr. B.H. is included in the disability packet. Tr. 235. Dr. B.H. reports the disability was caused by "accident or trauma," which is inconsistent with what the patient reported to Dr. F. and to the Respondent. Tr. 236. There is no indication in the Respondent's records for S.B. that he ever discussed, with S.B. or with Dr. F., the discrepancies revealed by Dr. F.'s report. Tr. 233-37.

Contemporaneous to the preparation of the disability claim, Dr. Rabadi ordered a series of radiologic tests for S.B., none of which were related to the Respondent's diagnosis of fibromyalgia. The progress notes from August 17, 2017, state that S.B. presented with "overactive thyroid, gait disturbance." Tr. 237-40; GX 1 at 5, 7, 9, 11, 13, 16, 17, 56. Respondent ordered

an MRI of the brain to rule out MS, a thyroid ultrasound to rule out hyperthyroidism, an MRI of the lumbar spine, and an MRI of the thoracic spine. The MRI of the cervical spine was ordered by Dr. F. Tr. 241. In the context of S.B.'s disability claim, the Respondent ordered a series of tests in support of the disability claim, but neglected to order any tests related to the fibromyalgia, for which the Respondent was treating S.B. According to Dr. Munzing, this further calls the Respondent's [prescribing for fibromyalgia] into question.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient S.B. from at least February 2, 2017, through January 30, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

Discussion as to Patient M.B.

The Respondent testified that Patient M.B. presented on April 19, 2006, with severe back pain, left knee pain, and history of dyslipidemia. Tr. 782. The Respondent testified that he obtained a full medical history, medication history, pain level, and performed a complete head to toe physical exam. Tr. 783. The Respondent claimed that M.B. had chronic back pain related to an injury, a knee injury, which was manageable, and dyslipidemia. Tr. 784. Although the Respondent maintains he obtained a complete medical history as to the back pain, and chronic knee pain, he concedes it is not detailed in the chart. Tr. 820-23. M.B. was already on hydrocodone, previously prescribed,

when he first saw the Respondent. The Respondent testified that he obtained informed consent in the same manner as described for his earlier patients. Tr. 784. [Testifying from memory alone,] Respondent said he discussed alternative forms of treatment with M.B., however M.B. had exhausted those. Respondent testified that M.B. had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827. The Respondent conceded he did not document these therapies in the chart. Tr. 828.

Dr. Munzing observed that between January 5, 2018, and November 20, 2019, the Respondent prescribed hydrocodone and Adderall. Tr. 245. As with patient S.B., Dr. Munzing characterized the patient file as meager. Tr. 245-47. The Respondent never obtained prior medical records of M.B. Tr. 288. Dr. Munzing observed that none of the subject prescriptions were within the California standard of care. Tr. 248, 289. On April 19, 2006, M.B. presented for his first visit. Tr. 248-49; GX 3 at 88, 91. In his "Comprehensive History and Physical Examination," the Respondent reported that M.B. presented with symptoms of "chronic back pain, left knee pain, dyslipidemia." Tr. 249-50. However, there are no diagnoses relating to the back and knee pain. Tr. 250-51, 258. To address the reported pain, the Respondent prescribed hydrocodone. Tr. 252. The file fails to evidence sufficient history to justify the pain prescriptions under the standard of care. Tr. 252-54. The file fails to evidence any physical exam to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287. The file fails to evidence any treatment plan or goals, past drug abuse to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287. Although M.B.

declared on a "Declaration of Pain medication Use" form that he had no prior drug abuse in August 2009, which was three years after his first visit, such static declaration does not satisfy the physician's ongoing responsibility under the standard of care to monitor this issue. Tr. 259-61; GX 3 at 93.

On July 9, 2013, M.B. presented with ADD and neck pain. Tr. 261-62; GX 3 at 46. He was prescribed Adderall for the ADD. Tr. 262. Again, the records reveal there was no history taken to support the diagnosis or prescriptions for Adderall. Tr. 262. There was no evident evaluation done by the Respondent. Tr. 287. There was no treatment plan. Tr. 263. Although there was a written diagnosis related to the neck pain, there was no history or physical exam evident in the file to support it. Tr. 263-64. The Respondent never established a legitimate medical purpose for hydrocodone. Tr. 264. On September 6, 2013, M.B. presented with ADD. Tr. 264-65; GX 3 at 46. He was prescribed Adderall for the ADD, but at double the dosage of the previous visit, yet without any reported justification. Tr. 264-65. On January 5, 2018, M.B. presented to the clinic. Tr. 265-66; GX 3 at 37. He was prescribed hydrocodone and Adderall. There was no medical history, no discussion of M.B.'s response to treatment, evaluation of pain or functioning, substance abuse history, diagnoses, or rationale for establishing a legitimate medical purpose to justify continuing the medication regimen. Tr. 265-66. On March 6, 2018, M.B. presented to the clinic with "ADD and opioid dependency." Tr. 266-67; GX 3 at 36. Absent was any report of pain. He was diagnosed with "Opioid dependency, refusing detox." Tr. 267. Hydrocodone as treatment for opioid dependency is not a

legitimate medical purpose and is outside the usual course of professional practice. Tr. 267-68. Dr. Munzing observed that the Respondent prescribed hydrocodone repeatedly to address his diagnosis of opioid dependency until November 20, 2019. Tr. 268-69. On November 20, 2019, M.B. presented with ADD and back pain. Tr. 269; GX 3 at 27. He was prescribed Adderall and his hydrocodone was increased. Tr. 270. No medical history was taken or updated. No response to treatment or patient functionality was included. Although vital signs were taken, no physical exam was performed. Tr. 270-71. There was no appropriate diagnosis for the back pain. Tr. 272. There was no evaluation for ADD, such as mental functioning. Tr. 271, 274, 287-88. The Respondent never obtained a sufficient history to support the diagnosis for ADD. Tr. 273. There was no appropriate diagnosis for ADD. Tr. 272. The Respondent never established a legitimate medical purpose to prescribe either hydrocodone or Adderall to M.B. throughout the reported treatment. Tr. 274. Such prescriptions were not in the usual course of professional practice, were not for a legitimate medical purpose, and were outside the standard of care. Tr. 274-75.

Dr. Munzing noted the inconsistency of the various diagnoses. Diagnoses would come and go within the records. Tr. 275-278; GX 3 at 35, 37, 43, 67. Although the reported pain was always treated with hydrocodone, the source of the pain varied greatly without any explanation in the file, as required by the standard of care. Tr. 278-80.

Dr. Munzing noted the serious dangers occasioned by the combination of Adderall and hydrocodone, by reference to his testimony regarding S.B.'s similar

prescriptions.[27] Tr. 281. Dr. Munzing deemed this combination of medications for over ten years inappropriate and unsafe. Tr. 284. The only semblance of a warning to M.B. regarding these dangerous combinations appeared in a 2009 "Controlled Substance Therapy Agreement." For the same reasons voiced as to Patient S.B., Dr. Munzing deemed the signed form wholly insufficient to satisfy the California standard of care in this regard. Tr. 281-82; GX 3 at 92. Similarly, the notation within the file, "SED" was insufficient to satisfy the standard of care. Tr. 283. There was never a UDS ordered for M.B., which is necessary under the standard of care for any patient receiving opioids, but especially for a patient who has refused opioid detox. Tr. 284-85. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not addressed by the Respondent repeatedly as to M.B. Tr. 285-87; GX 3 at 36.

The Respondent defended his treatment of M.B. by noting that he monitored M.B. throughout his treatment. Tr. 785. The Respondent believed his prescribing was justified on the basis of M.B.'s medical conditions, level of chronic pain and present level of functioning, working in a welding factory, and in the movie business. Tr. 786, 832. The Respondent conceded that

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[27] On September 29, 2017, and monthly from July 2018, to July, 2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition in which this combination would be appropriate. Tr. 211-12.

he did not document M.B.'s degree of pain and he minimized the value of the subjective pain scale. Tr. 823-24. The Respondent conceded there were no imaging reports in M.B.'s chart, but explained that these patients were from the movie business. They were treated by an HMO, from which it is almost impossible to obtain records. Tr. 829.

[While it may be] true that the Respondent [did some] monitoring of M.B. during treatment, not all this monitoring found its way into M.B.'s chart. Alarming evidence revealed the Respondent was or should have been aware that M.B. was receiving Suboxone from Dr. B.S. during the period the Respondent was prescribing high levels of dangerous medications and in dangerous combinations. DI identified GX 25, which is a CURES Audit Report run on the DEA Registration of Dr. B.S., which included the patient M.B., a patient common to the Respondent. Tr. 904. Between October 10, 2018, and September 11, 2020, Dr. B.S. prescribed Suboxone[28] to M.B. Tr. 909; GX 24, 25, 25B. On March 15, 2019, the Respondent accessed CURES and would have observed M.B. was receiving Suboxone from Dr. B.S. Tr. 910; GX 24. Despite having evidence of the Suboxone prescriptions, the Respondent continued prescribing these dangerous medications, and like his other patients, without any UDS.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient M.B. from at least January 5, 2018, through November 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his pro-

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[28] Buprenorphine.

fessional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

Discussion as to Patient B.C.

The Respondent explained his treatment of Patient B.C. He has been a patient of the Respondent since March 27, 2014. Tr. 750-51. Patient B.C. has been prescribed hydrocodone, Xanax and Adderall. Tr. 749. The Respondent testified that he obtained a complete history, a complete physical exam and then probed the complaint which brought him to the Respondent, which was right shoulder and chronic back pain. Tr. 751. [Based on his memory alone, Respondent testified that] without medication, B.C. reported pain at seven or eight; and with medication, the pain was one or two. Tr. 752. As far as his medication history, [Respondent testified based on his memory that] B.C. had been on pain medication for years following a neurosurgical procedure to treat a herniated disc with radiculopathy.[29] Tr. 752.

To obtain informed consent, the Respondent testified that he verbally discussed the pain management contract, which B.C. read and signed. Tr. 752-53. The Respondent then discussed side effects of the medication. B.C. is a married man with three children. He works full time. He gave the Respondent no indication he was a risk of diversion. Tr. 753. Regarding prior alternate treatment, [Respondent testified from memory that] B.C. reported that he had tried surgery, physical therapy and acupuncture, but that only pain medication therapy alleviates his pain to the extent he can

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[29] [Repeated text omitted for brevity.]

function. Tr. 754. At each visit, the Respondent reviewed B.C.'s progress and believed B.C.'s condition warranted the medication he was prescribed. Tr. 754, 757. Although the Respondent testified that he remembered discussing B.C.'s pain levels on March 27, 2014, which was a one or two on medication, he conceded it was not documented in the chart. Tr. 832-34; GX 5 at 48. Although the Respondent testified that he remembered B.C. reporting he had a herniated disc, this report was not documented in the chart. Tr. 836. Neither were B.C.'s reported prior therapies documented. Tr. 837.

Dr. Munzing reviewed the subject prescriptions, patient file and CURES report for Patient B.C, which he described as lean. Tr. 290-92; GDX 3. He opined that the subject controlled substance prescriptions issued for hydrocodone, Xanax and Adderall, from January 25, 2017, to December 19, 2019, were all issued outside the California standard of care. Tr. 290-92, 335-38. B.C. presented on March 27, 2014, with GAD and back pain. Tr. 293-94; GX 5 at 48, 55. B.C. was diagnosed with GAD and back pain, refusing detox. He was prescribed Xanax (6 mg per day) for the GAD, and hydrocodone for the back pain, refusing detox. Tr. 294. Dr. Munzing reiterated the risks involved in prescribing 6 mg of Xanax per day. Tr. 295.

The records failed to include the minimum history necessary under the standard of care to appropriately diagnose back pain and GAD [or to prescribe controlled substances to treat those conditions.]. Tr. 295-96. Other than limited vital signs, the records failed to disclose the minimum physical examination necessary under the standard of care to appropriately diagnose back pain, or to justify a hydrocodone prescription. Tr. 296-97. Dr. Munzing could not remember seeing

any prior medical records in the Respondent's subject files. Tr. 297. There were no entries in B.C.'s file indicating physical or mental functioning. Tr. 298, 33538. There is no treatment plan indicated. The Declaration of Pain Medication Use, signed by B.C. at his first visit, as discussed *supra,* is insufficient to evaluate B.C., and to establish informed consent for the controlled substances prescribed. Tr. 299-300. There was insufficient medical evidence to support either diagnosis. Tr. 298, 335-38. So, there was no legitimate medical purpose for either controlled substance prescription. Tr. 299, 335-38.

B.C. presented on May 20, 2014, with ADD and was prescribed Adderall. Tr. 301-02; GX 5 at 47. The ADD diagnosis was deficient, as no history was developed, no mental functioning was assessed, the medical evidence was deficient, and a treatment plan was lacking. The Respondent failed to establish a legitimate medical purpose for the Adderall. Tr. 302. Additionally, starting B.C. on 30 mg of Adderall twice daily is a very high dosage, and extremely inappropriate for an Adderall naive patient, which is not justified within the patient file. Tr. 302-03. B.C. presented on January 25, 2017, with ADD, opioid dependency and GAD. Tr. 303; GX 5 at 33. He was diagnosed with ADD for which he was prescribed Adderall, and GAD for which he was prescribed Xanax (6 mg per day). Tr. 304. Pain levels were not recorded at this visit. The diagnoses were unsupported by sufficient, medical history, medical evaluation, response to treatment, patient functionality, and medical evidence. Tr. 304-06. He failed to establish a legitimate medical purpose for both Adderall and Xanax. Tr. 306, 335-38. The Respondent further diagnosed, "Opioid dependency,

refusing detox" for which the Respondent again prescribed hydrocodone. Tr. 306. Prescribing hydrocodone for opioid dependence is not only outside the standard of care, but it is illegal in California according to Dr. Munzing. Tr. 307. Hydrocodone is not a legitimate medical treatment for opioid dependency and thus the prescription was outside the usual course of professional practice. Tr. 307. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was repeatedly left unaddressed by the Respondent as to B.C. Tr. 306-07; GX 5 at 33.

On July 31, 2018, B.C. presented with ADD, back pain and GAD. Tr. 308; GX 5 at 28. He was diagnosed with ADD for which he was prescribed Adderall (60 mg per day), "back pain, opiate dependent, refusing detox" for which he was prescribed hydrocodone, and GAD for which he was prescribed Xanax (6 mg per day). Tr. 308. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment and no indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 308-09, 335-38. There was no reference to pain levels or physical functionality. Tr. 309-10. There was no reference to mental functioning with respect to the ADD and GAD diagnoses. There was no appropriate or documented support for the three diagnoses. Tr. 309-10.

Neither did he establish a legitimate medical purpose for the three controlled substance prescriptions. Tr. 311. B.C. presented on December 19, 2019, with ADD and back pain, which were also his diagnoses, and for which he was prescribed Adderall (60 mg per day) and hydrocodone. Tr. 311-12; GX 5 at 20. The

record is absent medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. Tr. 312-13, 335-38. As a result, the three diagnoses are without sufficient medical evidence. Tr. 313. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are beneath the standard of care. Tr. 313-16, 335-38.

Dr. Munzing noted the inconsistency of diagnoses throughout B.C.'s records and the dual prescribing of hydrocodone for opioid abuse and for skeletal pain, without explanation in the record. Tr. 316-19; GX 5, p. 31, 32, 33. Dr. Munzing noted the GAD and ADD diagnoses appear and disappear within the record, as did their treatment medications. Tr. 319-24; GX 5 at 27, 31, 32, 33. Dr. Munzing deemed it highly unlikely that ADD and GAD were appropriate diagnoses. Tr. 322, 324. The Respondent prescribed B.C. a combination of hydrocodone, Adderall and Xanax. Tr. 327; GDX 3. Dr. Munzing could not conceive of a medical condition warranting this dosage, duration, and combination of medications, noting that Adderall is counter-indicated for GAD and that combining Xanax with an opioid represents a dangerous combination addressed in a FDA black box warning and CDC guidance. Tr. 327-29, 332-33; GDX 3. A further concern, as detailed earlier in his testimony, is reflected by the repeated combination of hydrocodone and Adderall prescribed by the Respondent. Tr. 329-30; GDX 3. These dangerous combinations were prescribed without an established legitimate medical

purpose, outside the usual course of professional practice, without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 330-35.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient B.C. from at least January 25, 2017, through December 19, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

Discussion as to Patient J.C.

The Respondent discussed his treatment of Patient J.C. He presented on May 18, 2009, with chronic back pain, ulcerative colitis, and GAD. Tr. 759-60, 761-62. [Respondent testified from memory that J.C.] was prescribed hydrocodone and Xanax, which was sometimes substituted with Valium. Tr. 759. The Government prompted the Respondent to visits in which several other controlled substances were also prescribed. Tr. 842-46; GX 7 at 181, 214, 215.

The Respondent explained that J.C. had suffered multiple injuries and had been immobile for some time. However, the Respondent did not document the injuries nor the immobility in the chart, nor did the file contain any prior medical records.[30] Tr. 839, 842; GX 7 at 216. [Respondent, testifying from memory,] stated that J.C. had undergone physical therapy, occupational therapy, and finally pain management,

[30] The Respondent again explained the difficulty in obtaining prior medical records. Tr. 842.

which permitted him to resume working full-time. These alternate treatments, therapies, and prior surgeries were not documented within the chart. Tr. 840. The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit. Tr. 840. The Respondent testified that he performed a full exam on J.C. Tr. 760-61. His GAD resulted from his ulcerative colitis. Tr. 762. The Respondent testified that he obtained informed consent to prescribe controlled substances by explaining the pain contract, and afterwards, J.C. read it and signed it. Tr. 763. The Respondent testified that he verbally explained the dangers of overdose to J.C. Tr. 764. The Respondent had no concerns over J.C. diverting his medication. Tr. 764-65. On the basis of J.C.'s considerable injuries and condition, the Respondent felt J.C.'s medication protocol was fully justified. Tr. 765. Although the Respondent remembered J.C. reporting that he had seen two previous doctors, including a pain physician, that report was not reflected in the chart. Tr. 841-42. Although the Respondent remembered performing a complete mental health evaluation on J.C., it is not documented in the chart. Tr. 842. The Respondent denied ever intentionally misspelling J.C.'s first name.*KK Tr. 765-66.

Dr. Munzing reviewed the subject prescriptions issued from January 16, 2018, to December 30, 2019, patient records and CURES data relating to Patient J.C. Tr. 381-82; GDX 4. Dr. Munzing opined that none of the subject prescriptions issued to J.C. were within the California standard of care. Tr. 381-82; GDX 4. J.C. presented to the Respondent's clinic on May 18,

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*KK *See supra*, n.*V.

2009, with a headache and GAD. Tr. 383-384; GX 7, at 216, 233. He was prescribed hydrocodone for migraines and Xanax for GAD, and he remained on this medication regimen for a long period. As to the migraines, insufficient medical history was obtained, symptom evaluation was absent, no neurological exam was conducted, no evaluation of functioning level, no treatment plan evident, and no evaluation of possible drug abuse. Tr. 384-90. In short, there was insufficient medical evidence to support the diagnosis of migraines and GAD, nor was there a legitimate medical purpose to prescribe hydrocodone and Xanax. TR. 386-88.

[On August 17, 2009, J.C. signed a "Declaration of Pain Medication Use" form indicating that he had no prior drug abuse, and Dr. Munzing testified that there is no record of J.C. ever being asked about illicit substance abuse again. Tr. 389-90. Dr. Munzing testified that the 2009 Declaration was an insufficient inquiry to cover prescribing occurring in 2018. *Id.*]

J.C. presented on July 21, 2016, with "GAD, chronic back pain, consented for H&P." Tr. 390; GX 7, p. 189. He was diagnosed with GAD, "back pain—refusing detox" for which he was prescribed Xanax and hydrocodone, respectively. Tr. 390-91. There was no updated history taken for either diagnosis, no physical exam, no treatment plan, no response to treatment, no pain or functioning level evaluations, no discussion regarding drug abuse, and no rationale for continued treatment, as was required by the standard of care. Tr. 390-94. According there was insufficient medical evidence to support either diagnosis. The Respondent did not establish a legitimate medical purpose to prescribe the controlled substances. Tr. 393-94. J.C. presented on January 16, 2018, with GAD and

back pain for which he was diagnosed with GAD and back pain, opiate dependent, refused detox. Tr. 394-95; GX 7 at 180. He was prescribed Valium for the GAD to replace Klonopin, and hydrocodone for back pain, although no explanation was giving for substituting the Valium for the Klonopin. Tr. 395. There was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no drug abuse history, rendering each diagnosis inappropriate. Tr. 395-97. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 396-98. J.C. presented on February 16, 2018, with "opioid dependency, GAD," yet without the previously noted back pain. Tr. 198; GX 7, 9. There is no reference to pain. He was diagnosed with "Opioid dependency, refusing detox" for which he was prescribed hydrocodone, which again, is outside the standard of care and usual course of professional practice, and illegal in California. Tr. 398-400. The diagnosis for opioid dependency being treated with hydrocodone appeared repeatedly in the records. Tr. 399. J.C. presented on May 6, 2019, however no treatment notes for this visit are evident in the file. Tr. 401; GDX 4, GX 7 at 168.

On April 9, 2019, J.C. presented with GERD, and back pain for which he was prescribed hydrocodone. Tr. 402. However, there was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no mental health history, no drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 402-04. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled

substances. Tr. 402-04. On December 30, 2019, J.C. presented with GERD and GAD. Tr. 404; GX 7 at 171. He was prescribed Valium for the GAD. However, there was no appropriate medical history included in the records, no response to treatment, no evaluation for GAD, or functioning evaluation, no mental health history, no drug abuse history, rendering the GAD diagnosis inappropriate from January 16, 2018, to December 30, 2019. Tr. 404-08, 425-28. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 408, 425-28. Such prescriptions, from January 16, 2018, to December 30, 2019, were outside the standard of care, without legitimate medical purpose, and outside the usual course of professional practice. Tr. 408, 425-28.

Dr. Munzing noted the inconsistency of diagnoses throughout J.C.'s records, and the dual prescribing of hydrocodone for opioid abuse, migraines and for skeletal pain, without explanation in the record. Tr. 410-14; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the skeletal pain diagnosis appears and disappears within the record. Tr. 414-15. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 415; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the Respondent had prescribed the combination of hydrocodone and Valium monthly between January 2018, and January 2019, without a legitimate medical purpose. Tr. 416-17; GX 4. Combining Valium with an opioid represents a dangerous combination and is contrary to a FDA black box warning and to CDC guidance, especially with the Valium at its highest available strength. Tr. 417. Dr. Munzing could not envision a condition in which this medication regimen would

be appropriate. Tr. 418. These dangerous combinations were prescribed without an established legitimate medical purpose, outside the usual course of professional practice, without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 418-23; GX 7 at 19, 25, 27, 180, 225.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient J.C. from at least January 16, 2018, through December 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a).]

Discussion as to Patient D.D.

The Respondent explained his treatment of Patient D.D. He first presented on July 9, 2008, with GAD and severe back pain, although the source of the back injury was not documented. Tr. 767-68, 850; GX 9 at 74. Over the course of treatment, the Respondent prescribed hydrocodone, Xanax, and Soma. Tr. 850. The Respondent added that he probably prescribed Valium, as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent remembered D.D. was prescribed Valium, hydrocodone, and Soma at the first visit. Tr. 851-52. The Respondent believes his treatment was within the standard of care in California. The Respondent testified that he took a complete medical history, family history, personal history and medication history. Tr. 768. The family history was not documented in the chart. Tr. 848. The Respondent explained that the family history was not documented

because it was non-contributory to his assessment. Tr. 848. [Based on Respondent's memory, he testified that] there were no heart conditions in his family, etc. Tr. 849. The Respondent did document that D.D. was married, which he deemed contributory. Tr. 849. Respondent testified that D.D. had a dirt bike accident, which shattered his shoulder and fractured several ribs, although the accident as the source of the injury was not documented. Tr. 850. [Based on his memory, Respondent testified that] D.D. underwent prior physical therapy and occupational therapy after treatment by an orthopedic surgeon, although it was not documented within the chart. Tr. 769, 771, 850-51. [Again from memory, Respondent testified that] it was several years before D.D. reached the medication regimen he was on when he first reported to the Respondent. The Respondent testified that he performed a full physical exam. He testified that he established informed consent with the pain contract and discussion of side effects and overdose, as with all his patients. Tr. 770. He verbally cautioned D.D. regarding diversion and other red flags. Again, Respondent testified that D.D. gave no indication of diversion. Tr. 771.

Dr. Munzing reviewed the subject prescriptions issued from January 4, 2018, to February 12, 2019, patient records and CURES data relating to Patient D.D. Tr. 428-29; GDX 5. Dr. Munzing opined that none of the subject prescriptions issued to D.D., which were for hydrocodone, Soma, and Xanax, were within the California standard of care. Tr. 430. Again, the records were very lean. D.D. presented on July 9, 2008, with GAD and back pain. Tr. 430-31 GX 9 at 74. For the GAD, he was prescribed Valium, and for back pain, hydrocodone and Soma. Tr. 431. The medical

records reflect that D.D. refused an MRI and referral to an orthopedist or pain specialist. Tr. 431. Each refusal was a red flag and was suggestive of drug-seeking behavior. Tr. 432. Instead of addressing the red flags, the Respondent prescribed opioids. Tr. 432. The Respondent's response was the same throughout the subject treatment of D.D., a total of nine and a half years. Tr. 433.

There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, or functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, and no patient monitoring, which rendered the GAD and back pain diagnoses inappropriate from July 9, 2008, to January 4, 2019. Tr. 433-38; GX 9 at 37, 39, 41, 43, 44. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 434-48. Such prescriptions, from July 9, 2008, to January 4, 2019, were beneath the standard of care, without a legitimate medical purpose, and outside the usual course of professional practice. Tr. 434-48. [On January 11, 2019, D.D. was diagnosed with GERD and back pain—opiate dependent refusing detox. Tr. 439. This is the last time Respondent prescribed D.D. both hydrocodone and Soma, but the medical records again reflected a lack of appropriate medical history, response to treatment, an appropriate physical examination, assessment of pain or physical functionality, an appropriate diagnosis, or an established legitimate medical purpose for the prescriptions. Tr. 439-40. On February 12, 2019, Respondent prescribed D.D. hydrocodone to treat opioid dependency—

refusing detox without there being any mention of pain, and Dr. Munzing testified that this was problematic for all of the reasons he had previously testified to. Tr. 441-42. Dr. Munzing testified that at no point during the treatment period did Respondent ever obtain a sufficient history to establish a diagnosis for back pain or support prescribing of hydrocodone, and that the prescriptions for hydrocodone and Soma were not issued within the usual course of professional practice and were beneath the standard of care. Tr. 443-44.]

Dr. Munzing noted a period of over a year, from May 10, 2017, to September 19, 2018, when no diagnosis for GAD appeared in D.D.'s records and the 30 mg daily dose of Valium was stopped. Tr. 447-48. Then on September 19, 2018, the Respondent prescribed 6 mg of Xanax, a very high dosage, especially for the beginning dosage. [Dr. Munzing testified that Respondent failed to obtain sufficient medical evidence upon which to base a GAD diagnosis. Tr. 446.] Compounding this dangerous dosage, D.D. was prescribed hydrocodone in combination, which heightened the risk of overdose [without any documented warning from Respondent regarding the dangers of the controlled substances being prescribed.] Tr. 446, 448-50, 458. [Dr. Munzing testified that there was no established legitimate medical purpose for prescribing Xanax to D.D. Tr. 446.]

Dr. Munzing noted the inconsistency of diagnoses throughout D.D.'s records, and the dual prescribing of hydrocodone and Soma for Fibromyalgia, opioid abuse, migraines, and for skeletal pain, without explanation in the record. Tr. 450-56; GX 9, p. 43, 51, 64, 70, GDX 5. Dr. Munzing noted the skeletal pain diagnosis

appears and disappears within the record. Tr. 450-56. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 456; GX 9 at 43, 51, 64, 70. Prescribing Soma with hydrocodone presents considerable risks to the patient. Each are respiratory depressants, which present a significant risk of overdose [and addiction.] Tr. 458. [Dr. Munzing also reiterated the risks of prescribing both hydrocodone and Xanax together. Tr. 458. Dr. Munzing testified that in 2009, D.D. signed "the same controlled substance therapy agreement we've seen with the previous four patients," and it was insufficient notice of the risks of using controlled substances for the reasons already discussed. Tr. 458-59. Dr. Munzing further testified that the record is lacking any documentation that Respondent adequately warned D.D. of the risks of the controlled substances he was taking, particularly in light of the various combinations and high dosages. Tr. 459-60.]

D.D. presented on March 23, 2019, with opioid dependency, refusing detox. He was again prescribed hydrocodone and Soma. Tr. 463; GX 9 at 42, 43. The Respondent failed to address this red flag repeatedly, and instead inappropriately prescribed Soma and hydrocodone. Tr. 465.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient D.D. from at least January 4, 2018, through February 12, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

Discussion as to Patient J.M.

The Respondent explained his treatment of J.M. He has been a patient for 13 years. Tr. 734. The Respondent has prescribed him Xanax, Soma, and hydrocodone. The Respondent believed his treatment of J.M. was within the California standard of care. J.M. first presented on May 14, 2007, with chronic pain syndrome, which sometimes manifests as back pain, and neck pain, and GAD. Tr. 735; GX 11 at 104. The Respondent testified that he took a history. [Testifying based on his memory, Respondent said] J.M. had been involved in a motor vehicle accident injuring his back, neck and lumbar spine. The motor vehicle accident as the source of the injury was not documented. Additionally, he suffered from GAD and hypertension. Tr. 736. Tr. 853. Respondent testified that J.M. had seen an orthopedic surgeon, although it was not documented in the chart. Tr. 853. [Testifying based on memory, Respondent said that without medication, J.M. reported severe pain of 10 or 11 out of 10. With medication, he reported three of ten, permitting him to function and to work full time, although the pain levels were not documented in the chart. Tr. 736, 854-55. J.M. reported prior treatments and medication. Based on his memory, Respondent testified] J.M. had received physical therapy, occupational therapy, hypnosis, and acupuncture to no avail prior to turning to chronic pain management, although these previous therapies were not documented in the chart. Tr. 737, 854. His present medication protocol delivered the best results with the least side effects he had. Tr. 737. The Respondent testified that he probed J.M.'s psychological history, which included an all-consuming fear.

The Respondent testified that he performed a comprehensive physical exam. Tr. 739. To obtain informed consent to prescribe J.M. controlled substances, the Respondent said he went over the pain management contract, which J.M. also read and signed. The Respondent testified that he verbally cautioned J.M. about diversion and the red flags of doctor shopping and pharmacy hopping, which would result in discharge. Tr. 739-40.[31] The Respondent then testified that he discussed the beneficial aspects of the pain medication and potential negative effects if abused. According to Respondent, J.M. never gave any indication he represented a risk of diversion. Tr. 741. Prior to seeing the Respondent, Respondent testified that J.M. was on a higher MME of opioids. He was able to reduce the dosages to the level he was on when he first saw the Respondent. He remains on that dosage. Again, he is able to function and work full-time on this dosage. Tr. 742. The Respondent noted that J.M. would sometimes try to avoid taking his medication, even if he suffered pain, as explanation for the breaks in prescribing. Tr. 743.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 10, 2017, to December 31, 2019, patient records and CURES data relating to Patient J.M. Tr. 469-70; GDX 6. [Again Dr. Munzing testified there was "very little information" in the medical records. Tr. 470.] Dr. Munzing opined that none of the subject prescriptions issued to J.M. were within the California standard of care. Tr. 470-71.

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[31] [This footnote and the preceding text are omitted for brevity and relevance.]

On May 13, 2007, J.M. presented with hypertension, back pain, GAD, dyslipidemia and insomnia. Tr. 470-72; GX 7 at 104, 111. He was diagnosed with hypertension, back pain, GAD, dyslipidemia and insomnia. He was prescribed hydrocodone for back pain and Xanax (6 mg per day) for GAD. Tr. 472. Xanax and hydrocodone were recurring prescriptions. As discussed earlier, the high dosage of Xanax was a concern, as well as its combination with an opioid. Tr. 473.

There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, no treatment plan, no pain or functioning evaluation, no mental health history, no ongoing drug abuse history or monitoring, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from May 13, 2007, to January 13, 2017. Tr. 473-76, 478, 481-83, 485-500. Per Dr. Munzing, the MRI of May 30, 2007, and its mild findings, did not independently satisfy the Respondent's related obligations or justify the subject prescriptions. Tr. 479-80, 485-87; GX 11 at 14, 16, 17, 22, 26, 31, 37, 41, 42, 115. [Dr. Munzing testified that for the five visits between January 10, 2017, through March 27, 2017, there is so little documentation that Dr. Munzing cannot tell whether the records reflect "actual visits" or just "documentation of a refill of the medication," because there are no examination or history notations, no documentation of the dose or strength prescribed, no diagnoses, nothing to meet the standard of care for prescribing hydrocodone and Xanax for that period. Tr. 482-85. The first prescription for Soma during the

relevant time period was on April 13, 2017, and according to Dr. Munzing, the medical note said "Xanax number 90, Soma number 50SED, and then a signature" with absolutely nothing else recorded and none of the elements of the standard of care met. Tr. 485-86. Dr. Munzing testified specifically about selected office visits. On April 25, 2018, Respondent's records for J.M. contain information suggesting an office visit occurred, but they continue to have the same deficiencies. That day, J.M. was not diagnosed with pain, but with GAD and opioid dependence—refusing detox which was treated with hydrocodone. Tr. 487. Dr. Munzing reiterated his concerns that hydrocodone was not appropriate treatment for opioid dependence and was inappropriate each time it was prescribed for that purpose. Tr. 488. Dr. Munzing testified about the November 19, 2018 visit where J.M. was prescribed Xanax for GAD and Soma for back pain; the February 20, 2019 visit where he was prescribed Xanax for GAD and hydrocodone for back pain; and the December 31, 2019 visit where he was prescribed Xanax for GAD and was not diagnosed with back pain. Tr. 489, 492-93, 495. Dr. Munzing again testified, amongst other things, that for each of these visits there was an insufficient medical history or physical examination to make the diagnoses, there is no information regarding the response to treatment, pain level, or functionality, and there was no legitimate medical purpose established for the prescriptions at issue. Tr. 489-91, 493-97.] Without a legitimate medical purpose, there was no appropriate rationale for the controlled substance prescriptions, or to continue treatment with controlled substances. Tr. 473-76, 478, 485-500, 505; GDX 7.

There were also red flags left unaddressed by the Respondent. J.M. refused to see a pain specialist, which gives rise to the suspicion that he is not concerned about getting better, but just getting medicated. Tr. 476-77. [Omitted for relevance.] Dr. Munzing noted that there were gaps in the hydrocodone and Soma prescriptions without any required explanation for changes to the medication regimen. Tr. 500-04; GX 11 at 36, 37, 40, 41, 42, 76. He observed that the hydrocodone was prescribed either for back pain or for opioid dependence. Tr. 504. However, the required evaluation for the diagnoses coming and going and explanation for treatment is lacking. This further diminishes any medical legitimacy for the hydrocodone. Tr. 504.

Additionally, the Respondent prescribed a very addictive and dangerous combination of medications, an opioid and a benzodiazepine. Tr. 558-60. Even more concerning, he added a muscle relaxant to this already dangerous combination to form the "Holy Trinity," a favorite drug combination for abuse by the drug-abusing community. Tr. 505-10. Dr. Munzing could not conceive of a medical condition in which the trinity combination would represent appropriate treatment. Tr. 512. This trinity of medications was prescribed to J.M. repeatedly. GDX 6. The file fails to reveal that appropriate warnings were given to J.M. in connection with these dangerous combinations. Tr. 511; GX 11 at 113. The CURES report reveals 40 Xanax prescriptions (3600 dosage units and 7200 mgs) were issued to J.M. between January 2017, and November 2018, a period of 22 months, which averages 10.5 mgs per day. Tr. 512-17; GX 7, 17, 18. This averaged a prescription every 16 days. Tr. 527-28. Ten and a half mgs per day

is considerably greater than the maximum 4 mg per day recommended for treatment of anxiety.

DI identified GX 26, an additional CURES Audit Report, one for Dr. B.S.2, which spanned from January 2017, to September 2020, and which shared a common patient with the Respondent, J.M. Tr. 911-13; GX 26, 26B. Dr. B.S.2 prescribed Suboxone to J.M. from January 2017, to August 2020. Tr. 913. The CURES Audit of the Respondent demonstrated that Respondent accessed the CURES database during the period J.M. was prescribed Suboxone by Dr. B.S.2, which would have been evident by this review. Tr. 914. The Respondent testified he cautioned J.M. regarding diversion and other red flags and J.M. gave no indication of diversion. Tr. 771. But the CURES report belies the Respondent's assurances. The Respondent was or should have been aware J.M. was obtaining Suboxone from Dr. B.S.2, yet the Respondent did not mention that critical fact in J.M.'s chart. [Dr. Munzing testified that he had "great concerns with continuing to prescribe hydrocodone despite the fact that he's on Suboxone and had been identified . . . as [having] opiate use disorder." Tr. 948.] Yet, the Respondent continued prescribing controlled substances to J.M. This action likely exceeds the bounds of benign neglect and crosses into the realm of intentional diversion. [Either way, I find that Respondent's prescribing was outside the usual course of professional practice and beneath the standard of care.]

The Respondent denied ever using a different first name for J.M. or using a different birth date for him [and attributed any mistake to the pharmacy.] Tr. 778-82. However, the CURES report lists two different dates of birth for J.M., as well as two

different spellings of his first name. Tr. 517-18, 547-49; GX 18. A CURES search would be name and date of birth specific. So that a search by one name and date of birth would not reveal prescriptions filed under the alternate name and date of birth. Tr. 526. The main sources of the CURES report information are two pharmacies, Reliable Rexall and Northridge Pharmacy. Tr. 51819. Despite the fact that J.M. was using different names and dates of birth at different pharmacies, a considerable red flag suggesting abuse or diversion, the Respondent did not address these issues. Tr. 519-20, 525-26. Even if J.M. or the pharmacies were the source of the alternate dates of birth and alternate first names, with due diligence, the Respondent would have discovered that a search by a single name and date of birth would only include half of the Xanax prescriptions the Respondent issued to J.M. Tr. 521-26, 54950. Additionally, a review of two prescriptions, one written by the Respondent and one called in by the Respondent on the same day contain two different dates of birth. Tr. 533-34.

Of further suspicion, the CURES report reveals J.M. is alternating the filling of the Xanax prescriptions between the two pharmacies, apparently trying to hide the bi-monthly frequency of the prescriptions. Tr. 520; GX 17, 18. Dr. Munzing noted this was a suspicious prescribing practice by the Respondent. Tr. 530; GX 17, #s 425 & 575.[32] He would issue two prescriptions on the same day to J.M., one for hydrocodone and one for Xanax. He would issue a written prescription for hydrocodone, which J.M. would invariably fill at Northridge Pharmacy, but call in to Reli-

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[32] These are prescription numbers.

able Pharmacy the prescription for Xanax. Tr. 531-33, 535-45, 550-58; GX 11 at 32, 33, 35, 36, 38, 40, 41, GX 12 at 5, 6, 10, 11, 14, 22, 24, 27, 33, 34; GX 13, at 20, 25, 27, 32, 34; GX 17, 18 #s 473, 474, 994, 1120, 1228, 1386, 1472, 1553, 2102, 2229, 2341, 2342. In accordance with Dr. Munzing's testimony, this appears to be an attempt by J.M. to avoid the suspicion generated by the opioid/benzodiazepine combination if filled at a single pharmacy. Tr. 532-33, 557-60. There was an additional suspicious circumstance related to a Xanax prescription. The Respondent wrote in his medical notes that the medication should be taken once every eight hours, while the call-in information to the pharmacy was once every six hours. Tr. 543-45, 554, 556-57.

In light of the fact that Respondent knew or should have known about the Suboxone prescriptions by Dr. B.S.2 and this prescribing strategy, which was unaddressed or unexplained by the Respondent in his testimony, and on the basis of this record, drawing all rational inferences warranted by the evidence, it is more believable than not that the Respondent was involved in J.M.'s sophisticated attempt to avoid detection by the pharmacies.[*LL]

[*LL] While I do not disagree with the ALJ's analysis here, it is unnecessary and immaterial to my decision. There is plenty of evidence supporting revocation on the grounds that Respondent's prescribing was outside the usual course of professional practice and beneath the standard of care in California, and Respondent has failed to take any responsibility for his actions. Thus, while I have left the ALJ's discussions and findings that Respondent assisted J.M. in a diversion scheme intact throughout this decision, I have ultimately not based my decision on those findings. *See also supra* n. *DD.

The red flag of refusing to detox was repeatedly evident within J.M.'s patient file. Tr. 562; GX 11 at 37. He was diagnosed with "Opioid dependency, refusing detox" for which he was prescribed hydrocodone, which again, is beneath the standard of care, outside the usual course of professional practice, and illegal in California. Tr. 563-64. The diagnosis for opioid dependency being treated with hydrocodone appeared repeatedly in the records. The Respondent never addressed this red flag. Tr. 564.

A review of the entirety of J.M.'s file and related records revealed there was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, or pain level/functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, no patient monitoring, no resolution of the multiple red flags noted, rendering the GAD and back pain diagnoses inappropriate from January 10, 2017, to December 31, 2019, and beneath the California standard of care. Each was without a legitimate medical purpose and outside the usual course of professional practice. Tr. 565-68.

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient J.M. from at least January 10, 2017, through December 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

Discussion as to Patient K.S.

The Respondent explained Patient K.S.'s treatment. K.S. presented on June 21, 2007, with chronic back pain. He was later diagnosed with ADD. He was prescribed hydrocodone, Soma, and sometimes Adderall. Tr. 788-89, 861; GX 14 at 110. The Respondent added that he may have also prescribed Xanax, but it is difficult to be sure with hundreds of patients and treatment dating back 15 years. Tr. 859. He testified that even with a "good memory, sometimes [the Respondent] just miss[es] something." Tr. 859. Additionally, he noted that patients do not always disclose all of their medications at the initial visit if they have plenty and do not then need them to be refilled. So, he is not always aware of all of their medications at the initial visit. Tr. 860-62.

The Respondent believed his prescribing was within the standard of care for California. The Respondent testified that he obtained a full medical history, medication history, pain level, and performed a complete head to toe physical exam. Tr. 789. [Based on memory alone,] the Respondent testified that he discovered K.S. had chronic back pain related to a bike accident for which he had been treated by several doctors for several years, although the bike accident as the source of the injury and treatment by other doctors was not documented. Tr. 856-57, 859. Additionally, there were no records from prior treatment in the patient's records. Tr. 857. Although the Respondent explained that he requested the prior medical records, none were provided. The Respondent explained that his request for records is simply faxed to the previous physician's office. Tr. 857-58. Respondent speculated that the absence of a documented request for records

in K.S.'s file was probably due to a staffer forgetting to file it. Tr. 858. The Respondent did not contest the Government's observation that no requests for previous medical records were in any of the seven patient files. Tr. 859. According to Respondent, K.S. was already on hydrocodone when K.S. first saw the Respondent. The Respondent testified that he obtained informed consent in the same manner as described for his earlier patients. Tr. 790. He discussed alternative forms of treatment with K.S., and [based on his memory] K.S. was obtaining physical therapy prior to seeing the Respondent. K.S. continued physical therapy after beginning treatment with the Respondent. Tr. 791. The Respondent testified that he monitored K.S. throughout his treatment. Tr. 791. Respondent believed that K.S. presented no indications of diversion. The Respondent has treated K.S. for thirteen years, during which time K.S. got married and had three children. Tr. 790-91.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 19, 2018, to January 31, 2019, patient records, and CURES data relating to Patient K.S. Tr. 46970; GDX 8. [Again Dr. Munzing testified there was "very little" information in the medical records. Tr. 569.] Dr. Munzing opined that none of the relevant prescriptions issued to K.S. were within the California standard of care. Tr. 568-70. K.S. presented on June 21, 2007, with "back pain" for which he was prescribed hydrocodone and Soma. Tr. 570; GX 13 at 117. Although the Respondent noted he would get an MRI for the lumbar spine, no such MRI appears in the records. Tr. 271. There was also no medical history included in this record regarding back pain, no treatment plan, no response to treatment, no

physical exam, no pain or functioning evaluation, no ongoing drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 570. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances for back pain. Tr. 571-76.

[On August 5, 2009, K.S. signed a "Declaration of Pain Medication Use" form indicating that he had no prior drug abuse, and Dr. Munzing testified that there is no record of K.S. ever being asked about illicit substance abuse again. Tr. 575. Dr. Munzing testified that the 2009 Declaration was an insufficient inquiry to cover prescribing occurring at any point in time when Respondent was treating K.S. Tr. 576.]

On May 1, 2012, K.S. presented with GAD and neck pain. Tr. 576; GX 14 at 80. He was diagnosed with GAD and neck pain, and prescribed Xanax for GAD and hydrocodone for the neck pain, refusing detox. Tr. 577. K.S. was prescribed the combination of hydrocodone and Xanax frequently throughout his treatment. This combination of an opioid and a benzodiazepine is dangerous, beneath the standard of care and represents a red flag that went unresolved by the Respondent throughout the records. Tr. 578-79. There was no medical history supporting the prescriptions. There was no indication of how the patient was responding to treatment. There was no treatment plan, and no indication that a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 579-81. There was no reference to pain levels or physical functionality. There was no reference to mental functioning with respect to the GAD diagnosis. There was no appropriate diagnosis for the GAD and neck pain. Neither did he establish a legiti-

mate medical purpose for the controlled substance prescriptions. Tr. 580-81.

K.S. presented on November 18, 2013, and was prescribed Adderall (60 mg per day) with no documented evaluation for or diagnosis of any condition which Adderall may treat. Tr. 581-82; GX 14 at 70. There is also no medical history, physical exam, or treatment plan, and accordingly, the subject prescription is without a legitimate medical purpose.*MM Tr. 582.

On January 19, 2018, K.S. presented with GAD, back pain, and ADD. Tr. 583, 599; GX 14 at 41. For GAD, the Respondent prescribed Xanax. For back pain—opioid dependent, refusing detox, the Respondent prescribed hydrocodone, and for ADD, Adderall was prescribed. Tr. 584. The record is missing a medical history, any updated medical history, an explanation of why back pain has returned, the patient's state of health, how he's responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 584-86. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are beneath the standard of care. Tr. 586.

On February 27, 2018, K.S. presented with ADD, opioid dependency, and GAD. Tr. 586-87, 599-600; GX 14 at 39, 40. He was diagnosed with ADD, opioid dependency-refusing detox, and GAD. Back pain was not reported, nor was any report of pain made. At the

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*MM This sentence was modified for clarity

April 30, 2018 visit, again, back pain was not reported, nor was any report of pain made. Tr. 601. Throughout the records, the Respondent failed to explain the appearance and disappearance of back pain. Tr. 601-02. Again, beneath the standard of care and contrary to the law in California, K.S. was prescribed hydrocodone for opioid dependency. Tr. 58788. On November 28, 2018, K.S. presented with opioid dependency-refusing detox and GAD, and for which he was prescribed hydrocodone and Xanax respectively. Tr. 588-589; GX 14 at 33; GDX 8. Again, beneath the standard of care and contrary to the law in California, K.S. was prescribed hydrocodone for opioid dependency. Tr. 588-89. And again the medication regimen included the dangerous combination of an opioid and benzodiazepine. The record is missing any medical history, any updated medical history, the patient's state of health, how he was responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 588-89. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are beneath the standard of care. Tr. 590.

On December 11, 2018, K.S. presented with ADD and eczema for which he was diagnosed with ADD and eczema. Tr. 591; GX 14 at 33. For ADD he was prescribed Adderall. [Dr. Munzing testified that the Adderall prescription lacked a legitimate medical purpose for the same reasons as the prior prescriptions he had just discussed. Tr. 591-93.] On January 31, 2019, K.S. presented with back pain and stomatitis. Tr. 593-

94; GX 14 at 31. For the back pain he was prescribed hydrocodone. [Again, Dr. Munzing testified that the hydrocodone prescription lacked a legitimate medical purpose for the same reasons as the prior prescriptions he had just discussed. Tr. 594-95.]

A review of the entirety of K.S.'s subject medical records reveals that the Respondent never obtained any prior medical records. Tr. 596, 619. The record is missing an adequate medical history, any updated medical history, the patient's state of health, how he was responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 598-99, 620. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are beneath the standard of care. Tr. 598, 619-20.

[Dr. Munzing testified that, similar to the other patients, Respondent prescribed hydrocodone to K.S. for back pain, then neck pain, then for opioid dependency, and sometimes for a combination of these reasons, without any documentation regarding these changes or the coming and going of the pain issues as would be required by the standard of care. Tr. 598-602.] Dr. Munzing also noted the inconsistency of the GAD diagnoses throughout the records. Tr. 602-05; GX 14 at 31, 42, 47, 48. With the GAD diagnoses appearing and disappearing within the records without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 605-09; GX 8. Similarly, ADD was inconsistently diagnosed and Adderall was inconsistently prescribed.

Tr. 605-06; GX 14 at 34, 35; GX 8. With the ADD diagnoses appearing and disappearing within the records without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 609.

Dr. Munzing noted the Respondent prescribed a dangerous combination of medications, including hydrocodone, Adderall and Xanax, which was prescribed from January 2018, through August 2018. Tr. 609-10. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity." Tr. 610. Additionally, the combination of an opioid and a benzodiazepine is present in August, October, and November 2018. Tr. 610-11. The records do not establish that the appropriate warnings were conveyed to K.S., or that informed consent was obtained. Tr. 611-13; GX 8. Dr. Munzing could not conceive of a medical condition warranting the dangerous combinations of medications prescribed. Tr. 614. [Dr. Munzing also noted that Respondent failed to properly monitor medication compliance, and conducted no urine drug screens, as was required by the standard of care in California. Tr. 614.]

Dr. Munzing noted the Respondent's failure to resolve red flags, including, K.S.'s refusal to detox, the dangerous combinations of medications, and high dosages of controlled medications. Tr. 615-18, 620; GX 14 at 39, 40, 41. The refusal to detox is a major red flag for opioid use disorder and for diversion. However, the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 615-17. The Respondent's prescribing was beneath the California standard of care.

Additionally, as noted above, during this time period the Respondent repeatedly prescribed hydrocodone to Patient K.S. as "treatment" for Patient K.S.'s opioid dependency, in violation of 21 CFR 1306.04(c).

I find, as alleged, that the Respondent's controlled substance prescriptions to Patient K.S. from at least January 19, 2018, through January 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice"; [they were issued outside the usual course of professional practice and beneath the standard of care in violation of 21 CFR 1306.04(a)

The Respondent's General Denial

The Respondent testified that, to the best of his knowledge, none of his thousands of patients have suffered any harm from his medication treatment. Tr. 793. The Respondent also disagreed with Dr. Munzing's assertion that there was likely no medical condition justifying the dangerous combinations of medications identified herein. Tr. 794-800. [Respondent testified that combinations of opiates, muscle relaxants, and benzodiazepines, when "used in the right dosages for the right indications, and used as prescribed by a knowledgeable M.D., . . . are safe to use in combination therapy." Tr. 797.] The Respondent conceded the potential danger of individual pain medications, and the potential increase in risk when combined with other medications. However, he stated that, if patients are responsible and take the medications as prescribed

for the indications intended, these combinations are fairly safe. Tr. 800.[33]

The Respondent recognized his obligation to follow all federal and state rules concerning the practice of medicine, including the directives of the California Board of Medicine. Tr. 862. California's Compliance with Controlled Substance Laws and Regulations includes a provision on records. Tr. 864; GX 20 at 61. It mandates that, "[t]he physician and surgeon should keep accurate and complete records according to the items above, [including] the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan." Tr. 864-65. The provision further requires, "[a] medical history and physical examination must be accomplished . . . this includes an assessment of the pain, physical and psychological function." Tr. 866; GX 20 at 59. The Respondent assured the tribunal that the necessary assessments were made, but admitted they were not fully documented. Tr. 866-67. The Respondent made the same assurances for the requirement as to "Treatment Plan Objectives," "Informed Consent," "Periodic Review," noting that these Guidelines were published in 2013.[34] Tr. 867-72.

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[33] [Omitted repetitious text for brevity]

[34] *See* Tr. 950-52. [Though this Decision discusses Respondent's early treatment of the seven individuals, which often predates 2013, Respondent is not being held responsible for any acts or omissions prior to the relevant time period which begins in January 2017. Any discussion of events prior to January 2017, are

The Respondent reiterated that, to his knowledge, none of his patients exhibited red flags, or violated the pain agreement. Tr. 888-89.

Credibility Analysis of the Respondent

In his testimony, the Respondent [initially] came off as very sincere and credible. Accepting his testimony as true and accurate (although his perception of the standard of care was, in several instances, unfounded, and his treatment was, in many cases, outside the standard of care), his explanations seemed to present that of a caring, dedicated practitioner, who may be guilty of benign neglect in his [prescribing] and failure to maintain complete and accurate records.

However, the discovery during rebuttal that Respondent had accessed the CURES report for S.B. and J.M. and made no changes to his prescribing practices thereafter, dramatically changed that perception.*NN

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only relevant to establishing that the subject prescriptions issued during the relevant time period were issued outside the usual course of professional practice and beneath the standard of care.] Dr. Munzing testified credibly that the 2013 version was the 7th edition and the basic requirement have not changed over the years.

*NN On direct and cross, Respondent agreed that it would "be a problem" and a "red flag of abuse or diversion" for a patient to be receiving two opioids at once. Tr. 888-89. He also testified that he tells his patients "that they cannot run to different doctors for medications," and he testified that all of his patients abided by the terms of the agreement "to the best of [his] knowledge, yes, because if not, then [they would] have to be discharged from the practice." Tr. 659, 888. Similarly, the Controlled Substances Therapy Agreement states that "[a]ll controlled substances must come from [Respondent,]" and that the patient's "failure to adhere to these policies may result in cessation of therapy with controlled substances." GX 11 at 114. The CURES reports that

The Respondent was [or should have been] fully aware that those patients were being prescribed Suboxone, an opioid commonly prescribed for abuse, by other physicians in violation of Respondent's own controlled substance agreements with those patients. Yet the Respondent failed to note that significant fact in the charts, and even more alarmingly, continued the patients on opioids and other controlled substances. Not only was this information missing from the patient charts, the Respondent failed to address the results of his CURES monitoring in his testimony. The Respondent has lost a great deal of credibility.

I was [originally] willing to give the Respondent the benefit of the doubt regarding the alias used by J.M. in filling opioid/benzodiazepine prescriptions, the unexplained simultaneous dispensing of the opioid and benzodiazepine prescriptions to two separate pharmacies by the Respondent, and the inconsistent instructions for usage of the benzodiazepine. But, [in light of the credibility issues], it appears more believable than not that the Respondent was a knowing participant in

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were introduced on rebuttal revealed that at least two patients were receiving controlled substances from other physicians, notably opioids when they were already getting opioids from Respondent, and there is no indication that this agreement violation was addressed by Respondent, let alone that the patients were discharged from the practice.

what appears to be a sophisticated attempt to divert medication by J.M.[35] *OO

The Respondent's testimony that he performed all of the procedures, undocumented in the charts, and [but for documentation failures] fully complied with the California standard of care suffers from the same loss of credibility.

[In his Exceptions, Respondent "disagree[d] with the weight that the ALJ assigned to the Government's rebuttal evidence regarding the CURES audit report, and [argued] that such rebuttal evidence is insufficient to overcome [Respondent's] testimony." Resp Exceptions, at 3-4 (internal citations omitted). This is because, Respondent argued, the substance of Respondent's testimony was that "he overlooked some details during his treatment of [the seven] patients," and that the rebuttal evidence affirms that testimony, "to wit: due to

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[35] "While proof of intentional or knowing diversion is highly consequential in these proceedings, the Agency's authority to act is not limited to those instances in which a practitioner is shown to have engaged in such acts. . . . Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion." *Dewey C. Mackay, M.D.*,75 FR 49956, 49974-75 n.35 (2010) (citing *Paul J. Caragine, Jr*, 63 FR at 51601 ("Just because misconduct is unintentional, innocent or devoid of improper motivation, does not preclude revocation or denial [of a registration]. Careless or negligent handling of controlled substances creates the opportunity for diversion and could justify revocation or denial.")).

*OO *See supra* n. *DD and n. *LL. While I have left the ALJ's discussions and findings that Respondent assisted J.M. in a diversion scheme intact throughout this decision, I have ultimately not based my decision on those findings.

the same benign negligence he overlooked S.B.'s and J.M.'s prescription by other physicians when accessing the CURES database." *Id.* at 4. In summary, all of Respondent's Exceptions challenge that ALJ's credibility finding because it is "solely based on [the Government's] questionable rebuttal evidence." *Id.* at 5.

I find, in agreement with the ALJ, that Respondent's testimony lacked credibility where it was inconsistent with, or provided additional information not included in, the patient files and documentary evidence in the record. However, I base my finding on Respondent's questionable credibility as demonstrated throughout the entirety of the hearing, not just on the Government's rebuttal evidence. The ALJ is best situated to observe the testimony of the Respondent, and I note that he appeared to be describing Respondent's demeanor when he stated that Respondent "came off as very sincere and credible." I credit the ALJ's description of Respondent's demeanor, but in spite of his described sincerity, both the ALJ[*PP] and I found many instances of objective issues with the credibility of Respondent's direct testimony. Specifically, when Respondent was asked questions about a specific patient, he often answered with testimony about his general practices or regarding his patients collectively. Secondly, Respondent's memory was shown to be less than fully reliable, which calls into question those

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[*PP] Although not included in the section dedicated to analyzing Respondent's credibility, the ALJ noted several instances of Respondent's memory failures and found that Respondent's memory was "not always infallible." RD, at 99; *see also supra* n. 23 and n. 24.

actions that he testified he remembered taking, but that he did not document in the patient files.

First, throughout Respondent's testimony about his prescribing, it was difficult to tell whether he was actually testifying specifically as to each individual. It often seemed that he was testifying generally as to the policies and procedures he purportedly followed in the regular course of his practice, and was just assuming that those policies and procedure were followed with regard to the named patients. Even where Respondent seemed to be testifying about a specific patient, his testimony quickly would morph into testimony about his patients collectively. *See supra* n. *X for an illustration of how difficult it was to pin down whether Respondent was testifying about a specific individual or his patients collectively. This sort of collective focus that appears throughout Respondent's testimony causes me to question Respondent's credibility—specifically whether he remembered the events that occurred at each specific visit for each specific patient that he discussed in the absence of medical records documenting these events. Indeed, Respondent testified that "[o]ver [his] career, [he] worked [with] about 5,000 patients," that he had "close to 550-600 patients" at the time of the hearing, and that prior to the order to show cause he "had between 175-200 [pain] patients."[QQ]

[QQ] But *see supra* n. 9 which documents confusion in the record regarding how many patients Respondent was actually seeing at any given point. There I noted that while the exact number of patients that Respondent was treating at any given time has little relevance to my decision in this matter, it is one another small thing that contributes to me questioning Respondent's ability to accurately recall the undocumented details of each medical visit to which he testified.

Tr. 792. With that many patients, Respondent surely would have been required to keep track of a lot of specific undocumented information. This concern about collective testimony and Respondent's specific memory was highlighted when during Respondent's entire testimony about J.M., Respondent and his counsel both called J.M. by the initials M.B. (a different individual at issue in the case). *See supra* n. 12; Tr. 734-43. The error was not discovered until sometime later when Respondent was questioned about J.M. again and responded that he had already discussed J.M. (though referring to him as M.B. the whole time). Tr. 772-76. This exchange did not fill me with confidence that Respondent's testimony reflected his true recollection of the specific actions he took with regard to the specific patient being discussed.

Secondly, Respondent's credibility is diminished where he testified based on his memory. Respondent repeatedly testified that we should trust him and his photographic memory. For example, he testified, "I rely on my photographic memory." Tr. 808-09. "As soon as the patient disclosed [the prior treatments] to me, I memorize it. I remember it. You've seen how several years later I still remember it. . . . I did not feel I have to clutter my charts with, you know, this information." Tr. 806-07. He also testified, "[W]hat's pertinent, what's your diagnosis, what's your main exam, and what's your treatment is reflected [in the notes]. The rest I remember. I don't need to write it." Tr. 807-08. But Respondent testified with equal frequency that we should not rely on his memory. For example, he testified, that even with a "good memory, sometimes you just miss something." Tr. 859. He testified that he could not always provide a specific response

because the information was not in his notes. "Whether [J.C.] mentioned the surgery the very first visit, that I cannot tell you yes or no at this point because it's not in my notes. So I'm just second guessing myself." Tr. 841; *supra* n. *U. And when directed to identify specifically which forms of alternative treatment M.B. had tried, Respondent testified, "I don't want to misspeak. I'm not sure if he had . . . acupuncture or not. But I know for a fact he had physical therapy." Tr. 827; *supra* n. *X. He also testified that the passage of time had impacted his memory. When asked what he prescribed to D.D., Respondent initially answered and then added, "[a]nd probably Valium. So I mean, I cannot testify exactly to you, depending on the visit, but yes, probably over the course, and again, this was in what, 2007 and now we are [in] 2020, 13 years." Tr. 851; *see also*, Tr. 853 ("I mean, again, this was 13, 14 years ago.").

There were also examples when Respondent's memory appears to have failed him and he seems to have provided a speculative response. For example, when asked where he had documented prior treatments tried by S.B., he testified "the record is probably missing these things, because maybe at the time of the documentation I did not feel that was crucial to be documented." Tr. 806; *see also* Tr. 870-71 ("Maybe I did not feel it was necessary because this is my patent, I am caring for the patient, I am doing the best job."). Ultimately, Respondent's memory was demonstrated to be less than fully credible.

It is for these reasons that I find that Respondent's testimony lacked credibility where it was inconsistent with, or provided additional information not included in, the patient files and documentary evidence in the

record. I have credited Respondent's testimony where it was supported by and consistent with the documentary record. In light of Respondent's failure to document almost any of the relevant and necessary information required by the standard of care, most of Respondent's testimony cannot be credited.

Ultimately, because of Respondent's extreme failure to document, Respondent's credibility has almost no bearing on my final decision in this case. Even if I fully credited Respondent's testimony regarding his treatment of the individuals at issue and found that Respondent otherwise acted within the standard of care, his repeated and severe documentation failures and failure to accept responsibility would have still led me to revoke his registration. DEA has previously made clear that "a physician may not expect to vindicate himself through oral representations at the hearing about his compliance with the standard of care that were not documented in appropriately maintained patient records."*RR *Lesly Pompy,* M.D., 84 FR 57749, 57760

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*RR Respondent's credibility also does not impact my findings based on Dr. Munzing's unrebutted expert testimony that Respondent's acts were beneath the standard of care. For example, Respondent does not contest that there was information missing from the patient files; he argues that the standard of care did not require him to document further. Similarly, Respondent does not contest that he prescribed the "Holy Trinity" and other combinations of dangerous drugs; he simply argues that the combinations were permitted by the standard of care. He does not contest the lack of urine drug screens; he argues his monitoring was proper under the standard of care. Here, Dr. Munzing is the unrebutted expert regarding the standard of care in California. Accordingly, Respondent's credibility issues aside, where Respondent and Dr. Munzing reached a different conclusion regard-

Dr. Munzing's Credibility

Conversely, Dr. Munzing was fully credible. His opinion regarding the California standard of care was consistent with the relevant California regulations, the practitioner Guides issued by the California Medical Board and guidance issued by federal agencies, such as the CDC, FDA and DEA. His specific opinions that the Respondent's subject treatment fell below the minimum California standard of care were factually well-founded, and were based on clear edicts of the standard. As the Government notes in its PHB, the Respondent did not credibly contest Dr. Munzing's opinions regarding the specific parameters of the standard of care. [As Dr. Munzing's expert opinion was unrebutted regarding the application of the standard of care to the facts in this case, I defer to Dr. Munzing on all issues related to the standard of care.]

Accordingly, I adopt each of Dr. Munzing's opinions regarding the Respondent's prescribing falling below the California standard of care.

Government's Burden of Proof and Establishment of *a Prima Facie* Case

Based upon my review of each of the allegations brought by the Government, it is necessary to determine if it has met its *prima facie* burden of proving the requirements for a sanction pursuant to 21 U.S.C. 824(a)(4). At the outset, I find that the Government has demonstrated and met its burden of proof in support of its allegations relating to the prescribing of

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ing whether uncontested acts were performed within the standard of care, I credit Dr. Munzing's opinion.

controlled substances to patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S.

Public Interest Determination: The Standard

[Under Section 304 of the CSA, "[a] registration . . . to . . . dispense a controlled substance . . . may be suspended or revoked by the Attorney General upon a finding that the registrant . . . has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined by such section." 21 U.S.C. 824(a)(4).][36] Evaluation of the following factors have been mandated by Congress in determining whether maintaining such registration would be inconsistent with the "the public interest":

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The [registrant's] experience in dispensing, or conducting research with respect to controlled substances.

(3) The [registrant's] conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

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[36] [This text replaces the ALJ's original text and omits his original footnote for clarity]

21 U.S.C. 823(f). "These factors are . . . considered in the disjunctive." *Robert A. Leslie,* M.D., 68 FR 15227, 15230 (2003).

Any one or a combination of factors may be relied upon, and when exercising authority as an impartial adjudicator. *Id.* (citation omitted); *David H. Gillis,* M.D., 58 FR 37507, 37508 (1993); *see also Morall v. DEA*, 412 F.3d at 173-74; *Henry J. Schwarz, Jr,* M.D.,5 4 FR 16422, 16424 (1989). Moreover, the Agency is "not required to make findings as to all of the factors," *Hoxie v. DEA,* 419 F.3d 477, 482 (6th Cir. 2005); *see also Morall,* 412 F.3d at 173. [Omitted for brevity.] The balancing of the public interest factors "is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest . . . . " *Jayam Krishna-Iyer,* M.D.,74 FR 459, 462 (2009).

The Government's case invoking the public interest factors of 21 U.S.C. 823(f) seeks revocation of the Respondent's COR based primarily on conduct most aptly considered under Public Interest Factors Two, and Four.[37]

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[37] [There is nothing in the record to suggest that a state licensing board made any recommendation regarding Respondent's prescribing practices (Factor One). Where the record contains no evidence of a recommendation by a state licensing board that absence does not weigh for or against revocation. *See Roni Dreszer, M.D.*,76 FR 19434, 19444 (2011) ("The fact that the record contains no evidence of a recommendation by a state licensing board does not weigh for or against a determination as to whether continuation of the Respondent's DEA certification is consistent with the public interest.") As to Factor Three, there is

[Factors Two and Four: The Respondent's Experience in Dispensing Controlled Substances and Compliance With Applicable Laws Related to Controlled Substances*SS

According to the Controlled Substances Act's implementing regulations, a lawful controlled substance order or prescription is one that is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 CFR 1306.04(a). The Supreme Court has stated, in the context of the CSA's requirement that schedule II controlled substances may be dispensed only by written prescription, that "the prescription requirement . . . ensures patients use controlled substances under the supervision of a doctor so as to prevent addiction and recreational abuse . . . [and] also bars doctors from peddling to patients who crave the drugs for those prohibited uses." *Gonzales v. Oregon,* 546 U.S. 243, 274 (2006).

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no evidence in the record that Respondent has a "conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances." 21 U.S.C. 823(f)(3). However, as Agency cases have noted, there are a number of reasons why a person who has engaged in criminal misconduct may never have been convicted of an offense under this factor, let alone prosecuted for one. *Dewey C.*, 49973 (2010). *MacKay, M.D.,* 75 FR 49956 Agency cases have therefore held that "the absence of such a conviction is of considerably less consequence in the public interest inquiry" and is therefore not dispositive. *Id.*] The Government does not allege Factor Five as relevant.

*SS The ALJ evaluated Factors 2 and 4 in separate sections and I have combined and expanded on his analysis herein. This change also addresses the Government's Exceptions.

Respondent has demonstrated substantial experience as a licensed California doctor since 1998 who has been operating his own practice for over 20 years. Tr. 627-27. Regarding his experience, Respondent testified that he is "an astute clinician who's been in the medical field for 41 years without a blemish to [his] reputation and career", and points out that "the Government seized more than 223 charts, . . . [but] they returned more than 200" and only seven patients are at issue in the case. Tr. 648-49. The Agency assumes that Respondent has prescribed legally except where the Government has established that the prescriptions at issue violated the law. Here, Respondent's treatment of the patients as alleged in the OSC demonstrates that his prescribing practices fell short of the applicable standard of care.

I found above that the Government's expert credibly testified as supported by California law and California's Guide to the Laws and Guidelines for Prescribing, that the standard of care in California for prescribing controlled substances requires a physician to, amongst other things, obtain a detailed medical history, perform and document a physical examination, assign a diagnosis, develop and document a customized treatment plan, monitor the patient including monitoring for medication compliance, and have complete and accurate records documenting all of the above steps in detail. *See supra* The Standard of Care for Prescribing Controlled Substances in California. I also found above, in accordance with Dr. Munzing's testimony, that Respondent issued each of the relevant controlled substance prescriptions at issue to the seven patients at issue without taking a proper medical or mental health history, conducting a

sufficient physical and/or mental examination, making a supportable diagnosis, recording pain and functionality levels, documenting an appropriate treatment plan, documenting discussion of the risks of the prescribed controlled substances, monitoring for medication compliance, and/or resolving red flags of diversion. *See supra* Respondent's Improper Prescribing of Controlled Substances. I further found that each of the relevant prescriptions Respondent issued to the seven individuals were issued without a legitimate medical purpose, and outside the usual course of professional practice and beneath the standard of care in California. Accordingly, I find that Respondent violated 21 CFR 1306.04(a)

Indeed, Respondent repeatedly issued prescriptions without complying with the applicable standard of care and state law, thus demonstrating that his conduct was not an isolated occurrence, but occurred with multiple patients. *See Kaniz Khan Jaffery,85* FR 45667, 45685 (2020). For each of the seven individuals, Respondent failed to perform and document a physical and/or mental examination that was sufficient to inform a diagnosis for which the controlled substances at issue could be prescribed. Additionally, I have found that for each of the seven individuals, Respondent prescribed dangerous combinations of controlled substances without properly discussing their risks.

Agency decisions highlight the concept that "[c]onscientious documentation is repeatedly emphasized as not just a ministerial act, but a key treatment tool and vital indicator to evaluate whether the physician's prescribing practices are 'within the usual course of professional practice.'" *Cynthia M. Cadet,* M.D., 76 FR 19450, 19464 (2011). DEA's ability to assess whether

controlled substances registrations are consistent with the public interest is predicated upon the ability to consider the evidence and rationale of the practitioner at the time that he prescribed a controlled substance—adequate documentation is critical to that assessment. *See Kaniz-Khan Jaffery,* 85 FR at 45686. Dr. Munzing testified that "[t]rue, and accurate, and thorough documentation is vitally important for patient safety. It's also part of the standard of care." Tr. 917. But, as Dr. Munzing testified, "practically none of the information that Respondent mentioned [during his testimony] was documented." Tr. 916. The extreme failures in Respondent's documentation extended to each of the seven individuals.

DEA decisions have found that "just because misconduct is unintentional, innocent, or devoid of improper motive, [it] does not preclude revocation or denial. Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify the revocation of an existing registration . . . " *Bobby D. Reynolds, N.P., Tina L. Killebrew, N.P., & David R. Stout,* N.P.,80 FR 28643, 28662 (2015) (quoting *Paul J. Caragine,* Jr.63 FR 51592, 51601 (1998). "Diversion occurs whenever controlled substances leave 'the closed system of distribution established by the CSA . . . '" *Id.* (citing *Roy S. Schwartz,* 79 FR 34360, 34363 (2014)). In this case, I have found that Respondent issued controlled substance prescriptions without complying with his obligations under the CSA and California law. *See George Mathew, M.D.*, 75 FR 66138, 66148 (2010)).

With regard to California law, just as I found a violation of 21 CFR 1306.04(a). I find that Respondent repeatedly issued controlled substance prescriptions

what were not "for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice," in violation of Cal. Health & Safety Code § 11153(a). California law also prohibits "[p]rescribing, dispensing, or furnishing" controlled substances "without an appropriate prior examination." Cal. Bus. & Prof. Code § 2242(a). Crediting Dr. Munzing's testimony, I have found above that the Respondent failed to conduct an appropriate prior physical and/or mental examination with regard to his prescribing to each of the seven individuals at issue, which I find violates Cal. Bus. & Prof. Code § 2242(a). Finally, California law prohibits "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs." Cal. Bus. & Prof. Code § 725(a). At the hearing Dr. Munzing unequivocally testified that Respondent's prescribing of high dosages of controlled substances to the seven individuals at issue, often in dangerous combinations, without a legitimate medical purpose constituted "clear excessive prescribing." Tr. 621. Accordingly, I find that Respondent's prescribing also violated Cal. Bus. & Prof. Code § 725(a). Crediting Dr. Munzing's testimony, I found above that Respondent acted outside the bounds of these laws with regard to his prescribing to each of the seven patients.] The Respondent has violated the charged federal and California regulations related to controlled substances. He has violated the California standard of care, as alleged. Thus [Factors Two and Four] weigh heavily in favor of revocation.

[Summary of Factors Two and Four and Imminent Danger

As found above, the Government's case establishes by substantial evidence that Respondent issued controlled substance prescriptions outside the usual course of the professional practice. I, therefore, conclude that Respondent engaged in misconduct which supports the revocation of his registration. *See Wesley Pope*, 82 FR 14944, 14985 (2017).

For purposes of the imminent danger inquiry, my findings also lead to the conclusion that Respondent has "fail[ed] . . . to maintain effective controls against diversion or otherwise comply with the obligations of a registrant" under the CSA. 21 U.S.C. 824(d)(2). The substantial evidence that Respondent issued controlled substance prescriptions outside the usual course of the professional practice establishes "a substantial likelihood of an immediate threat that death, serious bodily harm, or abuse of a controlled substance . . . [would] occur in the absence of the immediate suspension" of Respondent's registration. *Id.* The risk of death was established in this case. There was ample evidence introduced to establish that combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system has resulted in serious side effects including slowed or difficult breathing, comas, and deaths. GX 22, at 1.

Respondent testified that none of his patients had suffered any harm, such as overdose, as a result of his prescribing practices. Tr. 792. However, I credit Dr. Munzing's repeated testimony that not only did Respondent prescribe "incredibly high doses" of individual dangerous drugs, but that many of the prescriptions at issue were issued in dangerous combinations including the "holy trinity" the "new holy trinity" and other dangerous combinations as

have been discussed. As Dr. Munzing testified, "inherently [the controlled substances] each . . . have their own inherent dangers, but putting them together, it even escalated that much more dangerously, both for addictive issues for overdose and overdose death issues." Tr. 506; *see also id.* at 933-34. Even if I credit Respondent's testimony that none of his patients overdosed, I cannot rule out addiction issues. Two of the individuals at issue were prescribed Suboxone by other providers, which Dr. Munzing testified was typically prescribed for opioid use disorder or addiction, Tr. 943; and Respondent himself diagnosed almost all of the individuals at issue with opioid dependency. Accordingly, I cannot fully credit Respondent's testimony that none of them were harmed. Even the individuals' exposure to the increased risks caused by the dangerous combinations of the controlled substances Respondent prescribed could be harmful.

Thus, as I have found above, at the time the Government issued the OSC/ISO, the Government had clear evidence of violations of law based on the many controlled-substance prescriptions Respondent issued without complying with the California standard of care. *See supra* Respondent's Improper Prescribing of Controlled Substances.]

[Sanctions*TT

Where, as here, the Government has met its *prima facie* burden of showing that Respondent's continued registration is inconsistent with the public interest,

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*TT I am replacing portions of the Sanction section in the RD with preferred language regarding prior Agency decisions; however, the substance is primarily the same.

the burden shifts to the Respondent to show why he can be entrusted with a registration. *Garrett Howard Smith,* M.D.,83 FR 18882, 18910 (2018) (collecting cases). Respondent has made no effort to establish that he can be entrusted with a registration.

The CSA authorizes the Attorney General to "promulgate and enforce any rules, regulations, and procedures which he may deem necessary and appropriate for the efficient execution of his functions under this subchapter." 21 U.S.C. 871(b). This authority specifically relates "to 'registration' and 'control,' and 'for the efficient execution of his functions' under the statute." *Gonzales v. Oregon,* 546 U.S. 243, 259 (2006). A clear purpose of this authority is to "bar[] doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking." *Id.* at 270.

In efficiently executing the revocation and suspension authority delegated to me under the CSA for the aforementioned purposes, I review the evidence and arguments Respondent submitted to determine whether or not he has presented "sufficient mitigating evidence to assure the Administrator that he can be trusted with the responsibility carried by such a registration." *Samuel S. Jackson, D.D.S.,72* FR 23848, 23853 (2007) (quoting *Leo R. Miller,* M.D.,53 FR 21931, 21932 (1988)). "Moreover, because "past performance is the best predictor of future performance," *ALRA Labs, Inc. v. DEA,* 54 F.3d 450, 452 (7th Cir. 1995), [the Agency] has repeatedly held that where a registrant has committed acts inconsistent with the public interest, the registrant must accept responsibility for [the registrant's] actions and demonstrate that [registrant] will not engage in future misconduct.'"

Jayam Krishna-Iyer,74 FR 459, 463 (2009) (quoting *Medicine Shoppe,73* FR 364 (2008)); *see also Jackson,* 72 FR at 23853; *John H. Kennedy,* M.D.,71 FR 35705, 35709 (2006); *Prince George Daniels, D.D.S.,60 FR 62884, 62887* (1995).

The issue of trust is necessarily a fact-dependent determination based on the circumstances presented by the individual respondent; therefore, the Agency looks at factors, such as the acceptance of responsibility and the credibility of that acceptance as it relates to the probability of repeat violations or behavior, and the nature of the misconduct that forms the basis for sanction, while also considering the Agency's interest in deterring similar acts. *See Arvinder Singh, M.D.,81* FR 8247, 8248 (2016).

Here, the Respondent did not accept responsibility for any of his misconduct and instead excused his deficiencies and provided unsupportable explanations for why he should not have to comply with California's laws. For example, Respondent testified, "[n]ow, is it deficient on my part not to have written all that [in the medical record]? I'm not going to say deficiency, but maybe it was, you know, inappropriate. Maybe I should have written that. But it is too much. . . . I don't have the luxury of writing every single thing that transpires." Tr. 808-09. In no way is this an unequivocal acceptance of responsibility. He excused his lack of documentation by claiming documentation was unnecessary because of his "photographic memory," which was clearly not infallible, because he was a clinician with 41-years of experience not a medical student, and because "maybe" he did not feel it was crucial information to document. Moreover, based on Respondent's testimony, I am not confident that he

has any desire to improve his conduct in the future. He testified, "I am not going to just say, okay, write in the chart I told the patient hello, they said hello, I said, okay, what did you have for breakfast? I am not going to document all that, there is no reason. It is just excessive [wreaking] havoc on the documentation. . . . [E]verything was addressed, everything was talked about, and every exam, every consent, everything was done by the book. I am a perfectionist. I am a perfectionist." Tr. 871.]

The following testimony by Respondent further supports my finding that Respondent failed to accept responsibility for his actions: "[S]o, [the Government is] just looking at the charts and some notes and immediately demonizing an astute clinician who's been in the medical field for 41 years without a blemish to my reputation and career. And now, I'm just portrayed as I'm just feeding the addicts; I'm just distributing his medications." Tr. 648-49.]

Additionally, as I have found, the Respondent's testimony was less than credible [for a wide variety of reasons,*UU including] as evidenced by the Govern-

*UU Respondent, in his Exceptions, argues that the ALJ's finding that the Respondent did not unequivocally accept responsibility was flawed because it was based entirely on the ALJ's credibility analysis, which as discussed above, was the subject to another exception. Resp Exceptions, at 5; Supra Credibility Analysis of the Respondent. My finding that Respondent failed to unequivocally accept responsibility is based primarily on Respondent's own testimony. He testified at times that "maybe" his documentation could be better, but never without excuses and equivocation. He refused to take any responsibility for his prescribing of high dosages of controlled substances or dangerous combinations of controlled substances. I find Respondent's second exception to be without merit.

ment's rebuttal evidence. The Respondent cannot credibly claim that he forgot the alarming discoveries he made as to Patients S.B. and J.M. when he monitored their CURES reports. The Respondent's failure to discuss this critical information in describing the justification for their treatment during testimony constitutes a significant lack of candor[38]

I therefore find that the Respondent has not unequivocally accepted responsibility.[39]

Egregiousness and Deterrence

[The Agency also looks to the egregiousness and extent of the misconduct, which are significant factors in determining the appropriate sanction. *Garrett Howard Smith, M.D.,* 83 FR at 18910 (collecting cases).] I find that the proven misconduct is egregious and that deterrence considerations weigh in favor of revocation. In addition to the myriad of prescribing events falling below the California standard of care, the proven misconduct involved being directly aware of two patients' apparent abuse or diversion of controlled substances, and being an apparent party to one of those patient's abuse or diversion. Respondent treated opioid abuse with hydrocodone which is not a legiti-

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[38] The degree of candor displayed by a registrant during a hearing is "an important factor to be considered in determining . . . whether [the registrant] has accepted responsibility" and in formulating an appropriate sanction. *Hills Pharmacy, LLC*,81 FR 49816, 49845 (2016) (citing *Michael S. Moore*,76 FR 45867 45868 (2011)).

[39] A registrant's acceptance of responsibility must be unequivocal, or relief for sanction is not available, and where there is equivocation any evidence of remedial measures is irrelevant. *Daniel A. Glick, D.D.S.*, 80 FR 74800, 74801, 74810 (2015).

mate medical purpose for prescribing hydrocodone and is outside the usual course of professional practice, therefore it was an illegal action under state regulations. Beyond that, his actions unnecessarily exposed his patients to dangerous levels of medication and to dangerous combinations of those medications.*VV

[In sanction determinations, the Agency has historically considered its interest in deterring similar acts, both with respect to the respondent in a particular case and the community of registrants. *See Joseph Gaudio*, M.D.,74 FR 10083, 10095 (2009); *Singh,* 81 FR at 8248. I find that considerations of both specific and general deterrence weigh in favor of revocation in this case.] Allowing the Respondent to retain his COR despite the proven misconduct would send the wrong message to the regulated community. Imposing a sanction less than revocation would create the impression that registrants can maintain DEA registration despite ongoing treatment below the California standard of care, knowledge and acquiescence of the abuse or diversion demonstrated herein, the repeated prescribing of dangerous combinations of medications, and the wholesale failure to maintain complete and accurate medical charts. Revoking the Respondent's COR communicates to registrants that DEA takes all failings under the CSA seriously and that severe violations will result in severe sanctions.

[There is simply no evidence that Respondent's behavior is not likely to recur in the future such that I can entrust him with a CSA registration; in other

*VV Remaining analysis of egregiousness omitted for relevance.

words, the factors weigh in favor of revocation as a sanction.]

Recommendation

Considering the entire record before me, the conduct of the hearing, and observation of the testimony of the witnesses presented, I find that the Government has met its burden of proof and has established a *prima facie* case for revocation. In evaluating Factors Two and Four of 21 U.S.C. 823(f), I find that the Respondent's COR is inconsistent with the public interest. Furthermore, I find that the Respondent has failed to overcome the Government's *prima facie* case by unequivocally accepting responsibility.

Therefore, I recommend that the Respondent's DEA COR No. BR6081018 should be revoked, and that any pending applications for modification or renewal of the existing registration, and any applications for additional registrations, be denied.

/s/ Mark M. Dowd
U.S. Administrative Law Judge

ORDER

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a) and 21 U.S.C. 823(f), I hereby revoke DEA Certificate of Registration No. BR6081018 issued to Fares Jeries Rabadi, M.D. Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a) and 21 U.S.C. 823(f) I further hereby deny any other pending applications for renewal or modification of this registration, as well as any other pending application of Fares Jeries Rabadi, M.D., for registration in California. This Order is effective June 21, 2022.

Anne Milgram
Administrator

[FR Doc. 2022-10592 (/d/2022-10592) Filed 5-18-22; 8:45 am]

RECOMMENDED RULINGS, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DECISION OF THE ADMINISTRATIVE LAW JUDGE (DECEMBER 22, 2020)

UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION

IN THE MATTER OF FARES JERIES RABADI

Docket No. 20-14

Mark M. Dowd
U.S. Administrative Law Judge

December 22, 2020

David Locher, Esq.
for the Government

Joshua Lowther, Esq.
for the Respondent

RECOMMENDED RULINGS, FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DECISION OF THE ADMINISTRATIVE LAW JUDGE

The Drug Enforcement Administration (DEA) Acting Administrator, filed an Order to Show Cause and Immediate Suspension of Registration (OSC/ISO)[1] on March 2, 2020, immediately suspending the Certificate of Registration (COR), No. BR6081018, of

[1] ALJ Ex. 1.

Fares Jeries Rabadi, M.D. (Respondent), pursuant to 21 U.S.C. § 824(d), and proposing to revoke the Respondent's COR pursuant to 21 U.S.C. § 824(a)(4) on the ground that the Respondent's registration is inconsistent with the public interest, as defined in 21 U.S.C. § 823(f)(2) and (4). The OSC/ISO further proposed denying any pending applications for modification or renewal of the Respondent's existing registration, and any pending applications for additional registrations. The Respondent timely requested a hearing on March 20, 2020,[2] and prehearing proceedings were initiated.[3] A hearing was conducted in this matter on September 28, 29, and 30, via video teleconference technology.

The issue to be decided by the Acting Administrator is whether the record as a whole establishes by a preponderance of the evidence that the DEA Certificate of Registration, No. BR6081018, issued to Respondent should be revoked, and any pending applications for modification or renewal of the existing registration should be denied, and any pending applications for additional registrations should be denied, because his continued registration would be inconsistent with the public interest under 21 U.S.C. §§ 823(f) and 824(a)(4).

After carefully considering the testimony elicited at the hearing, the admitted exhibits, the arguments of counsel, and the record as a whole, I have set forth my recommended findings of fact and conclusions of law below.[1]

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[2] ALJ Ex. 2.

[3] ALJ Ex. 3

THE ALLEGATIONS

The Government alleges the Respondent violated federal and California law,[4] by issuing numerous prescriptions for Schedule II through IV controlled substances outside the usual course of professional practice and not for a legitimate medical purpose to seven individuals as recently as December 31, 2019. These prescriptions fell below minimal medical standards applicable to the practice of medicine in California. Therefore, these prescriptions violated federal and California state law.

The Government alleges the Respondent regularly prescribed highly addictive and intoxicating combin-

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[4] A prescription for a controlled substance is legitimate only if "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. § 1306.04(a); *see*, *e.g.*, *MacKay v. DEA*, 664 F.3d 808, 816 (10th Cir. 2011) (applying state law to determine if a prescription complied with 21 C.F.R. § 1306.040); *Marcia L. Sills, M.D.*, 82 Fed. Reg. 36,423-01, 36,443-44 (2017) (discussing 21 C.F.R. § 1306.04(a)). "Careless or negligent handling of controlled substances creates the opportunity for diversion and [can] justify revocation or denial." *Paul J. Caragine, Jr.*, 63 Fed. Reg. 51,592, 51,601 (1998). Furthermore, except in certain defined circumstances, a "prescription may not be issued for 'detoxification treatment' or 'maintenance treatment.'" 21 C.F.R. § 1306.04(c).

In addition to complying with the above-cited federal statutes and regulations, as a California physician, the Respondent is also required to comply with applicable California state law, including, but not limited to, the following:

a. Cal. Health & Safety Code § 11153(a), requiring that a "prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice";

b. Cal. Health & Safety Code § 11154(a), directing that "no person shall knowingly prescribe, administer, dispense, or

furnish a controlled substance to or for any person . . . not under his or her treatment for a pathology or condition . . . .,

c. Cal. Bus.& Prof. Code § 2242, prohibiting the "[p]rescribing, dispensing, or furnishing [of controlled substances] . . . without an appropriate prior examination and a medical indication," the violation of which constitutes unprofessional conduct;

d. Cal. Bus. & Prof. Code § 2234, defining unprofessional conduct to include: "[g]ross negligence"; "[r]epeated negligent acts"; "[i]ncompetence"; or "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon"; and

e. Cal. Bus. & Prof. Code § 725, further defining unprofessional conduct to include "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs. . . ."

Additionally, California's applicable standard of care is outlined in the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons," Medical Board of California, 7th ed. 2013 (the "Guide"). As relevant here, the Guide explains that a practitioner, when prescribing controlled substances, must perform a sufficient physical examination and take a medical history. Guide, at 57. The practitioner must make an assessment of a patient's pain, their physical and psychological function, and their history of prior pain treatment. *Id* The practitioner must also make an assessment of any underlying or coexisting diseases or conditions and order and perform diagnostic testing if necessary. *Id.* In addition, the practitioner must adequately discuss the risks and benefits of the use of controlled substances and any other treatment modalities; periodically review the course of pain treatment or gather new information, if any, about the etiology of a patient's state of health; and give special attention to patients who, by their own words and actions, pose a risk for medication misuse and/or diversion. *Id* at 57-59. Further, the practitioner must keep accurate and complete records, including but not limited to, records of the patient's medical history, physical examinations

ations of controlled substances to his patients, and that he consistently failed to: (1) perform adequate physical evaluations and obtain appropriate patient histories; (2) make appropriate diagnoses based on sufficient clinical evidence, and document these diagnoses in his medical records; (3) document a legitimate medical purpose for the controlled substances that he prescribed; (4) monitor his patients' medication compliance; and (5) respond to red flags of drug abuse and diversion. These failures constitute extreme departures from the standard of care in California, and that his actions were dangerous and reckless. Because of these failures, he regularly put his patients at significant risk for harm, including overdose or death. He also continued to prescribe controlled substances to these patients despite the fact that he knew they were suffering from opioid dependencies.

The Government alleges the Respondent's practice resembled an illicit drug dealing operation rather than a legitimate medical clinic. For each of the seven patients below, he continued to prescribe opioids to them, even while noting that each patient suffered from an opioid dependency.

The specific allegations as to the individual patients is set out in the Analysis section of the decision.

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of the patient, the treatment plan objectives and the treatments given, and the rationale for any changes in treatment. *Id.* at 59.

See ALJ Ex. 1

THE HEARING

1. Government's Opening Statement[5]

The DEA initiated an investigation into Dr. Rabadi, a California registered physician, upon receipt of a report from the Department of Health and Human Services Office of Inspector General. Tr. 23. The report characterized him as a "high-risk prescriber" due to his prescribing of a large number of highly diverted and high abused drugs. Initially, the DEA reviewed Dr. Rabadi's prescribing practices through the California PDMP. Tr. 23. Significant red flags were revealed, including dangerous combinations of controlled substances. Three drugs, Hydrocodone acetaminophen, alprazolam and Carisoprodol constituted over 95% of the controlled substance prescriptions he issued between November 20, 2015 and November 21, 2018. Tr. 24. In combination, these three drugs make up a highly dangerous and diverted cocktail commonly known among drug seekers as the Holy Trinity.

On November 6, 2018, an undercover agent, posing as a prospective patient with back pain sought treatment from Dr. Rabadi. Dr. Rabadi declined to treat the UC, explaining that he was an internist and did not treat back pain. Tr. 24.

In February of 2019, DEA executed federal search warrants on Dr. Rabadi's clinic, home and three safety deposit boxes. The DEA seized a number of prescriptions and patient files. Tr. 24. The DEA also seized an unusually large amount of cash from Dr. Rabadi's home and clinic examination room suggestive of diversion and mis-prescribing. Tr. 25. Subpoenas to

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5 The Respondent waived making an opening statement. Tr. 30.

pharmacies produced prescriptions for a number of Dr. Rabadi's patients, including the seven patients at issue in this case. Tr. 25.

The Government's expert, Dr. Timothy Munzing, will testify that his review of the patient files and prescriptions revealed, in his opinion, that Dr. Rabadi prescribed controlled substances to each of the seven patients outside the usual course of professional practice in California. Tr. 25. Dr. Munzing will testify that Dr. Rabadi never established a legitimate medical purpose for the controlled substances he prescribed, and was not acting in the usual course of professional practice. Tr. 25. Dr. Munzing will testify that Dr. Rabadi consistently failed to meet fundamental elements of the California standard of care for prescribing controlled substances, including failure to obtain appropriate medical histories, failure to perform minimally appropriate physical exams, failure to make appropriate diagnoses based on sufficient medical evidence, failure to document appropriate treatment plans, failure to document a legitimate medical purpose for the controlled substances, failure to discuss the risks and benefits of the cocktails and controlled substances he prescribed, failure to conduct even a single urine drug screen, and failure to respond to red flags of abuse and diversion. Tr. 27. Dr. Rabadi prescribed controlled substances in dangerous and addictive combinations, thus outside the usual course of professional practice and without establishing a legitimate medical purpose. Dr. Rabadi frequently and plausibly diagnosed opioid dependency for patients on long term opioid use. Dr. Rabadi diagnosed neck and back pain without sufficient medical evidence. Tr. 27. Dr. Rabadi frequently issued narco prescriptions to treat M.B., B.C., J.C., D.D., J.M., and K.S. for opioid dependency,

a dangerous and illegal course, and outside the standard of care. Tr. 27-28. Dr. Rabadi prescribed Xanax in dangerously high dosages to Patients S.B., B.C., J.M., and K.S. of six to eight mgs per day, almost twice the maximum dosage for anxiety disorder. Tr. 28. With early refills of Xanax, the Respondent exposed J.M. to more than 10 mgs per day for nearly two years. Tr. 29. He further exposed these patients to overdose and death by concurrently prescribing them opioids. Tr. 28.

Thus, the Respondent was not providing medical care to these patients, he was exposing them to risk of harm by handing out dangerous and addictive drugs without medical justification. Dr. Rabadi's controlled substance prescriptions to Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. were not issued for a legitimate medical purpose, were not issued by a practitioner acting within the usual course of professional practice in California, but were issued in violation of the standard of care in California and in violation of the laws of the United States. Tr. 29. Accordingly, the Government will request that the tribunal recommend revocation of Dr. Rabadi's DEA certificate of registration.[6]

GOVERNMENT'S CASE-IN-CHIEF

The Government presented its case-in-chief through the testimony of two witnesses. First, the

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[6] Government allegations included a reference to statistics that 95% of the Respondent's prescriptions were for the "Holy Trinity" suggesting that evidence, in itself, demonstrated illegitimate prescribing by the Respondent. The Government confirmed that those statistics did not form an independent allegation. Tr. 32-33.

Government presented the testimony of Diversion Investigator Desiree Johnson. Secondly, the Government presented the testimony of Dr. Timothy Munzing, M.D.

Diversion Investigator (DI) Desiree Johnson

Desiree Johnson has served as a Diversion Investigator (DI) at DEA's Los Angeles Field Division for three years. Tr. 33-34. Previously, she served with United States Citizenship and Immigration Service (U.S. CIS) for four years. Tr. 75. As a DI, DI Johnson enforces compliance with the Controlled Substance Act (CSA), looking for signs of diversion within the registration system, including monitoring for regulatory compliance. Tr. 34-35. She has attended the basic diversion investigation training at the DEA Academy, which included training to spot signs of diversion, investigating diversion and enforcing compliance with the CSA, both in the criminal and administrative settings. Tr. 35. She has also received training regarding the CURES, the California prescription drug monitoring program.

Regarding the Respondent, Dr. Rabadi, in April 2018, DEA received a report from the Department of Health and Human Service (HHS) that the Respondent was on a "high-risk model for overprescribing of controlled substances". Tr. 37, 75. DEA ran two CURES reports, one in April of 2018, which revealed numerous red flags, including prescribing Hydrocodone at the maximum strength, a large amount of polypharmaceutical cocktails or combinations of a benzodiazepine and an opioid, as well as the volume of opioid prescribing, over 9,000 prescriptions over the three years from November 2015 – November 2018, and later January 6, 2019 – January 6, 2020. Tr. 38-39, 42, 56-57,

82; GX 16-19. Fifty-percent of these were for Hydrocodone. Tr. 42. The combination of a benzodiazepine and an opioid are significant as they are highly sought after by the black market and are dangerous to the patient. Tr. 39. The Respondent also prescribed a large number of combinations of the highly sought after "Holy Trinity", the combination of amounts of a narcotic, a muscle relaxant and a benzodiazepine, 96% of his prescriptions during that three-year period. Tr. 40, 42-43. These highly addictive and highly dangerous combinations were prescribed over a long period of time. Tr. 40-41.

With these red flags, on September 26, 2018, the DEA sent an undercover agent (UC) to the Respondent's clinic, posing as a prospective patient. Tr. 43. The first attempt was foiled as the clinic was closed. The second attempt occurred on October 30, 2018. Tr. 44, 75-76. The clinic was again closed. The third attempt occurred on November 6, 2018. The UC complained of back pain and shoulder pain and sought help from Dr. Rabadi. Dr. Rabadi declined to help the UC, explaining he was not taking new patients and that he was an internist and not a pain specialist. Tr. 45, 75-76. Ultimately, DEA obtained five search warrants, four of which were executed on February 21, 2019. Tr. 46, 76-77. The fifth was served on February 22, 2019. Tr. 74. They were served on his clinic, his home and on two safety deposit boxes at two separate banks. Tr. 46. The DEA seized 1.2 million dollars in cash at his home.[7] Dr. Rabadi was home when the search warrant was served. Tr. 77. He agreed to be interviewed regarding his prescribing practices. Tr. 77. At his

[7] The Respondent objected to the evidence of the cash seizure as irrelevant and immaterial. The objection was carried. Tr. 47-49.

clinic, the DEA seized patient files and some prescriptions for S.B., B.C., M.B., J.C., D.D., J.M. and K.S. Tr. 49-50. Additional prescriptions and fill stickers were obtained from pharmacies.[8] Tr. 50-55; GX 1-15. Thereafter, in January 2020, DEA issued an administrative subpoena to the Respondent for any and all updated medical records and prescriptions for the noted patients. Tr. 55-56.[9] In all, DEA obtained twenty-seven files or updated files. Tr. 78.

Dr. Timothy Munzing

Dr. Munzing is a physician licensed in California and holds a DEA Certificate of Registration there. Tr. 86-87; GX 23. Dr. Munzing graduated from UCLA Medical School in 1982. Tr. 89. He completed his internship and residency in family medicine at the Kaiser Permanente Medical Center in Los Angeles in 1985. Tr. 89. He then went to Kaiser Permanente Orange County, where he has been employed for the last 35 years in the family medicine department. He is also available as a consultant. Tr. 90.

In his family medicine practice, he takes care of his patients from "cradle to grave". Most of his present patients are adults. Tr. 90. Twenty-five percent of his work day is spent treating his patients. Tr. 92. In his clinical practice, he prescribed controlled substances,

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8 DI Johnson noted record-keeping deficiencies on the part of some of the pharmacies, but clarified they were not a negative reflection on the Respondent. Tr. 79-80.

9 The government authenticated Government Demonstrative Exhibits 1-8, which were summary charts for each of the eight subject patients containing the subject prescriptions and patient files consistent with the seized and stipulated to records. Tr. 57-73.

including opioids and benzodiazepines. Tr. 92. Thirty-two years ago Dr. Munzing founded a family medicine practice residency program, and continues to be the residency director for twenty-four residents. Tr. 90. He also sits on the National Accreditation Board for Family Medicine Residency. He is a member of the American Medical Association, the California Medical Association, and the American Academy of Family Physicians, to name a few. Tr. 91; GX 23. He also serves as a full clinical professor at the University of California Irvine, and at the Kaiser Permanente School of Medicine. Tr. 91. He has been called as an expert witness by the California Medical Board for the past ten years, and by federal law enforcement for the past six years. Tr. 623. Dr. Munzing has been qualified approximately thirty-five times to offer his expert opinion for the California Medical Board, DEA, FBI, and the Department of Justice, including the standard of care for prescribing controlled substances, and whether a prescription was issued for a legitimate medical purpose in the usual course of professional practice. Tr. 92-94. He has testified as an expert in five or six prior DEA Administrative hearings. Most of his opinions have related to illegal prescribing of opioids. Tr. 95. Internal rules of Kaiser Permanente prevent him from testifying on behalf of physicians. Tr. 623. Dr. Munzing estimated he has received approximately $20,000 for his time on the instant case at $400 per hour. Tr. 624.

He is familiar with the California standard of care for prescribing controlled substances. Tr. 94. The California standard of care is informed by publications by the California Medical Board. Tr. 95-97; GX 20 at 59-61, GX 21. In particular, "The Laws Governing the Practice of Medicine by Physicians and Surgeons",

sets out minimum requirements for care, including history and physical examination, assessment of pain, physical and psychological functioning, substance abuse history, treatment plan, and maintaining accurate and complete records. Tr. 374-80. In forming his opinions in this case, Dr. Munzing reviewed the medical records and prescriptions of the subject patients. Tr. 100-01. Dr. Munzing was qualified, without objection, as an expert in California medical practice, including the applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine. Tr. 101-02.

Dr. Munzing explained that the standard of care is generally what a responsible, knowledgeable physician would do under similar circumstances. Tr. 102-03. In prescribing controlled substances this would include a physical examination, taking a history, including both medical, psychological and substance abuse, attempting to obtain prior medical records, formulating a diagnosis, evaluating risk factors for the controlled medication including the risk of abuse, discussing the risks with the patient to obtain informed consent, developing a customized treatment plan with goals and objectives, documenting all of the above in the medical record, and providing ongoing monitoring of the patient and of his treatment, including urine drug screens (UDS) and alternate therapies. Tr. 103-112, 114-25, 128-35. Ongoing and comprehensive documentation is critical for accurate evaluation of a patient's condition and treatment. Tr. 142-50. The goal is to maximize function, while minimizing risk. Tr. 139-40. Compliance with all relevant California statutes and regulations is also required by the standard of care. Tr. 104. It requires addressing, resolving

and documenting red flags. Tr. 112. Dr. Munzing identified the FDA "black box" warning regarding combining opioids with benzodiazepines, New Safety Measures Announced for Opioid Analgesics, dated August 31, 2016. Tr. 151; GX 22 at 1-3, 4, 25, 40. The FDA specifically noted diazepam, Klonopin, and Xanax should not be combined with opioids unless absolutely necessary, and for no longer than absolutely necessary. Tr. 153-55.

The higher the Morphine Milligram Equivalent (MME) prescribed, the increased risk of addiction and overdose. Tr. 126-28. Prescribing controlled substances for psychological illness requires an even greater emphasis on history, yet a more-focused physical exam. Tr. 136, 138-39, 141. The General Anxiety Disorder screening tool, GAD-7, is a useful tool in assessing the level of anxiety. Tr. 136-37.

Dr. Munzing reviewed the patient files, prescriptions, and CURES data for Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. Tr. 156. Dr. Munzing noted the history for these seven patients was deficient. Tr. 157. There was no indication prior medical records were obtained. Tr. 157. The physical exams, if present, were missing key elements. There were no documented CURES checks. Tr. 158. Diagnoses appeared and disappeared. Opioids were prescribed at high dosages. There was no indication of the necessary patient monitoring to assure informed consent. Tr. 159-60, 207. Dr. Munzing summarized that none of the controlled prescriptions issued for the charged patients were issued for a legitimate medical purpose by a practitioner acting within the usual course of professional practice. Tr. 620-21. All of such prescriptions were outside the standard of care. Tr. 621.

Patient S.B.

As per the parties' stipulations, between February 2, 2017 and January 30, 2019, S.B. was prescribed Hydrocodone, Carisoprodol, Adderall and alprazolam. Tr. 162-63; GDX 1. Dr. Munzing characterized the patient file as meager. He characterized the controlled substance prescriptions as outside the standard of care. Tr. 163, 207, 241-44. For S.B.'s initial visit on August 3, 2016, she was diagnosed with Generalized Anxiety Disorder (GAD), Attention Deficit Disorder (ADD), and Fibromyalgia. Tr. 163-65; GX 1 at 62, 66. There was no supporting findings or history for the fibromyalgia diagnosis, which typically is reached after a certain number of tender points are determined. Tr. 166. Similarly, there was no supporting findings or history to support the GAD or ADD diagnoses. Tr. 166-71, 241-44. There is no physical functioning level documented nor mental functioning level documented. Tr. 171. Without sufficient evaluation and supporting documentation for the three diagnoses, Dr. Munzing deemed the diagnoses inappropriate. Tr. 24144. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44. Similarly, there is no documented treatment plan. Tr. 241-44. On February 2, 2017, S.B. presented to the clinic suffering from fibromyalgia and ADD. Tr. 173; GX 1 at 59. The Respondent diagnosed her fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed Hydrocodone, Carisoprodol, and Adderall. Tr. 173-74. Again, there was no medical history justifying the diagnosis. The physical exam conducted on February 2, 2017, consisted of blood pressure, cardiovascular, heart and lung, which were normal. Again, insufficient to justify the fibromyalgia and ADD diagnoses. Tr. 175. There was

no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 175-76. For the progress notes of June 28, 2017, the Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed Hydrocodone, Carisoprodol, and Adderall. Tr. 177. Again, there was no medical history justifying the diagnoses. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 177-78; GX 1 at 57. Again, only a blood pressure and heart and lung exams were performed. Tr. 177. There was insufficient medical evidence to justify the three diagnoses. Tr. 177-78. For the progress noted of December 21, 2018, S.B. presented with eczema and fibromyalgia. Tr. 179; GX 1, p. 49. The Respondent diagnosed her with fibromyalgia-opioid dependent, refusing detox. She was prescribed Hydrocodone. No history was recorded. Again, only a blood pressure and heart and lung exams were performed. Tr. 180. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 180. There was insufficient medical evidence to justify the fibromyalgia diagnosis. Tr. 181. In the progress notes for January 30, 2019, S.B. reported to the clinic with ADD and rhinitis. Tr. 181; GX 1 at 47. She was prescribed Adderall for the ADD. No medical history was taken. ADD patient progress was reported as "stable". There was insufficient medical evidence to justify the ADD diagnosis. Tr. 183. Dr. Munzing deemed the ADD diagnoses inappropriate. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescription. Tr. 185-86. During the subject period of the Respondent's treatment of S.B., he never obtained any prior medical

records. Tr. 184. He never recorded a history, which would justify his diagnoses for Fibromyalgia, GAD or ADD. He never reported a sufficient physical or mental exam to justify the Fibromyalgia, GAD or ADD diagnoses. He never reported a sufficient evaluation to justify his diagnoses for Fibromyalgia, GAD or ADD. Tr. 184-85. The controlled substance prescriptions for S.B. were not issued within the California standard of care, nor were they issued within the usual course of professional practice. Tr. 187, 244.

Dr. Munzing observed that the diagnoses would come and go in the records, were inconsistently reported, which is atypical for chronic diagnoses. Tr. 188-97. A chronic disease, with symptoms which appear to come and go would question whether the patient had the disease at all. Tr. 192. Even a lessening of symptoms should cause evaluation of whether tapering of medication was appropriate. Tr. 196.

Dr. Munzing noted that the Respondent prescribed S.B. both Hydrocodone and Soma to treat Fibromyalgia on numerous occasions. Tr. 197-98. On other occasions, he prescribed the Hydrocodone without Soma, without any explanation for changing the medication protocol, contrary to the California standard of care for documentation. Tr. 198-201; GX 20 at 61. Dr. Munzing noted that S.B. was on a dangerous, highly addictive, combination of medications, popular for abuse, Hydrocodone and Soma, which are respiratory depressants, and Adderall, a Schedule II medication. Tr. 202. Another dangerous combination, Hydrocodone, Adderall and Xanax was prescribed March 1, 2017, in April 2017, and June 2017. Tr. 203; GX 1. Dr. Munzing noted this is referred to by drug abusers as the "new Holy Trinity". Tr. 204. It includes the depressants, Hydro-

codone, and Soma, and is followed by the stimulant, Adderall, to counteract the effects of the depressants. Again, the combination of Hydrocodone and Soma are the subject of the FDA "black box" warning. Tr. 205. The high dosage of Xanax, 6 mg per day, heightens the risk of this already dangerous combination. With Xanax and Adderall prescribed at their highest commercially available dosage units, the danger and risk of addiction are further increased. Tr. 205. Additionally, two mg tablets of Xanax are popular for abuse and diversion. Tr. 217-18. On September 29, 2017, and monthly from July 2018 to July 2019, S.B. was prescribed Hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the Hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition in which this combination would be appropriate. Tr. 211-12. Dr. Munzing noted that the medical records failed to disclose any indication that the Respondent warned S.B. regarding the risks associated with these dangerous combinations of medications. This failure precludes any informed consent by S.B. Tr. 207. The Declaration of Pain Medication Use document in the file, dated August 3, 2016, which requires the patient to alert the Respondent if the patient takes additional medications which could result in drug interactions, does not put the patient on notice of the dangerous combinations prescribed by the Respondent. Tr. 207-10; GX 1 at 67. Similarly, Dr. Munzing noted the repeated notation within the patient records of "SED", which Dr. Munzing assumed meant, "side effects discussed", was insufficient documentation within the

standard of care for discussing the various risks of these medication combinations. Tr. 210-11; GX 1 at 59. In March, April and June of 2017, the Respondent prescribed S.B. Xanax at 6 mg per day, in excess of the FDA recommended daily limit of 4 mg per day. Tr. 212-15; GX 1 at 57, 58, 59. GX 22 at 40, 59-61. In May of 2017, the Xanax was abruptly stopped. Tr. 21617; GDX 1. And abruptly restarted in June of 2017, and again stopped. Tr. 217. This is very dangerous as the abrupt stoppage of Xanax, especially at this high dosage, can cause seizures, and restarting at this high dosage can trigger an overdose, especially in conjunction with the prescribed opioid. Tr. 212-18.

Regarding the monitoring of S.B., there were no urine drug screens evident in the records, which the standard of care would have required at least quarterly. Tr. 218-21; GX 1 at 44. In the progress notes for February, March, April 2017, all the way to January 30, 2019, the Respondent noted "refusal to detox". Tr. 220-21, 22729; GX 1 at 58, 59. This is a huge red flag for opioid use disorder and for diversion. However, the chart reflects the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 222-23. The Respondent's course of action was outside the California standard of care. Tr. 223, 229. In a June 2017 report from Dr. Falakassa, an orthopedic surgeon, who saw S.B. for reported neck and back pain, S.B. reported her past medical history as only "anxiety". Tr. 229; GX 1 at 30, 32, 36-42, 56. She did not report Fibromyalgia, ADD or GAD. Tr. 229-30. S.B. further reported to Dr. Falakassa that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription

evidence. Tr. 231-32. Dr. Falakassa's report was part of S.B.'s disability application, claiming disability as of June 15, 2017. A report from Chiropractor, Bruce Hall is included in the disability packet. Tr. 235. Dr. Hall reports the disability was caused by "accident or trauma", which is inconsistent with what the patient reported to Dr. Falkassa and to the Respondent. Tr. 236. There is no indication within the Respondent's records for S.B. that he ever discussed, with S.B. or with Dr. Falkassa, the discrepancies revealed by Dr. Falkassa's report. Tr. 233-37.

Contemporaneous to the preparation of the disability claim, Dr. Rabadi ordered a series of radiologic tests on S.B., none of which were related to the Respondent's diagnosis of fibromyalgia. The progress notes from August 17, 2017, S.B. presented with "overactive thyroid, gait disturbance". Tr. 237-40; GX 1 at 5, 7, 9, 11, 13, 16, 17, 56. Dr. Rabadi ordered an MRI of the brain to rule out MS, a thyroid ultrasound to rule out hyperthyroidism, an MRI of the lumbar spine, and an MRI of the thoracic spine. The MRI of the cervical spine was ordered by Dr. Falkassa. Tr. 241.

Patient M.B.

After a review of M.B.'s patient file, CURES report and related prescriptions, Dr. Munzing observed that between January 5, 2018 and November 20, 2019, the Respondent prescribed Hydrocodone and Adderall. Tr. 245. As with patient S.B., Dr. Munzing characterized the patient file as meager. Tr. 245-47. The Respondent never obtained prior medical records of M.B. Tr. 288. Dr. Munzing observed that none of the subject prescriptions were within the California standard of care. Tr. 248, 289. On April 19, 2006, M.B. pre-

sented for his first visit Tr. 248-49; GX 3, p. 88, 91. In his "Comprehensive History and Physical Examination", the Respondent reported that M.B. presented with symptoms of "chronic back pain, left knee pain, dyslipidemia". Tr. 249-50. However, there are no diagnoses relating to the back and knee pain. Tr. 250-51, 258. To address the reported pain, the Respondent prescribed Hydrocodone. Tr. 252. The file fails to evidence sufficient history to justify the pain prescriptions under the standard of care. Tr. 252-54. The file fails to evidence any physical exam to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287. The file fails to evidence any treatment plan or goals, or past drug abuse to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287.

Although M.B. declared on a "Declaration of Pain medication Use" form that he had no prior drug abuse in August 2009, which was three years after his first visit, such static declaration does not satisfy the physician's ongoing responsibility under the standard of care to monitor this issue. Tr. 259-61; GX 3 at 93. On July 9, 2013, M.B. presented with ADD and neck pain. Tr. 261-62; GX 3 at 46. He was prescribed Adderall for the ADD. Tr. 262. Again, the records reveal there was no history taken to support the diagnosis or prescriptions for Adderall. Tr. 262. There was no evident evaluation done by the Respondent. Tr. 287. There was no treatment plan. Tr. 263. Although there was a diagnosis related to the neck pain, there was no history or physical exam evident in the file. Tr. 263-64. The Respondent never established a legitimate medical purpose for Hydrocodone. Tr. 264. On September 6, 2013, M.B. presented with ADD. Tr. 264-65; GX 3 at 46. He was prescribed Adderall for the ADD,

but at double the dosage of the previous visit, yet without any reported justification. Tr. 264-65. On January 5, 2018, M.B. presented to the clinic. Tr. 265-66; GX 3 at 37. He was prescribed Hydrocodone and Adderall. There was no medical history, M.B.'s response to treatment, evaluation of pain or functioning, substance abuse history, diagnoses, rationale for establishing a legitimate medical purpose or to justify continuing the medication regimen. Tr. 265-66. On March 6, 2018, M.B. presented to the clinic with "ADD and opioid dependency". Tr. 266-67; GX 3 at 36. Absent was any report of pain. He was diagnosed with "Opioid dependency, refusing detox". Tr. 267. He was prescribed Hydrocodone, which not only is outside the standard of care, but is illegal in California. Tr. 267-68. Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 268. Dr. Munzing observed that the Respondent prescribed Hydrocodone repeatedly to address his diagnosis of opioid dependency until November 20, 2019. Tr. 268-69. On November 20, 2019, M.B. presented with ADD and back pain. Tr. 269; GX 3 at 27. He was prescribed Adderall, and his Hydrocodone was increased. Tr. 270. No medical history was taken or updated. No response to treatment or patient functionality was included. Although vital signs were taken, no physical exam was performed. Tr. 270-71. There was no appropriate diagnosis for the back pain. Tr. 272. There was no evaluation for ADD, such as mental functioning. Tr. 271, 274, 287-88. The Respondent never obtained a sufficient history to support the diagnosis for ADD. Tr. 273. There was no appropriate diagnosis for ADD. Tr. 272. The Respondent never established a legitimate medical purpose to prescribe either Hydroco-

done or Adderall to M.B. throughout the reported treatment. Tr. 274. Such prescriptions were not in the usual course of professional practice, were not for a legitimate medical purpose and were outside the standard of care. Tr. 274-75.

Dr. Munzing noted the inconsistency of the various diagnoses. Diagnoses would come and go within the records. Tr. 275-278; GX 3 at 35, 37, 43, 67. Although the reported pain was always treated with Hydrocodone, the source of the pain varied greatly, yet no explanation for this is included in the file, as required by the standard of care. Tr. 278-80.

Dr. Munzing noted the serious dangers occasioned by the combination of Adderall and Hydrocodone, by reference to his testimony regarding S.B.'s similar prescriptions.[10] Tr. 281. Dr. Munzing deemed this combination of medications for over ten years inappropriate and unsafe. Tr. 284. The only semblance of a warning to M.B. regarding these dangerous combinations appeared in a 2009 "Controlled Substance Therapy Agreement". For the same reasons voiced to Patient S.B., Dr. Munzing deemed the signed form wholly insufficient to satisfy the California standard of care in this regard. Tr. 281-82; GX 3 at 92. Similarly, the notation within the file, "SED" was insufficient to

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[10] On September 29, 2017, and monthly from July 2018 to July, 2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition in which this combination would be appropriate. Tr. 211-12.

satisfy the standard of care. Tr. 283. There was never a UDS ordered for M.B., necessary under the standard of care for any patient receiving opioids, but especially for a patient who has refused opioid detox. Tr. 284-85. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not addressed by the Respondent repeatedly as to M.B. Tr. 285-87; GX 3 at 36.

Patient B.C.

Dr. Munzing reviewed the subject prescriptions, patient file and CURES report for Patient B.C, which he described as lean. Tr. 290-92; GDX 3. He opined that the subject controlled substance prescriptions issued for Hydrocodone, Xanax and Adderall, from January 25, 2017 to December 19, 2019, were all issued outside the California standard of care. Tr. 290-92, 335-38. B.C. presented on March 27, 2014, with GAD and back pain. Tr. 293-94; GX 5 at 48, 55. B.C. was diagnosed with GAD and back pain, refusing detox. He was prescribed Xanax (6 mg per day) for the GAD, and Hydrocodone for the back pain, refusing detox. Tr. 294. Dr. Munzing reiterated the risks involved in prescribing 6 mg of Xanax per day. Tr. 295.

The records failed to disclose the minimum history necessary under the standard of care to appropriately diagnose "back pain" and GAD. Tr. 295-96. Other than limited vital signs, the records failed to disclose the minimum physical examination necessary under the standard of care to appropriately diagnose "back pain", or to justify a Hydrocodone prescription. Tr. 296-97. Dr. Munzing could not remember seeing any prior medical records in the Respondent's subject files. Tr. 297. There were no entries in B.C.'s file indicating physical or mental functioning. Tr. 298,

335-38. There is no treatment plan indicated. The Declaration of Pain Medication Use, signed by B.C. at his first visit, as discussed previously, is insufficient to evaluate B.C., and to establish informed consent for the controlled substances prescribed. Tr. 299-300. There was insufficient medical evidence to support either diagnosis. Tr. 298, 335-38. So, there was no legitimate medical purpose for either controlled substance prescription. Tr. 299, 335-38.

B.C. presented on May 20, 2014 with ADD, and was prescribed Adderall. Tr. 301-02; GX 5 at 47. The ADD diagnosis was deficient, as no history was developed, no mental functioning was assessed, the medical evidence was deficient, and a treatment plan was lacking. The Respondent failed to establish a legitimate medical purpose for the Adderall. Tr. 302. Additionally, starting B.C. on 30 mg of Adderall twice daily is a very high dosage, and extremely inappropriate to an Adderall naive patient, which is not developed within the patient file. Tr. 302-03. B.C. presented on January 25, 2017, with ADD, opioid dependency and GAD. Tr. 303; GX 5 at 33. He was diagnosed with ADD, for which he was prescribed Adderall, and GAD, for which he was prescribed Xanax (6 mg per day). Tr. 304. Pain levels were not reported at this visit. The diagnoses were unsupported by sufficient medical history, medical evaluation, response to treatment, patient functionality, and medical evidence. Tr. 304-06. He failed to establish a legitimate medical purpose for both Adderall and Xanax. Tr. 306, 335-38. The Respondent further diagnosed, "Opioid dependency, refusing detox" to which the Respondent again prescribed Hydrocodone. Tr. 306. Prescribing Hydrocodone for opioid dependence is not only not within the standard of care, but it is illegal in California. Tr. 307.

Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 307. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not addressed by the Respondent repeatedly as to B.C. Tr. 306-07; GX 5, at 33.

On July 31, 2018, B.C. presented with ADD, back pain and GAD. Tr. 308; GX 5 at 28. He was diagnosed with ADD, for which he was prescribed Adderall (60 mg per day), "back pain, opiate dependent, refusing detox", for which he was prescribed Hydrocodone, GAD, for which he was prescribed Xanax (6 mg per day). Tr. 308. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment and no indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 30809, 335-38. There was no reference to pain levels or physical functionality. Tr. 309-10. There was no reference to mental functioning with respect to the ADD and GAD diagnoses. There was no appropriate diagnosis for the three diagnoses. Tr. 309-10. Neither did he establish a legitimate medical purpose for the three controlled substance prescriptions. Tr. 311. B.C. presented on December 19, 2019, with ADD and back pain, which was also his diagnosis, and for which he was prescribed Adderall (60 mg per day) and Hydrocodone. Tr. 311-12; GX 5 at 20. The record is absent medical history, any updated medical history, the patient's state of health, how he's responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. Tr. 312-13, 335-38. As a result, the three diagnoses are without

sufficient medical evidence. Tr. 313. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are contrary to the standard of care. Tr. 313-16, 33538.

Dr. Munzing noted the inconsistency of diagnoses throughout B.C.'s records, and the dual prescribing of Hydrocodone for opioid abuse and for skeletal pain, without explanation in the record. Tr. 316-19; GX 5 at 31, 32, 33. Dr. Munzing noted the GAD and ADD diagnoses appears and disappears within the record, as did their treatment medications. Tr. 319-24; GX 5 at 27, 31, 32, 33. Dr. Munzing deemed it highly unlikely that ADD and GAD were appropriate diagnoses. Tr. 322, 324. The Respondent prescribed B.C. a combination of Hydrocodone, Adderall and Xanax. Tr. 327; GDX 3. Dr. Munzing could not conceive of a medical condition warranting this dosage, duration, and combination of medications, noting Adderall is counter-indicated for GAD, and combining Xanax with an opioid represents a dangerous combination and is contrary to an FDA black box warning and CDC guidance. Tr. 327-29, 332-33; GDX 3. A further concern, as detailed earlier in his testimony, is reflected by the repeated combination of Hydrocodone and Adderall by the Respondent. Tr. 329-30; GDX 3. These dangerous combinations were without an established legitimate medical purpose, outside the usual course of professional practice, prescribed without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 330-35.

Patient J.C.

Dr. Munzing reviewed the subject prescriptions issued from January 16, 2018 to December 30, 2019, patient records and CURES data relating to Patient J.C. Tr. 381-82; GDX 4. Dr. Munzing opined that none of the subject prescriptions issued to J.C. were within the California standard of care. Tr. 382. J.C. presented to the Respondent's clinic on May 18, 2009 with headache and GAD. Tr. 383-384; GX 7, at 216, 233. He was prescribed Hydrocodone for migraine and Xanax for GAD, and remained on this medication regimen for a long period. As to the migraines, insufficient medical history was obtained, symptom evaluation was absent, no neurological exam was conducted, no evaluation of functioning level was made, no treatment plan evident, and no evaluation of possible drug abuse was provided. Tr. 384-90.

In short, there was insufficient medical evidence to support the diagnosis of migraines and GAD, nor was there a legitimate medical purpose to prescribe Hydrocodone and Xanax. TR. 386-88. J.C. presented on July 21, 2016 with "GAD, chronic back pain, consented for H&P". Tr. 390; GX 7 at 189. He was diagnosed with GAD, back pain – refusing detox, for which he was prescribed Xanax and Hydrocodone, respectively. Tr. 390-91. There was no updated history taken for either diagnosis, no physical exam, no treatment plan, no response to treatment, no pain or functioning level evaluations, no discussion regarding drug abuse, and no rationale for continued treatment, as required by the standard of care. Tr. 390-94. There was deficient medical evidence to support either diagnosis. The Respondent did not establish a legitimate medical purpose to prescribe the controlled substances. Tr. 393-94. J.C. presented on January 16, 2018 with GAD and back pain, for which he was diagnosed with GAD and

back pain, opiate dependent, refused detox. Tr. 394-95; GX 7 at 180. He was prescribed Valium for the GAD, discontinue Klonopin, and Hydrocodone for back pain, although no explanation was giving for substituting the Valium for the Klonopin. Tr. 395. There was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no drug abuse history, rendering each diagnosis inappropriate. Tr. 395-97. Without a legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 39698. J.C. presented on February 16, 2018, with "opioid dependency, GAD", yet without the previously noted back pain. Tr. 198; GX 7, 9. There is no reference to pain. He was diagnosed with "Opioid dependency, refusing detox", for which he was prescribed Hydrocodone, which again, is outside the standard of care and usual course of professional practice, and illegal in California. Tr. 398-400. The diagnosis for opioid dependency being treated with Hydrocodone appeared repeatedly in the records. Tr. 399. J.C. presented on May 6, 2019, however no treatment notes for this visit are evident in the file. Tr. 401; GDX 4, GX 7 at 168.

On April 9, 2019, J.C. presented with GERD, and back pain, for which he was prescribed Hydrocodone. Tr. 402. However, there was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no mental health history, and no drug abuse history, which rendered the back pain diagnosis inappropriate. Tr. 402-04. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 402-04. On December 30, 2019, J.C. presented with GERD and GAD. Tr.

404; GX 7, p. 171. He was prescribed Valium for the GAD. However, there was no appropriate medical history included in the records, no response to treatment, no physical exam, no evaluation for GAD, or functioning evaluation, no mental health history, and no drug abuse history, rendering the GAD diagnosis inappropriate from January 16, 2018 to December 30, 2019. Tr. 404-08, 425-28. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 408, 425-28. Such prescriptions, from January 16, 2018 to December 30, 2019, were outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice. Tr. 408, 425-28.

Dr. Munzing noted the inconsistency of diagnoses throughout J.C.'s records, and the dual prescribing of Hydrocodone for opioid abuse, migraines and for skeletal pain, without explanation in the record. Tr. 410-14; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the skeletal pain diagnoses appears and disappears within the record. Tr. 414-15. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 415; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the Respondent had prescribed the combination of Hydrocodone and Valium monthly between January 2018 and January 2019, without a legitimate medical purpose. Tr. 416-17; GX 4. Combining Valium with an opioid represents a dangerous combination and is contrary to an FDA black box warning and to CDC guidance, especially with the Valium at its highest available strength. Tr. 417. Dr. Munzing could not envision a condition in which this medication regimen would be appropriate. Tr. 418. These dangerous combinations were without an established legitimate medical purpose, outside the usual

course of professional practice, prescribed without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 418-23; GX 7 at 19, 25, 27, 180, 225.

Patient D.D.

Dr. Munzing reviewed the subject prescriptions issued from January 4, 2018 to February 12, 2019, patient records and CURES data relating to Patient D.D. Tr. 428-29; GDX 5. Again, the records were very lean. D.D. presented on July 9, 2008, with GAD and back pain. Tr. 430-31 GX 9 at 74. For the GAD, he was prescribed Valium. For back pain, Hydrocodone, and Soma. Tr. 431. D.D. refused an MRI and refused referral to orthopedist or a pain specialist. Tr. 431. Each refusal is a red flag, and suggestive of drug-seeking behavior. Tr. 432. Instead of addressing the red flags, the Respondent prescribed opioids. Tr. 432. The Respondent's response was the same throughout the subject treatment of D.D., a total of nine and a half years. Tr. 433. There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, no functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from July 9, 2008 to January 4, 2019. Tr. 433-38; GX 9 at 37, 39, 41, 43, 44. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 434-48. Such prescriptions, from July 9, 2008 to January 4, 2019, were outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice.

Tr. 434-48. Dr. Munzing noted a period of over a year when no diagnosis for GAD appeared in D.D.'s records, from May 10, 2017 to September 19, 2018, and the 30 mg daily dose of Valium was stopped. Tr. 447-48. Then on September 19, 2018, the Respondent was placed on 6 mg of Xanax, a very high dosage, especially for the beginning dosage. Compounding this dangerous dosage, D.D. was prescribed Hydrocodone in combination, heightening the risk of overdose. Tr. 448-50.

Dr. Munzing noted the inconsistency of diagnoses throughout D.D.'s records, the dual prescribing of Hydrocodone and Soma for fibromyalgia, D.D.'s opioid abuse, migraines and skeletal pain, without explanation in the record. Tr. 450-56; GX 9 at 43, 51, 64, 70; GDX 5. Prescribing Soma with Hydrocodone presents considerable risks to the patient. Each are respiratory depressants, which present a significant risk of overdose. Tr. 458. Dr. Munzing noted the skeletal pain diagnoses appears and disappears within the record. Tr. 450-56. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 456; GX 9 at 43, 51, 64, 70.

D.D. presented on March 23, 2019 with opioid dependency, refusing detox. He was again prescribed Hydrocodone and Soma. Tr. 463; GX 9 at 42, 43. The Respondent failed to address this red flag repeatedly, instead prescribing Soma and Hydrocodone. Tr. 465.

Patient J.M.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 10, 2017 to December 31, 2019, patient records and CURES data relating to Patient J.M. Tr. 469-70; GDX 6. Dr. Munzing opined that none of the subject prescriptions

issued to J.C. were within the California standard of care. Tr. 470-71.

On May 13, 2007, J.M. presented with hypertension, back pain, GAD, dyslipidemia and insomnia. Tr. 470-72; GX 7 at 104, 111. He was diagnosed with hypertension, back pain, GAD, dyslipidemia and insomnia. He was prescribed Hydrocodone for back pain, Xanax (6 mg per day) for GAD. Tr. 472. Xanax was a recurring prescription. As discussed, its high dosage was a concern, as well as its combination with an opioid. Tr. 473.

There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, no treatment plan, no pain or functioning evaluation, no mental health history, no ongoing drug abuse history or monitoring, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from May 13, 2007 to January 13, 2017. Tr. 473-76, 478, 481-83, 485-500. The MRI of May 30, 2007, and its "mild" findings, did not satisfy the Respondent's related obligations or justify the subject prescriptions. Tr. 479-80, 485-87; GX 11 at 14, 16, 17, 22, 26, 31, 37, 41, 42, 115. Without legitimate medical purpose, there was no appropriate rationale for the controlled substance prescriptions, or to continue treatment with controlled substances. Tr. 473-76, 478, 485-500, 505; GDX 7. There were red flags left unaddressed by the Respondent. J.M. refused to see a pain specialist, which gives rise to the suspicion that he is not concerned about getting better, but just getting medicated. Tr. 476-77. On May 29, 2007, J.M. presented with back pain and insomnia. Tr. 477-78; GX

11 at 103. He was prescribed Hydrocodone and Soma for back pain, a recurring prescription for this malady. Tr. 477-78. Dr. Munzing noted gaps in prescribing the Hydrocodone and Soma, without any required explanation for changes to the medication regimen. Tr. 500-04; GX 11 at 36, 37, 40, 41, 42, 76. He observed that the Hydrocodone was prescribed either for back pain or for opioid dependence. Tr. 504. However, the required evaluation for the diagnoses coming and going and explanation for treatment is lacking. This further diminishes any medical legitimacy for prescribing Hydrocodone. Tr. 504.

Additionally, the Respondent prescribed a very addictive and dangerous combination of medications, an opioid, and a benzodiazepine. Tr. 558-60. Even more concerning, he added a muscle relaxant, to this already dangerous combination to form the "Holy Trinity", a favorite drug combination of abuse by the drug-abusing community. Tr. 505-10. Dr. Munzing could not conceive of a medical condition in which the trinity combination would represent appropriate treatment. Tr. 512. This trinity of medications was prescribed to J.M. repeatedly. GDX 6. The file fails to reveal appropriate warnings were given to J.M. in connection with these dangerous combinations. Tr. Tr. 511; GX 11 at 113. The CURES report reveals 40 Xanax prescriptions (3600 dosage units and 7200 mgs) were issued to J.M. between January 2017 and November 2018, a period of 22 months, which averages 10.5 mgs per day. Tr. 512-17; GX 7, 17, 18. This averaged a prescription every 16 days. Tr. 527-28. Ten and a half mgs per day is considerably greater than the maximum 4 mg per day recommended for treatment of anxiety. The CURES report lists two different dates of birth for J.M., as well as two different

spellings of his first name. Tr. 517-18, 547-49; GX 18. A CURES search would be name and date of birth specific, so a search by one name and date of birth would not reveal prescriptions filed under the alternate name and date of birth. Tr. 526. The main sources of the CURES report information are two pharmacies, Reliable Rexall and Northridge Pharmacy. Tr. 51819. Despite the presence of two dates of birth and alternate first names, a considerable red flag suggesting abuse or diversion, the Respondent did not address these issues. Tr. 519-20, 525-26. Even if J.M. or the pharmacies were the source of the alternate dates of birth and alternate first names, with due diligence, the Respondent would have discovered a search by a single name and date of birth would only include half of the Xanax prescriptions the Respondent issued to J.M. Tr. 52126, 549-50. Additionally, a review of two prescriptions, one written by the Respondent and one called in by the Respondent on the same day contain two different dates of birth. Tr. 533-34.

Of further suspicion, the CURES report reveals J.M. is alternating the filling of the Xanax prescriptions between the two pharmacies, apparently trying to hide the bi-monthly frequency of the prescriptions. Tr. 520; GX 17, 18. Dr. Munzing noted a suspicious prescribing practice by the Respondent. Tr. 530; GX 17, # 425 & 575.[11] He would issue two prescriptions on the same day to J.M., one for Hydrocodone and one for Xanax. He would issue a written prescription for Hydrocodone, which J.M. would invariably fill at Northridge Pharmacy, but call in to Reliable pharmacy the prescription for Xanax. Tr. 531-33, 535-45, 550-58; GX

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[11] These are prescription numbers.

11 at 32, 33, 35, 36, 38, 40, 41, GX 12 at 5, 6, 10, 11, 14, 22, 24, 27, 33, 34; GX 13, at 20, 25, 27, 32, 34; GX 17, 18 #473, #474, #994, #1120, #1228, #1386, #1472, #1553, #2102, #2229, #2341, #2342. This appears to be an attempt to avoid the suspicion generated by the opioid/benzodiazepine combination if filled at a single pharmacy. Tr. 532-33, 557-60. There was an additional suspicious circumstance related to a Xanax prescription. The Respondent wrote in his medical notes that the medication should be taken once every eight hours, while the call-in information to the pharmacy was once every six hours. Tr. 543-45, 554, 556-57.

The red flag of refusing to detox was repeatedly evident within J.M.'s patient file. Tr. 562; GX 11 at 37. He was diagnosed with "Opioid dependency, refusing detox", for which he was prescribed Hydrocodone, which again, is outside the standard of care and usual course of professional practice, and illegal in California. Tr. 563-64. The diagnosis for opioid dependency being treated with Hydrocodone appeared repeatedly in the records. The Respondent never addressed this red flag. Tr. 564.

A review of the entirety of J.M.'s file and related records revealed there was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, or pain level/functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, no patient monitoring, no resolution of the multiple red flags noted, rendering the GAD and back pain diagnoses inappropriate from January 10, 2017 to December 31, 2019, and outside the California standard of care. Each was without legitimate medical

purpose and outside the usual course of professional practice. Tr. 565-68.

Patient K.S.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 19, 2018 to January 31, 2019, patient records and CURES data relating to Patient K.S. Tr. 469-70; GDX 8. Dr. Munzing opined that none of the subject prescriptions issued to K.S. were within the California standard of care. Tr. 568-70. K.S. presented on June 21, 2007 with "back pain", for which he was prescribed Hydrocodone and Soma. Tr. 570; GX 13 at 117. Although the Respondent noted he would get an MRI for the lumbar spine, no such MRI appears in the records. Tr. 271. However, there was no medical history included in this record, no treatment plan, no response to treatment, no physical exam, no pain or functioning evaluation, no ongoing drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 570. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances of back pain. Tr. 571-76. On May 1, 2012, K.S. presented with GAD and neck pain. Tr. 576; GX 14 at 80. He was diagnosed with GAD and neck pain, and prescribed Xanax for GAD and Hydrocodone for the neck pain, refusing detox. Tr. 577. K.S. was prescribed the combination of Hydrocodone and Xanax frequently throughout his treatment. This combination of opioid and benzodiazepine is dangerous, outside the standard of care and represents a red flag, unresolved by the Respondent throughout the records. Tr. 578-79. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment. There was no treatment

plan. No indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 579-81. There was no reference to pain levels or physical functionality. There was no reference to mental functioning with respect to the GAD diagnosis. There was no appropriate diagnosis for the GAD and neck pain. Neither did he establish a legitimate medical purpose for the controlled substance prescriptions. Tr. 580-81.

K.S. presented on November 18, 2013, with ADD, but with no diagnosis, and for which he was prescribed Adderall (60 mg per day). Tr. 581-82; GX 14 at 70. The record is absent medical history, any updated medical history, the patient's state of health, how he's responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 582. Accordingly, the subject charged prescription is without a legitimate medical purpose, is outside the usual course of professional practice, and is contrary to the standard of care. Tr. 582.

On January 19, 2018, K.S. presented with GAD, back pain and ADD. Tr. 583, 599; GX 14 at 41. For GAD, the Respondent prescribed Xanax. For back pain – opioid dependent, refusing detox, the Respondent prescribed Hydrocodone. And for ADD, Adderall. Tr. 584. The record is absent medical history, any updated medical history, an explanation why back pain has returned, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without suf-

ficient medical evidence. Tr. 584-86. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 586.

On February 27, 2018, K.S. presented with ADD, opioid dependency and GAD. Tr. 586-87, 599-600; GX 14 at 39, 40. He was diagnosed with ADD, opioid dependency-refusing detox, and GAD. Back pain was not reported, nor was any report of pain made. At the April 30, 2018 visit, again, back pain was not reported, nor was any report of pain made. Tr. 601. Throughout the records, the Respondent failed to explain the appearance and disappearance of back pain. Tr. 601-02. Again, contrary to the standard of care and the law in California, K.S. was prescribed Hydrocodone for opioid dependency. Tr. 587-88. On November 28, 2018, K.S. presented with opioid dependency and GAD, for which he was diagnosed with opioid dependency-refusing detox and GAD, and for which he was prescribed Hydrocodone and Xanax respectively. Tr. 588-589; GX 14 at 33; GDX 8. Again, contrary to the standard of care and to the law in California, K.S. was prescribed Hydrocodone for opioid dependency. Tr. 588-89. And again the medication regimen included the dangerous combination of an opioid and benzodiazepine. The record is absent medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 588-89. Accordingly, the subject charged prescriptions are without a legitimate medical pur-

pose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 590.On December 11, 2018, K.S. presented with ADD and eczema, for which he was diagnosed with ADD and eczema. Tr. 591; GX 14 at 33. For ADD he was prescribed Adderall. K.S. presented with back pain and stomatitis. Tr. 593-94; GX 14 at 31. For the back pain he was prescribed Hydrocodone.

A review of the entirety of K.S.'s subject medical records reveals the Respondent never obtained any prior medical records. Tr. 596, 619. The record is absent medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 598-99, 620. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 598, 619-20.

Dr. Munzing noted the inconsistency of the GAD diagnoses throughout the records. Tr. 602-05; GX 14 at 31, 42, 47, 48. With the GAD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 605-09; GX 8. Similarly, ADD was inconsistently diagnosed with Adderall inconsistently prescribed. Tr. 605-06; GX 14 at 34, 35; GX 8. With the ADD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there

is no medical evidence it was a medically legitimate diagnosis. Tr. 609.

Dr. Munzing noted the Respondent prescribed a dangerous combination of medications, including Hydrocodone, Adderall and Xanax, which was prescribed from January 2018 through August 2018. Tr. 609-10. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity". Tr. 610. Additionally, the combination of an opioid and a benzodiazepine is present in August, October and November 2018. Tr. 610-11. The records fail to reveal the appropriate warnings were conveyed to K.S., nor was informed consent obtained. Tr. 611-13; GX 8. Dr. Munzing could not conceive of a medical condition warranting the dangerous combinations of medications prescribed. Tr. 614.

Dr. Munzing noted the Respondent's failure to resolve red flags, including K.S.'s refusal to detox, the dangerous combinations of medications, and high dosages of controlled medications. Tr. 615-18, 620; GX 14 at 39, 40, 41. The refusal to detox is a major red flag for opioid use disorder and for diversion. However, the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 615-17. The Respondent's course of action was outside the California standard of care.

RESPONDENT'S CASE-IN-CHIEF

The Respondent presented his case-in-chief through the testimony of one witness, the Respondent, Fares Rabadi, M.D.

2. Fares Rabadi, M.D.

Dr. Rabadi attended medical school in the former Soviet Union. Tr. 626. He underwent a three-year residency training in internal medicine at State University of New York School of Medicine and Biomedical Science in Buffalo, New York. Tr. 627. He is currently licensed to practice medicine in New York, California, and Indiana. Tr. 627. He has been licensed in California since September 25, 1998. His first two years practicing in California were spent working at another medical group. For the past twenty-years he has had his own practice. Tr. 628. He is a member of the AMA, the American College of Physicians, a Master of the College of Physicians, the American Society of Internal Medicine, the Los Angeles Medical Association and Arab American Medical Association. Tr. 628. He is affiliated with the USC Keck School of Medicine, and on the volunteer faculty with the UCLA's David Geffen School of Medicine. He teaches family medicine at the Northridge Hospital. Tr. 628-29.

Dr. Rabadi was familiar with the federal regulations, the California Health and Safety Code, and the California Business and Professional Code cited in the Order to Show Cause. Tr. 630. Dr. Rabadi was familiar with the Government Exhibits 1-19 (records relating to the prescribing to the charged patients), and 20 (The [California] Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons). Tr. 630. He was specifically familiar with pages 59–60 relating to pain management. Tr. 630; GX 20. He was also familiar with the Guidelines for Prescribing Controlled Substances. Tr. 630; GX 21.

In his medical career Dr. Rabadi has treated thousands of patients, hundreds of pain patients. At the time of the issuance of the Order to Show Cause, Dr. Rabadi had three to four hundred patients, of which 175-200 were pain management patients. Tr. 631, 792. In both 2017 and 2018, he estimated he treated 400 to 500 patients. Tr. 803. In 2019, he estimated he saw 400 patients, and less than 200 in 2020.[12] Tr. 804.

Dr. Rabadi described his protocol upon a patient's first visit to his clinic, until the issuance of a prescription. Tr. 631. The patient initially fills out paperwork. His office verifies insurance coverage. The patient is weighed, and then sent to an examination room. Dr. Rabadi enters the room, sits on a stool at the same level as the patient, so Dr. Rabadi can look into the patient's eyes to evaluate the patient. Tr. 362. Dr. Rabadi determines how the patient was referred to him. Dr. Rabadi then takes the patient's history, which begins with the patient's main complaint. Dr. Rabadi disagreed with Dr. Munzing's estimate that a diagnosis is 85% based on the patient's history. Dr. Rabadi believed it was upwards of 95% based on history. Tr. 635-36. The Respondent conceded history is critical in understanding the patient's condition and in how to treat the patient. Tr. 804. He inquires about family history and their medical issues. Dr. Rabadi then enquires regarding social history, surgeries and present pain. He enquires into habits, such as smoking, and past and present use of illegal drugs. He then probes any allergies, including allergies to medications.

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[12] There was some confusion in the transcript as to the total number of patients in 2019. The Respondent estimated 400 total patients for 2019, but later agreed it was approximately 200 total patients in 2019. Tr. 804.

If a patient has no allergies, he reports NKDA. Tr. 635. Following history, Dr. Rabadi probes the main complaint, with an eye toward isolating the ultimate medical source of the malady, and whether the symptoms are resolved with medication. Tr. 63537. Regarding complaints of "back pain", Dr. Rabadi will review previous diagnoses, probe the source and triggers for his pain, explore any nerve restrictions, and discuss the success of different past treatment methods. Tr. 638-40. If pain medication management was the only treatment that alleviated the pain, Dr. Rabadi would explore the history of that treatment and its efficacy.

Dr. Rabadi's physical exam for all patients starts with the head. He examines the skull. He explores headaches, noted in the records as, "HEENT". Tr. 641. He then checks the eyes, the ears and the mouth. Tr. 642. He moves down to the neck, checking for issues with the veins of the neck. He then checks the efficiency of the heart's pumping and its rhythm. Next, he checks the lungs. Moving down to the abdominal cavity, he palpates the liver and spleen for abnormal size. Tr. 643. He then checks the remaining organs of the abdomen and the bowel for irregularities. Tr. 643. He then checks the extremities for circulation issues, often noting in the records, "No ECC" (edema, clubbing or cyanosis). He then checks for skin issues. Finally, he performs a neurological examination, including a mini mental-state exam and their orientation as to time and space. Tr. 643-45. He checks their reflexes, their cranial nerves. Tr. 645. He decides if further radiologic testing is necessary. Tr. 651-52. For men aged 17-35, he offers a testicular exam to check for cancer. For men over 50, he offers a rectal exam to determine indications of prostate and colorectal cancer.

The complete exam takes from 30-40 minutes. Then Dr. Rabadi formulates his diagnosis. Tr. 647. He then establishes a treatment plan. Tr. 649. He discusses the treatment plan with the patient and obtains informed consent. Tr. 658. For patients experiencing pain, he explains the mechanism of pain, the modalities of pain and the type of pain, chronic pain, acute pain, malignant pain, post-traumatic pain, rheumatological pain, psychogenic pain, and neuropathic pain.[13] Tr. 668. For patients to be prescribed pain medication, Dr. Rabadi explains the medications, their side effects, including addiction, overdose and death, and cautions patients not to operate machinery or use heavy equipment. Tr. 668-70. Dr. Rabadi assures his patients that if they take the medication as prescribed, they will not overdose. Tr. 670.[14] He typically sees his pain patients monthly. Tr. 672.

For return visits, Dr. Rabadi is focused on the specific reason for their visit. Tr. 673. This explains why Dr. Munzing noted diagnoses would appear and disappear from month to month. Tr. 673. Dr. Rabadi did not make note each month of long-term chronic conditions. Tr. 673. If a patient has new symptoms, Dr. Rabadi will focus on these new symptoms and tailor his examination to these symptoms, although at least two organ systems are always examined. Tr. 674.

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[13] Dr. Rabadi contrasted these classifications with those he indicated were described by Dr. Munzing, mild, moderate and severe. Tr. 667-68.

[14] As I understand Dr. Rabadi's testimony, Dr. Rabadi noted that an unnamed study found that dosages 5-6 times higher than that recommended by the FDA were safe. This highly specific evidence was not noticed prehearing, is not reasonably anticipated by the Government, and will not be considered.

At least every three months blood pressure is checked. Tr. 675. Dr. Rabadi explained that much depended on the physician's judgment. Guidelines are essentially recommendations. Following the guidelines does not make the Respondent a good doctor. The most important thing is to perform with knowledge, with care and in good faith, placing the interest of the patient as the Respondent's top priority. Tr. 676.

If patients' symptoms subsided and they did not finish their medication, Dr. Rabadi would not prescribe more medication. He would wait until the medication was finished. This explains why prescriptions would sometimes stop and restart from month to month. Tr. 673.

For patients on pain medication and desiring to continue on pain medication, he discusses the options of detox and referral to a pain specialist. Tr. 650. All of his patients on pain medications are required to sign a "Controlled Substance Agreement". Tr. 658. Dr. Rabadi explains that they cannot obtain pain medication from different physicians, and they cannot go to different pharmacies for refills. Tr. 660. If a patient overdoses, or is arrested selling medications, he is banned from further treatment. Tr. 660. Dr. Rabadi had little sympathy for reports of lost or stolen medication. Tr. 661.

In the United States the patient "is in the driver's seat". The patient's wishes are granted unless they are asking for something illegal or abnormal. Treatment cannot be forced on them. Tr. 650. When a patient reports that he has received extensive radiologic testing and has exhausted medical treatment and surgeries for his injury and wishes to remain on pain medications, the only option is to prescribe those medications or to

drop the patient, which Dr. Rabadi did not view as an ethical option. Tr. 651. No one deserves to be in pain. Tr. 664-65, 670. If chronic pain patients were dropped from the practice, they may turn to buying illegal drugs off the street. Tr. 663. Dr. Rabadi was realistic as to most of his pain patients. Some had been on pain medications for 10, 15 and 20 years. They were chemically dependent on them. Tr. 662. The goal was not to make them pain free, which would be impossible. It was to minimize the pain, and maximize their functionality without making them a slave to the medications. Tr. 662, 664. For acute pain, Dr. Rabadi typically restricted pain medication to one week. Tr. 662.

Dr. Rabadi noted that almost all of his patients work full time within the motion picture industry at hard labor, and suffer serious and sometimes recurring injuries. Tr. 647, 663. They have had long term injuries, with surgeries, and have been on pain medication for a long period of time prior to coming to see him, and are still able to function. Tr. 647-48, 663.

Regarding the use of pain scales in diagnosing, Dr. Rabadi noted its limitations. It is purely subjective to each patient. Tr. 658-59. Regarding the high doses of medications he prescribed, Dr. Rabadi agreed with Dr. Munzing that starting patients on such high doses was dangerous. Tr. 640. However, if the patients were acclimated to such high doses, prescribing lower doses would be ineffectual and potentially dangerous. Tr. 656-58. If Dr. Rabadi was just starting treatment for ADD, for example, he would start the patient on .25 mg of Xanax per day. Tr. 657.

3. Patient S.B.

Patient S.B. remained a patient of Dr. Rabadi. Tr. 708-09. She was prescribed Hydrocodone, Xanax and Adderall. Tr. 709. Dr. Rabadi believed his prescription practice concerning S.B. was within the California standard of care. Tr. 709. Dr. Rabadi began his treatment of S.B. on August 3, 2016. Tr. 718. She presented as a 29 year-old female to establish care for the treatment of ongoing conditions of GAD, fibromyalgia and ADD. Tr. 719. As per Dr. Rabadi's policy, and detailed in his earlier testimony, he took a complete history. Tr. 719-20. He performed a complete physical exam, reviewed her existing diagnoses of GAD and ADD, and her medication history in general, and specifically for those diagnoses. Tr. 720, 722-24. He obtained her pain level with and without medication. Without medication her subjective pain level was eight. With medication, it was one to two, which permitted her to function and perform daily activities. Tr. 721. The Respondent conceded that the detailed findings of the complete physical exam are not reflected in his chart, but noted he was a clinician with 41-years of experience, and not a medical student. Tr. 810. Tr. 810. Dr. Rabadi noted that patients with ADD are six times more likely to have other psychiatric conditions as people without ADD. Ultimately, Dr. Rabadi concurred with the previous physician's diagnoses of ADD, GAD and fibromyalgia. Tr. 724, 728. To obtain informed consent to prescribe controlled substances to S.B., the Respondent executed the "pain management contract". Tr. 728-29. The patient reads it and signs it. The Respondent then goes over the contract in detail with the patient. The Respondent then explains that the medications are meant to help the patient, not to cause side effects or addiction, although they tend to cause

chemical dependence. Tr. 729. The Respondent then goes over all the alternative treatments, but in the end, it is the patient's decision as to the treatment he will receive. Tr. 729. If the Respondent objected to every patient's choice of treatment, there would no medical care. If a patient says she is on medication and it permits her to function, the Respondent will continue that treatment. Tr. 729-30. S.B. indicated she had been through several alternate treatments, including, occupational therapy, physical therapy, hydrotherapy, yoga and meditation. Tr. 731, 805.

The Respondent conceded the list of prior therapies was not in his progress notes. Tr. 805-06, 808. The Respondent explained its absence as maybe he did not feel it was crucial to document them, as he memorizes what the patient tells him. Tr. 806. Including references to prior, concluded treatment, the Respondent found to be irrelevant as the prior treatment was concluded and the patient had moved on to the new treatment. Tr. 807-08. The Respondent testified to S.B.'s prior treatment from memory. Tr. 808. The Respondent explained that, as he still maintained handwritten records, seeing up to 20 patients a day, with new patients taking an hour and returning patients taking up to 20 minutes each, he did not have the luxury of documenting in detail. Tr. 807, 849. So, the basic information is reflected in his written notes, while the rest he remembers, as he has a photographic memory. Tr. 808-09. The Respondent conceded that "maybe" it was "inappropriate" of him not to more thoroughly detail this information in the charts. Tr. 809. But with handwritten charts he was only able to include the "main ideas". His notes are simply to remind him of the matters. Tr. 810-11. He keeps his notes as brief as possible to remind him in the future. Tr. 815.

She further reported that she had been on the same dosage of medications for several years to good effect. Tr. 731-32. To reduce her from those dosages would have to be done gradually, lest the patient have withdrawal and suffer severe pain. Tr. 732. Prior to each prescription, the Respondent discussed side effects, and changes in status. Tr. 733.

The Government sought to test the Respondent's memory by asking to confirm that, consistent with his direct testimony, he only treated S.B. with Hydrocodone, Xanax and Adderall. Tr. 810-13. The Respondent confirmed his direct testimony. Tr. 812. The Government reminded the Respondent that he prescribed Soma as well. Tr. 813.

Although the Respondent testified he developed a treatment plan for each of his patients, the Government pointed out S.B.'s treatment plan and objectives were not documented in her chart. Tr. 813-14.

Although the Respondent testified he did not introduce any of his subject patients to controlled substances, the chart reflects he did prescribe Soma to S.B. for the first time. Tr. 816-17; GX 1 at 61, 62. The Respondent remembered during cross-examination that, although not in the chart, S.B. told him she had been on Soma previously. Tr. 817-19.

4. Patient J.M.[15]

J.M. has been a patient for thirteen years. Tr. 734. The Respondent has prescribed him Xanax, Soma and Hydrocodone. The Respondent believed his treat-

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15 From pages 734-43, Patient J.M. is discussed. However, due to some confusion with patient initials, the Respondent described his treatment of J.M. as M.B. within the transcript. Tr. 774.

ment of J.M. was within the California standard of care. J.M. first presented on May 14, 2007 with chronic pain syndrome, which sometimes manifests as back pain, and neck pain, and GAD. Tr. 735; GX 11 at 104. The Respondent took a history. J.M. had been involved in a motor vehicle accident injuring his back, neck and lumbar spine. Additionally, he suffered from GAD and hypertension. Tr. 736. The motor vehicle accident source of the injury was not documented. Tr. 853. He had seen an orthopedic surgeon, although it was not documented in the chart. Tr. 853. Without medication, J.M. reported severe pain, 10 or 11 of 10. With medication, he reported three of ten, permitting him to function and to work full time, although the pain levels were not documented in the chart. Tr. 736, 854-55. J.M. reported prior treatments and medication. He had received physical therapy, occupational therapy, hypnosis and acupuncture to no avail, prior to turning to chronic pain management, although these previous therapies were not documented in the chart. Tr. 737, 854. His present medication protocol delivered the best results with the least side effects. Tr. 737. The Respondent probed his psychological history, which included an all-consuming fear.

The Respondent performed a comprehensive physical exam. Tr. 739. To obtain informed consent to prescribe J.M. controlled substances, the Respondent went over the pain management contract, which J.M. also read and signed. The Respondent cautioned J.M. about diversion and red flags of doctor shopping and pharmacy hopping, which would result in discharge. Tr. 739-40. The Respondent noted that J.M. is a very well-respected man. He's very well-known in the com-

munity. Tr. 740.[16] The Respondent then discussed the beneficial aspects of the pain medication and potential negative effects if abused. J.M. never gave any indication he represented a risk of diversion. Tr. 741. Previous to seeing the Respondent, J.M. was on a higher MME of opioids. He was able to reduce the dosages to the level he was on when he first saw the Respondent. He remains on that dosage. Again, he is able to function, to work full-time on this dosage. Tr. 742. The Respondent noted that J.M. would sometimes try to avoid taking his medication, even if he suffered pain, as explanation for the breaks in prescribing. Tr. 743.

The Respondent denied ever using a different first name for J.M., or using a different birth date for him. Tr. 778-82.

5. Patient B.C.

Patient B.C. has been a patient of the Respondent since March 27, 2014. Tr. 750-51. Patient B.C. has been prescribed Hydrocodone, Xanax and Adderall. Tr. 749. The Respondent obtained a complete history, a complete physical exam and then probed the complaint which brought him to the Respondent, which was right shoulder and chronic back pain. Tr. 751. Without medication, B.C. reported pain at seven or eight, with medication, one or two. Tr. 752. As far as his medication history, B.C. had been on pain medication for years following a neurosurgical procedure to

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16 J.M.'s prestigious background will not be considered. It is an unnoticed matter that the government would have no way of checking or countering.

treat a herniated disc with radiculopathy.[17] Tr. 752. To obtain informed consent, the Respondent discussed the pain management contract, which B.C. read and signed. Tr. 752-53. The Respondent then discussed side effects of the medication. B.C. is a married man with three children. He works full time. He gave the Respondent no indication he was a risk of diversion. Tr. 753. Regarding prior alternate treatment, B.C. reported that he has tried surgery, physical therapy and acupuncture, but that only pain medication therapy alleviates his pain to the extent he can function. Tr. 754. At each visit, the Respondent reviewed B.C.'s progress and believed B.C.'s condition warranted the medication he was prescribed. Tr. 754, 757. Although the Respondent remembered discussing B.C.'s pain levels on March 27, 2014, that it was one or two on medication, he conceded it was not documented in the chart. Tr. 832-34; GX 5 at 48. Although the Respondent remembered B.C. reporting he had a herniated disc, this report was not documented in the chart. Tr. 836. Neither were B.C.'s reported prior therapies documented. Tr. 837.

6. Patient J.C.

Patient J.C. presented on May 18, 2009 with chronic back pain, ulcerative colitis and GAD. Tr. 759-60, 761-62. He was prescribed Hydrocodone, and Xanax, sometimes substituted with Valium. Tr. 759. The Government prompted the Respondent to visits

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[17] The Government objected to B.C.'s prior treatment history, which was not noticed in the RPHS. I ruled it was reasonably anticipated. The Respondent cited to specific treatment from a prior physician. The contested evidence is reflected in GX 5 at 14, so the Government was certainly not surprised by the evidence.

in which several other controlled substances were prescribed. Tr. 842-46; GX 7 at 181, 214, 215.

He had suffered multiple injuries, and had been immobile for some time. However, the Respondent did not document the injuries or the immobility in the chart, nor did the file contain any prior medical records.[18] Tr. 839, 842; GX 7 at 216. He had undergone physical therapy, occupational therapy and finally pain management, which permitted him to resume working full-time. These alternate treatments and therapies and prior surgeries were not documented within the chart. Tr. 840. The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit. Tr. 840. The Respondent performed a full exam on J.C. .

Tr. 760-61. His GAD resulted from his ulcerative colitis. Tr. 762. The Respondent obtained informed consent to prescribe controlled substances by explaining the pain contract, after J.C. read it and signed it. Tr. 763. The Respondent explained the dangers of overdose. Tr. 764. The Respondent had no concerns over J.C. diverting his medication. Tr. 764-65. On the basis of J.C.'s considerable injuries and condition, the Respondent felt J.C.'s medication protocol was fully justified. Tr. 765. The Respondent denied ever intentionally misspelling J.C.'s first name. Tr. 765-66. Although the Respondent remembered J.C. reporting that he had seen two previous doctors, including a pain physician, that report was not reflected in the chart. Tr. 841-42. Although the Respondent remem-

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[18] The Respondent again explained the difficulty in obtaining prior medical records. Tr. 842

bered performing a complete mental health evaluation on J.C., it is not documented in the chart. Tr. 842.

7. Patient D.D.

Patient D.D. first presented on July 9, 2008 with GAD and severe back pain, although the source of the back injury was not documented. Tr. 767-68, 850; GX 9 at 74. Over the course of treatment, the Respondent prescribed Hydrocodone, Xanax and Soma. Tr. 850. The Respondent added that he probably prescribed Valium, as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent remembered D.D. was prescribed Valium, Hydrocodone and Soma the first visit. Tr. 851-52. The Respondent believes his treatment was within the standard of care in California. The Respondent took a complete medical history, family history, personal history and medication history. Tr. 768. The family history was not documented in the chart. Tr. 848. The Respondent explained that the family history was not documented because it was non-contributory to his assessment. Tr. 848. There was no heart conditions in his family, etc. Tr. 849. The Respondent did document that D.D. was married, which he deemed contributory. Tr. 849. D.D. had a dirt bike accident, which shattered his shoulder and fractured several ribs, although the accident source of the injury was not documented. Tr. 850. He underwent physical therapy, occupational therapy after treatment by an orthopedic surgeon, although it was not documented within the chart. Tr. 769, 771, 850-51. It was several years before he reached the medication regimen he was on when he first reported to the Respondent. The Respondent performed a full physical exam. He established informed consent with the pain contract and discussion of side effects and

overdose, as with all his patients. Tr. 770. He cautioned D.D. regarding diversion and other red flags. Again, D.D. gave no indication of diversion. Tr. 771. Patient M.B.

Patient M.B. presented on April 19, 2006 with severe back pain, left knee pain and history of dyslipidemia. Tr. 782. The Respondent obtained a full medical history, medication history, pain level, performed a complete head to toe physical exam. Tr. 783. The Respondent discovered M.B. had chronic back pain related to an injury, a knee injury, which was manageable, and dyslipidemia. Tr. 784. Although the Respondent maintains he obtained a complete medical history as to the back pain, and chronic knee pain, he concedes it is not detailed in the chart. Tr. 82023. He was already on Hydrocodone, previously prescribed, when M.B. first saw the Respondent. The Respondent obtained informed consent in the same manner as described for his earlier patients. Tr. 784. He discussed alternative forms of treatment with M.B., however M.B. had exhausted those. M.B. had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827. The Respondent conceded he did not document these therapies in the chart. Tr. 828. The Respondent monitored M.B. throughout his treatment. Tr. 785. The Respondent believed his prescribing was justified on the basis of M.B.'s medical conditions, level of chronic pain and present level of functioning, working in a welding factory, and in the movie business. Tr. 786, 832. The Respondent conceded that he did not document M.B.'s degree of pain, but minimized the value of the subjective pain scale. Tr. 823-24. The Respondent conceded there were imaging reports in M.B.'s chart, but explained that these patients were from the movie business.

They were treated by an HMO, from which is almost impossible to obtain records. Tr. 829.

8. Patient K.S.

Patient K.S. presented June 21, 2007 with chronic back pain. He was later diagnosed with ADD. He was prescribed Hydrocodone, Soma and sometimes Adderall. Tr. 788-89, 861; GX 14 at 110. The Respondent added that he may have also prescribed Xanax, but it is difficult to be sure with hundreds of patients and treatment dating back fifteen years. Tr. 859. Even with a "good memory, sometimes you just miss something". Tr. 859. Additionally, he noted that many times patients don't disclose all of their medications at the initial visit, if they have plenty and don't then need them to be refilled. So, he is not always aware of all of their medications at the initial visit. Tr. 860-62.

The Respondent believed his treatment was within the standard of care for California. The Respondent obtained a full medical history, medication history, pain level, and performed a complete head to toe physical exam. Tr. 789. The Respondent discovered K.S. had chronic back pain related to a bike accident, for which he had been treated by several doctors for several years, although the bike accident source of the injury and treatment by other doctors was not documented. Tr. 856-57, 859. Additionally, there were no records from prior treatment in the patient's records. Tr. 857. Although the Respondent explained that he requested the prior medical records, none were provided. The Respondent explained that his request for records is simply faxed to the previous physician's office. Tr. 857-58. Its absence from the file probably resulted in a staffer forgetting to file it. Tr. 858. The

Respondent did not contest the Government's observation that no requests for previous medical records were in any of the seven patient files. Tr. 859. He was already on Hydrocodone, when K.S. first saw the Respondent. The Respondent obtained informed consent in the same manner as described for his earlier patients. Tr. 790. He discussed alternative forms of treatment with K.S. K.S. was obtaining physical therapy prior to seeing the Respondent. He continued physical therapy after beginning treatment with the Respondent. Tr. 791. The Respondent monitored K.S. throughout his treatment. Tr. 791. K.S. presented no indications of diversion. The Respondent has treated K.S. for thirteen years, during which time K.S. got married and had three children. Tr. 790-91.

The Respondent noted that, to the best of his knowledge, none of his thousands of patients have suffered any harm from his medication treatment. Tr. 793. The Respondent disagreed with Dr. Munzing's assertion that he could perceive of no medical condition justifying the dangerous combinations of medications identified herein. Tr. 794-800. The Respondent conceded the potential danger of individual pain medications, and the potential increase in risk in combination with other medications. However, if patients are responsible and take the medications as prescribed for the indications intended, these combinations are fairly safe. Tr. 800.[19]

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[19] Although the government objected to this opinion by the Respondent, I overruled its objection. A general disagreement by the Respondent of the government expert's opinion is certainly reasonably anticipated. The Respondent did not cite to any unnoticed medical practice guide, medical theories or other basis for his contrary opinion. The government was readily able to

The Respondent recognized his obligations to follow all federal and state rules concerning the practice of medicine, including the directives of the California Board of Medicine. Tr. 862. Compliance with Controlled Substance Laws and Regulations, includes a provision on records. Tr. 864; GX 20 at 61. It mandates, [t]he physician and surgeon should keep accurate and complete records according to the items above between the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan. Tr. 864-65. The provision further requires, "[a] medical history and physical examination must be accomplished . . . this includes an assessment of the pain, physical and psychological function". Tr. 866; GX 20 at 59. The Respondent assured that the necessary assessments were made, but not fully documented. Tr. 866-67. The Respondent made the same assurances for the requirement as to "Treatment Plan Objectives", "Informed Consent", and "Periodic Review", noting these Guidelines were published in 2013.[20] Tr. 867-72. On February 2, 2017, the Respondent prescribed Soma to S.B. Tr. 875; GX 1 at 59. By March 1, 2017, Soma had been discontinued, yet the chart reflected no rationale for that change in medication regimen. Tr. 876-77. As the Respondent varied his prescribing between Soma and

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confront the Respondent's opinion. The Respondent's opinions were not considered expert opinions.

[20] *See* Tr. 950-52. Dr. Munzing testified credibly that the 2013 version was the 7th edition and the basic requirement have not changed over the years

Xanax, he conceded he did document the reason for the variation in medication. Tr. 878-83. The Respondent conceded he did not document the rationale for the change in medication for J.M. and K.S. as well. Tr. 885. Similarly, the Respondent conceded he did not document pain level, function level and quality of life in the seven charged patients Tr. 885-87; GX 20 at 61. The Respondent reiterated that, to his knowledge, none of his patients exhibited red flags, or violated the pain agreement. Tr. 888-89.

REBUTTAL TESTIMONY

Desiree Johnson

DI Johnson identified a CURES Audit Report for the Respondent's Registration number. Tr. 893-94; GX 24. The audit report shows each time the Respondent accessed CURES to run a query on patients. Tr. 894. This particular audit includes data from January 1, 2016 through January 13, 2020. DI Johnson also identified GX 25, which is a CURES Audit Report run on the DEA Registration of Dr. Bruce Stark, which included the patient S.B., a patient common to the Respondent. Tr. 904. Between October 10, 2018 and September 11, 2020, Dr. Stark prescribed Suboxone[21] to M.B. Tr. 909; GX 24, 25, 25B. On March 15, 2019, the Respondent accessed CURES and would have observed M.B. was receiving Suboxone from Dr. Starks. Tr. 910; GX 24. DI Johnson identified GX 26, an additional CURES Audit Report, one for Dr. Steinberg, which spanned from January 2017 to September 2020, and which shared a common patient with the Respondent,

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[21] Buprenorphine.

J.M. Tr. 911-13; GX 26, 26B.Dr. Steinberg similarly prescribed Suboxone to J.M. from January 2017 to August 2020. Tr. 913. The CURES Audit of the Respondent demonstrated he accessed the CURES database during the period J.M. was prescribed Suboxone by Dr. Steinberg, which would have been evident by this review. Tr. 914.

Dr. Munzing

Dr. Munzing repeatedly gave his opinion regarding the credibility of the Respondent's testimony. I find that Dr. Munzing's opinion as to the Respondent's credibility is beyond Dr. Munzing's qualified expertise and invades the prerogative of the fact finder. Accordingly, those opinions will not be considered herein.[22]

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[22] *United States v. Candoli*, 870 F.2d 496, 506 (9th Cir. 1989) (The jury must decide a witness' credibility); *United States v. Binder,* 769 F.2d 595, 602 (9th Cir.1985) (overruled on other grounds). An expert witness is not permitted to testify specifically to a witness' credibility or to testify in such a manner as to improperly buttress a witness' credibility. *Id. Dr. Poole-Ward v. Affiliates for Women 's Health, P.A.* 329 F.R.D. 156, USDC, S.D. Tx, (2018) (A district court may admit expert testimony to help "the trier of fact to understand the evidence or to determine a fact in issue." FED. R. EVID. 702(a). "An expert may base an opinion on facts or data in the case that the expert has been made aware of or personally observed." *Id.* 703. "As a general rule, an expert may not opine on another witness' credibility because this testimony does not help the trier of fact, who can make its own credibility determinations." *Nagle v. Sheriff Marlin Gusman*, No. 12-1910, 2016 WL 541436, at *4 (E.D. La. Feb. 11, 2016) (citing *United States v. Hill*, 749 F.3d 1250, 1260 (10th Cir. 2014)); *see also Engesser v. Dooley*, 457 F.3d 731, 736 (8th Cir. 2006); *Nimely v. City of New York*, 414 F.3d 381, 397–98 (2d Cir. 2005). "The jury is solely responsible for determining the weight and credibility of the evidence." *United States v. Williams*, 132 F.3d 1055, 1059 (5th Cir. 1998).

Dr. Munzing opined on the importance of documentation within medical records, including medical history, pain levels. Tr. 917, 936-38. He noted that documentation was not just for the then treating physician. It was important for other physicians, perhaps years later, who may treat the patient in an emergency room setting. He reiterated that the elements identified in the Board of Medicine's Guidelines on documentation are part of the standard of care. Tr. 917-18; GX 20, pp. 59, 60, 61. He noted the lapse in documentation regarding the history, pain levels, mental health exams, treatment plans the Respondent testified he performed for each patient. Tr. 916, 921-22. Dr. Munzing observed that the examination described by the Respondent for fibromyalgia was medically deficient and inconsistent with the standard of care, as it did not include a musculoskeletal exam. Tr. 918-20. Dr. Munzing observed that the standard of care applies to electronic records as well as written records. It does not matter whether the physician documents electronically or in writing, the standard remains the same. Tr. 922.

Regarding the Respondent's testimony that he would continue patients on medication prescribed by previous physicians, if they reported they were doing well on the medication, Dr. Munzing opined that additional independent evaluation by the Respondent was necessary to comply with the standard of care. Tr. 923-27, 928-29. Dr. Munzing observed that the Respondent's warnings regarding the potential for overdose were not consistent with the standard of care. Tr. 927. The Respondent's caution that overdose was a potential if the patients took the medication other than as directed, Dr. Munzing believed was misleading and contrary to the standard of care. Tr. 927, 929-31.

Regarding the Respondent's explanation that he only documented the condition of which the patient was complaining, and didn't document all the medications the patients were already on when coming to his clinic, Dr. Munzing opined such practice was inconsistent with the standard of care, noting documentation was not just to remind the treating physician, but to alert any physician who may treat the patient. Tr. 931-34. Dr. Munzing also criticized the Respondent's handling of situations in which patients reported they still had medication remaining from the previous month. Rather than simply refraining from prescribing additional medication, Dr. Munzing indicated that situation should trigger a discussion with the patient and evaluation whether the existing level of medication is appropriate, whether titration is warranted. Tr. 934-36. Dr. Munzing deemed the Respondent's prescribing 10 mg a day of Xanax to J.M. to treat GAD and panic attacks as excessive and contrary to the standard of care. Tr. 938-39. Dr. Munzing deemed the Respondent's reluctance to reduce the opioid dosage lest the patient suffer pain or withdrawal symptoms misguided. Tr. 941. Titration of high opioid dosage of high risk patients or exploration of alternate treatment is consistent with the standard of care. Tr. 941. Dr. Munzing was critical of the Respondent's handling of J.M. and S.B. after discovering they were being prescribed Suboxone by other physicians. Tr. 941-48. Suboxone is typically prescribed for opioid use disorder or addiction. Tr. 943. It directly violates the Respondent's pain contract for these patients, yet the Respondent took no action and continued to prescribe opioids. Tr. 947.

THE FACTS

STIPULATIONS OF FACT

The Government and the Respondent have agreed to the below stipulations, which I recommend be accepted as fact in these proceedings:

1. Government Exhibit No. 1 is a true and correct copy of Respondent's patient file for [23] ("Patient S.B.").

2. Respondent issued at least the following prescriptions to Patient S.B.:3. Government Exhibit No. 2 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient S.B.

Date Issued	Drug	Dosage	Dosage Units
2/2/2017	Norco	10-325 mg	200
2/2/2017	Soma	350 mg	90
2/2/2017	Adderall	30 mg	60
3/1/2017	Norco	10-325 mg	200
3/1/2017	Xanax	2 mg	90

3. Government Exhibit No. 2 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient S.B.

4. Government Exhibit No. 3 is a true and correct copy of Respondent's patient file for ("Patient M.B.").

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[23] Although the original stipulations include the patients' full names, for concerns of patient privacy, and in the absence of any relevance, the full names are not included herein. The patients are referred to by their initials.

5. Respondent issued at least the following controlled substance prescriptions to Patient M.B.:

Date Issued	Drug	Dosage	Dosage Units
3/1/2017	Adderall	30 mg	60
4/4/2017	Norco	10-325 mg	200
4/4/2017	Xanax	2 mg	90
4/4/2017	Adderall	30 mg	60
5/8/2017	Norco	10-325 mg	200
5/8/2017	Adderall	30 mg	60
5/8/2017	Soma	350 mg	90
6/2/2017	Norco	10-325 mg	200
6/2/2017	Adderall	30 mg	60
6/2/2017	Soma	350 mg	90
6/28/2017	Norco	10-325 mg	180
6/28/2017	Xanax	2 mg	90
6/28/2017	Adderall	30 mg	60
8/1/2017	Norco	10-325 mg	200
8/1/2017	Soma	350 mg	90
8/1/2017	Adderall	30 mg	60
8/30/2017	Norco	10-325 mg	200
8/30/2017	Soma	350 mg	90
8/30/2017	Adderall	30 mg	60
9/29/2017	Norco	10-325 mg	200
9/29/2017	Adderall	30 mg	60
11/6/2017	Norco	10-325 mg	200

11/6/2017	Soma	350 mg	90
11/6/2017	Adderall	30 mg	60
12/5/2017	Adderall	30 mg	60
1/23/2018	Norco	10-325 mg	200
1/23/2018	Soma	350 mg	30
1/23/2018	Adderall	30 mg	60
4/4/2018	Adderall	30 mg	60
5/18/2018	Adderall	30 mg	60
6/15/2018	Adderall	30 mg	60
7/5/2018	Adderall	30 mg	60
7/13/2018	Norco	10-325 mg	180
8/8/2018	Adderall	30 mg	60
8/13/2018	Norco	10-325 mg	180
9/10/2018	Adderall	30 mg	60
9/12/2018	Norco	10-325 mg	180
10/12/2018	Norco	10-325 mg	180
10/12/2018	Adderall	30 mg	60
11/16/2018	Norco	10-325 mg	180

6. Government Exhibit No. 4 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient M.B., with the exception of the November 20, 2019 prescriptions, which are not included therein.

7. Government Exhibit No. 5 is a true and correct copy of Respondent's patient file for ("Patient B.C.").

8. Respondent issued the at least following controlled substance prescriptions to Patient B.C.:

Date Issued	Drug	Dosage	Dosage Units
1/25/2017	Norco	10-325 mg	200
1/25/2017	Xanax	2 mg	90
1/25/2017	Adderall	30 mg	60
4/18/2017	Norco	10-325 mg	200
4/18/2017	Xanax	2 mg	90
4/18/2017	Adderall	30 mg	60
5/19/2017	Norco	10-325 mg	200
5/19/2017	Xanax	2 mg	90

Date Issued	Drug	Dosage	Dosage Units
6/19/2017	Norco	10-325 mg	200
6/19/2017	Xanax	2 mg	90
6/19/2017	Adderall	30 mg	60
7/17/2017	Norco	10-325 mg	200
2/16/2018	Norco	10-325 mg	180
2/16/2018	Xanax	2 mg	90
3/16/2018	Norco	10-325 mg	180
3/16/2018	Xanax	2 mg	90
4/13/2018	Norco	10-325 mg	180
4/13/2018	Xanax	2 mg	90
5/11/2018	Norco	10-325 mg	180
5/11/2018	Xanax	2 mg	90
6/8/2018	Norco	10-325 mg	180

6/8/2018	Xanax	2 mg	90
7/3/2018	Norco	10-325 mg	180
7/3/2018	Xanax	2 mg	90
7/31/2018	Norco	10-325 mg	180
7/31/2018	Adderall	30 mg	60
7/31/2018	Xanax	2 mg	90
8/28/2018	Norco	10-325 mg	180
9/25/2018	Norco	10-325 mg	180
9/25/2018	Adderall	30 mg	60
10/22/2018	Norco	10-325 mg	180
11/20/2018	Norco	10-325 mg	180
12/19/2018	Norco	10-325 mg	180
12/19/2018	Adderall	30 mg	60
1/16/2019	Norco	10-325 mg	180
2/13/2019	Norco	10-325 mg	180
2/13/2019	Adderall	30 mg	60
3/13/2019	Norco	10-325 mg	90
4/9/2019	Norco	10-325 mg	100
4/9/2019	Adderall	30 mg	60
5/8/2019	Norco	10-325 mg	100
6/5/2019	Norco	10-325 mg	95
6/5/2019	Adderall	30 mg	60
7/2/2019	Norco	10-325 mg	90
7/30/2019	Norco	10-325 mg	90
7/30/2019	Adderall	30 mg	60
8/27/2019	Norco	10-325 mg	90
9/25/2019	Norco	10-325 mg	90

10/25/2019	Norco	10-325 mg	90
10/25/2019	Adderall	30 mg	60

Date Issued	Drug	Dosage	Dosage Units
11/22/2019	Norco	10-325 mg	90
12/19/2019	Adderall	30 mg	60
12/19/2019	Norco	10-325 mg	90

Date Issued	Drug	Dosage	Dosage Units
1/16/2018	Norco	10-325 mg	100
1/16/2018	Valium	10 mg	90
2/16/2018	Norco	10-325 mg	100
2/16/2018	Valium	10 mg	90
3/16/2018	Norco	10-325 mg	100
3/16/2018	Valium	10 mg	90
4/16/2018	Norco	10-325 mg	100
4/16/2018	Valium	10 mg	90
5/16/2018	Norco	10-325 mg	100
5/16/2018	Valium	10 mg	90
6/15/2018	Norco	10-325 mg	100
6/15/2018	Valium	10 mg	90

Date Issued	Drug	Dosage	Dosage Units
7/16/2018	Norco	10-325 mg	100
7/16/2018	Valium	10 mg	90
8/15/2018	Norco	10-325 mg	100
8/15/2018	Valium	10 mg	90
9/13/2018	Norco	10-325 mg	100
9/13/2018	Valium	10 mg	90
10/17/2018	Norco	10-325 mg	100
10/17/2018	Valium	5 mg	90
11/14/2018	Norco	10-325 mg	100
11/14/2018	Valium	10 mg	90
12/13/2018	Norco	10-325 mg	100
12/13/2018	Valium	5 mg	90
1/18/2019	Norco	10-325 mg	100
1/18/2019	Valium	2 mg	90
2/19/2019	Norco	10-325 mg	100
3/14/2019	Norco	5-325 mg	100
4/9/2019	Norco	7.5-325 mg	70
5/6/2019	Norco	5-325 mg	45
5/6/2019	Valium	5 mg	45
6/3/2019	Valium	10 mg	45
7/2/2019	Valium	5 mg	60
8/6/2019	Valium	5 mg	60
8/28/2019	Valium	5 mg	60
10/1/2019	Valium	5 mg	60
10/30/2019	Valium	5 mg	60

11/26/2019	Valium	5 mg	60
12/30/2019	Valium	5 mg	60

9. Government Exhibit No. 6 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient B.C., with the exception of the following prescriptions, which are not included therein:

a. June 19, 2017 prescription for Xanax

b. July 31, 2018 prescription for Xanax

c. September 25, 2019 prescription for Norco

d. October 25, 2019 prescriptions for Norco and Adderall

e. November 22, 2019 prescription for Norco Government Exhibit No. 7 is a true and correct copy of Respondent's patient file for ("Patient J.C.").

10. Respondent issued at least the following controlled substance prescriptions to Patient J.C.:

11. Government Exhibit No. 8 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient J.C., with the exception of the December 30, 2019 prescription for Valium, which is not included therein.

12. Government Exhibit No. 9 is a true and correct copy of Respondent's patient file for ("Patient D.D.").

13. Respondent issued at least the following controlled substance prescriptions to Patient D.D.:

Date Issued	Drug	Dosage	Dosage Units
1/4/2018	Norco	10-325 mg	240
1/4/2018	Soma	350 mg	90
2/2/2018	Norco	10-325 mg	240
2/2/2018	Soma	350 mg	90
3/23/2018	Norco	10-325 mg	180
3/23/2018	Soma	350 mg	90
5/2/2018	Norco	10-325 mg	180
5/2/2018	Soma	350 mg	90
6/6/2018	Norco	10-325 mg	180
6/6/2018	Soma	350 mg	90
7/6/2018	Norco	10-325 mg	180
7/6/2018	Soma	350 mg	90
8/10/2018	Norco	10-325 mg	180
8/10/2018	Soma	350 mg	90
9/19/2018	Norco	10-325 mg	180
9/19/2018	Xanax	2 mg	90
10/16/2018	Norco	10-325 mg	180
10/16/2018	Soma	350 mg	90
11/15/2018	Norco	10-325 mg	180
11/15/2018	Soma	350 mg	90
12/13/2018	Norco	10-325 mg	180
12/13/2018	Soma	350 mg	90
1/11/2019	Norco	10-325 mg	150
1/11/2019	Soma	350 mg	90
2/12/2019	Norco	10-325 mg	180

14. Government Exhibit No. 10 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient D.D. Government Exhibit No. 11 is a true and correct copy of Respondent's patient file for ("Patient J.M.").

15. Respondent issued at least the following controlled substances prescriptions to Patient J.M.:

Date Issued	Drug	Dosage	Dosage Units
1/10/2017	Xanax	2 mg	90
1/25/2017	Norco	10-325 mg	50
1/25/2017	Xanax	2 mg	90
2/16/2017	Xanax	2 mg	90
3/8/2017	Xanax	2 mg	90
3/27/2017	Xanax	2 mg	90
4/13/2017	Xanax	2 mg	90
4/13/2017	Soma	350 mg	50
5/1/2017	Xanax	2 mg	90
5/18/2017	Xanax	2 mg	90
6/2/2017	Xanax	2 mg	90
6/19/2017	Norco	10-325 mg	60
6/19/2017	Xanax	2 mg	90
7/7/2017	Xanax	2 mg	90
7/25/2017	Xanax	2 mg	90
8/14/2017	Norco	10-325 mg	60
8/14/2017	Xanax	2 mg	90
8/30/2017	Xanax	2 mg	90
9/14/2017	Norco	10-325 mg	60

9/14/2017	Xanax	2 mg	90
10/3/2017	Xanax	2 mg	90
10/17/2017	Norco	10-325 mg	60
10/17/2017	Xanax	2 mg	90
11/6/2017	Norco	10-325 mg	60
11/6/2017	Xanax	2 mg	90
11/20/2017	Norco	10-325 mg	60
11/20/2017	Xanax	2 mg	90
12/7/2017	Xanax	2 mg	90
12/21/2017	Xanax	2 mg	90
1/11/2018	Xanax	2 mg	90
1/25/2018	Norco	10-325 mg	60
1/25/2018	Xanax	2 mg	90
2/7/2018	Norco	10-325 mg	60
2/7/2018	Xanax	2 mg	90
2/23/2018	Norco	10-325 mg	60
2/23/2018	Xanax	2 mg	90
3/12/2018	Xanax	2 mg	90
3/28/2018	Norco	10-325 mg	60
4/9/2018	Xanax	2 mg	90
4/9/2018	Norco	10-325 mg	60
4/25/2018	Norco	10-325 mg	60
4/25/2018	Xanax	2 mg	90

Date Issued	**Drug**	**Dosage**	**Dosage Units**
5/2/2018	Soma	350 mg	30

5/11/2018	Norco	10-325 mg	60
5/11/2018	Xanax	2 mg	90
5/23/2018	Norco	10-325 mg	60
5/23/2018	Xanax	2 mg	90
6/11/2018	Norco	10-325 mg	60
6/11/2018	Xanax	2 mg	90
6/27/2018	Norco	10-325 mg	60
6/27/2018	Xanax	2 mg	90
7/11/2018	Norco	10-325 mg	60
7/11/2018	Xanax	2 mg	90
7/25/2018	Xanax	2 mg	90
7/25/2018	Norco	10-325 mg	60
8/13/2018	Soma	350 mg	50
8/13/2018	Xanax	2 mg	90
8/29/2018	Norco	10-325 mg	60
8/29/2018	Xanax	2 mg	90
9/17/2018	Norco	10-325 mg	60
9/17/2018	Xanax	2 mg	90
10/3/2018	Xanax	2 mg	90
10/17/2018	Norco	10-325 mg	60
10/17/2018	Xanax	2 mg	90
11/2/2018	Xanax	2 mg	90
11/7/2018	Norco	10-325 mg	60
11/19/2018	Soma	350 mg	30
11/19/2018	Xanax	2 mg	90
12/5/2018	Norco	10-325 mg	60
12/5/2018	Xanax	2 mg	90

12/21/2018	Xanax	2 mg	90
12/21/2018	Norco	10-325 mg	60
1/9/2019	Xanax	2 mg	90
1/16/2019	Norco	10-325 mg	60
1/23/2019	Xanax	2 mg	90
2/6/2019	Xanax	2 mg	90
2/6/2019	Norco	10-325 mg	60
2/20/2019	Xanax	2 mg	90
3/13/2019	Xanax	2 mg	60
4/5/2019	Xanax	2 mg	60
4/29/2019	Xanax	2 mg	60
5/20/2019	Xanax	2 mg	60
6/10/2019	Xanax	2 mg	60

Date Issued	**Drug**	**Dosage**	**Dosage Units**
9/9/2019	Xanax	2mg	60
9/27/2019	Xanax	2mg	60
10/15/2019	Xanax	2mg	60
11/1/2019	Xanax	2mg	60
11/20/2019	Xanax	2mg	60
12/11/2019	Xanax	2mg	60
12/31/2019	Xanax	2mg	60
1/19/2018	Norco	10-325 mg	200
1/19/2018	Xanax	2 mg	90
1/19/2018	Adderall	30 mg	60
2/27/2018	Norco	10-325 mg	200

2/27/2018	Adderall	30 mg	60
2/27/2018	Xanax	2 mg	90
3/29/2018	Adderall	30 mg	60

16. Government Exhibit No. 12 is a true and correct copy of certain of the above-listed prescriptions that Respondent issued to Patient J.M. Government Exhibit No. 13 is a true and correct copy of fill stickers for certain of the above-listed prescriptions that Respondent issued to Patient J.M.

17. Government Exhibit No. 14 is a true and correct copy of Respondent's patient file for ("Patient K.S.").

18. Respondent issued at least the following controlled substances prescriptions to Patient K.S.:

Date Issued	**Drug**	**Dosage**	**Dosage Units**
1/19/2018	Norco	10-325 mg	200
1/19/2018	Xanax	2 mg	90
1/19/2018	Adderall	30 mg	60
2/27/2018	Norco	10-325 mg	200
2/27/2018	Adderall	30 mg	60
2/27/2018	Xanax	2 mg	90
3/29/2018	Adderall	30 mg	60
3/29/2018	Norco	10-325 mg	200
3/29/2018	Xanax	2 mg	90
4/30/2018	Norco	10-325 mg	200
4/30/2018	Xanax	2 mg	90

5/4/2018	Adderall	30 mg	60
6/8/2018	Norco	10-325 mg	200
6/8/2018	Xanax	2 mg	90
6/14/2018	Adderall	30 mg	60
Date Issued	**Drug**	**Dosage**	**Dosage Units**
7/3/2018	Norco	10-325 mg	200
7/3/2018	Xanax	2 mg	90
7/13/2018	Adderall	30 mg	60
8/3/2018	Norco	10-325 mg	180
8/3/2018	Xanax	2 mg	90
8/13/2018	Adderall	30 mg	60
8/29/2018	Norco	10-325 mg	180
8/29/2018	Xanax	2 mg	90
10/2/2018	Norco	10-325 mg	180
10/2/2018	Xanax	2 mg	90
10/31/2018	Norco	10-325 mg	175
10/31/2018	Xanax	2 mg	90
11/6/2018	Adderall	30 mg	60
11/9/2018	Norco	10-325 mg	200
11/9/2018	Xanax	2 mg	90
11/9/2018	Adderall	30 mg	60
11/28/2018	Norco	10-325 mg	170
11/28/2018	Xanax	2 mg	90
12/11/2018	Adderall	30 mg	60
1/2/2019	Norco	10-325 mg	170
1/31/2019	Norco	10-325 mg	170

19. Government Exhibit No. 15 is a true and correct copy of the above-listed controlled substance prescriptions that Respondent issued to Patient K.S.

20. Government Exhibit No. 16 is a true and correct copy of the California Substance Utilization, Review and Evaluation System ("CURES") report for Respondent for the period of November 20, 2015 to November 21, 2016.

21. Government Exhibit No. 17 is a true and correct copy of the CURES report for Respondent for the period of November 20, 2016 to November 21, 2017.

22. Government Exhibit No. 18 is a true and correct copy of the CURES report for Respondent for the period of November 20, 2017 to November 21, 2018.

23. Government Exhibit No. 19 is a true and correct copy of the CURES report for Respondent for the period of January 6, 2019 to January 6, 2020.

24. Government Exhibit No. 20 is a true and correct copy of the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons" published by the Medical Board of California.

25. Government Exhibit No. 21 is a true and correct copy of the "Guidelines for Prescribing Controlled Substances for Pain" published by the Medical Board of California.

26. Government Exhibit No. 22 contains a true and correct copy of "New Safety Measures Announced for Opioid Analgesics, Prescription Opioid Cough Products, and Benzodiazepines," published by the Food and Drug Administration ("FDA").

27. Government Exhibit No. 22 contains a true and correct copy of the FDA labels for Klonopin, Valium, and Xanax.

FINDINGS OF FACT

The factual findings below are based on a preponderance of the evidence, including the detailed, credible, and competent testimony of the aforementioned witnesses, the exhibits entered into evidence, and the record before me.

During the hearing conducted, via video teleconference, from September 28, 2020, to September 30, 2020, the Government established the following facts through evidence, testimony, or stipulation ("Proposed Findings of Fact" or "PFF"): I. Investigatory Background

1. Desiree Johnson has been employed by the DEA as a Diversion Investigator for three years. Tr. 33.

2. The DEA began investigating Respondent in April of 2018 after receiving a February 2018 report issued by the Department of Health and Human Services indicating that Respondent's prescribing habits presented a high-risk for overprescribing. Tr. 37-38.

3. DEA monitored California's prescription drug monitoring program, known as CURES, and identified several red flags regarding Respondent's prescribing. Tr. 35, 38. CURES reports obtained by DEA were admitted into evidence as Government's Exhibits ("GX") 16, 17, 18, and 19. Tr. 16-18; *see also* Joint Stipulation Nos. 31-34. Among other things, DEA found that (1) Respondent frequently prescribed opioids at their maximum strength, Tr. 38-39; (2) Respondent frequently prescribed patients a combination of an opioid

and a benzodiazepine, Tr. 39; (3) Respondent issued prescriptions for a combination of an opioid, a benzodiazepine, and Carisoprodol – a combination that is highly sought after on the illicit market, and known as "the Holy Trinity," Tr. 40; (4) Respondent prescribed high doses of controlled substances to patients for long periods of time, Tr. 40-41; (5) between November 20, 2015 and November 21, 2018, Respondent issued approximately 9,000 prescriptions for controlled substances, Tr. 39; GX 16; GX 17; GX 18; (6) Over half of those 9,000 prescriptions were for Hydrocodone, and approximately 96 percent of these prescriptions were for either Hydrocodone, alprazolam, or Carisoprodol – which together make up the "Holy Trinity" cocktail. Tr. 39, 42-43; GX 16; GX 17; GX 18.

4. The DEA obtained medical files from Respondent, pursuant to a federal search warrant executed at Respondent's medical clinic in February of 2019, and pursuant to an administrative subpoena issued to Respondent in January of 2020. Tr. 46, 49, 49, 55-56. These included medical files for Patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S. (admitted as GXs 1, 3, 5, 7, 9, 11, and 14; Tr. 16-18).

5. The DEA also obtained prescriptions for the above-mentioned patients (see PFF ¶4) from its search of Respondent's clinic, and from pharmacies at which these prescriptions were filled (admitted as GXs 2, 4, 6, 8, 10, 12, and 15; Tr. 16:15-18:3). The DEA also obtained fill stickers for certain prescriptions issued to Patient J.M. from one of the pharmacies at which Patient J.M. filled prescriptions Respondent issued to Patient J.M. (admitted as GX 13; Tr. 16:15-18:3).

9. II. The Government's Expert's Qualifications

6. Dr. Munzing's curriculum vitae was admitted into evidence as GX 23; Tr. 89. He is a licensed physician in the state of California, who has worked in the field of family medicine for nearly forty years. Tr. 89.

7. Dr. Munzing received his medical degree from the University of California, Los Angeles, in 1982, and did his residency at Kaiser Permanente Medical Center in Los Angeles. Tr. 89. He then began working in the family medicine department of Kaiser Permanente Orange County, where he has been for the last thirty-five years, twice serving as president of the hospital. Tr. 89, 94. He has a DEA COR and an active clinical practice, prescribing, inter alia, opioids, benzodiazepines, and other controlled substances when indicated. Tr. 91-92.

8. In addition to his clinical practice, Dr. Munzing teaches extensively to physicians, serving as the director of the Kaiser Permanente Orange County family medicine residency program. Tr. 90. Further, he is a full clinical professor at University of California, Irvine. Tr. 91. He also sits on the National Accreditation Board for Family Medicine Residency, which accredits all of the residency programs in the United State of America. Tr. 90-91.

9. Dr. Munzing has been called upon to provide opinions about the prescribing of other medical professionals, and he has been qualified as an expert witness in over 30 cases, including in DEA administrative hearings. Tr. 93-94.

10. As a licensed California physician who has been practicing in California for nearly 40 years, Dr. Munzing is familiar with the standard of care for prescribing controlled substances in California. He also has reviewed publications by the Medical Board of California that inform his understanding of the standard of care, including the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons (7th Edition)" (admitted as GX 20, Tr. 16-18), and the "Guidelines for Prescribing Controlled Substances for Pain," (admitted as GX 21, Tr. 16). In addition, he is familiar with the FDA's black box warning regarding the risks of overdose and death posed by concurrently taking opioids and benzodiazepines, and the FDA labels for benzodiazepines including Klonopin, Valium, and Xanax (admitted as GX 22, Tr. 16-18). Further, Dr. Munzing reviewed several laws and regulations that informed his understanding of the standard of care. Tr. 99.

11. Dr. Munzing was qualified as an expert in California medical practice, including, but not limited to, applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine. Tr. 102.

10. III. The Standard of Care for Prescribing Controlled Substances in California

12. Dr. Munzing testified that the standard of care in California first requires that, before prescribing controlled substances, a practitioner perform a sufficient evaluation of the patient, including, a medical history and appropriate physical examination. Tr. 103.

a. In the context of treating a patient with controlled substances for pain, the standard of care in the state of California requires the following:

i. Medical history: The practitioner must obtain detailed information about the pain, including where the pain is, how long a patient has had it, how severe the pain is, the impact of the pain on the patient's functionality and activities of daily living, and any previous diagnoses and treatments the patient has received for the pain. The practitioner must also seek to obtain any relevant prior medical records and imaging. Tr. 114-115.

ii. Physical examination: The practitioner must look at the area of pain unclothed for any swelling, redness, or mass. Tr. 116-17. The practitioner must palpate the affected area and identify areas of particular tenderness or pain. Tr. 117-18. The practitioner also is required to test a patient's range of motion, as well as the patient's neurological conditions via targeted tests for the area affected by pain (*e.g.*, tendon reflexes, and strength tests for the affected area). Tr. 118-19.

b. In the context of treating a patient with controlled substances for mental health conditions, the standard of care in the state of California requires the following:

i. Medical history: The practitioner must inquire into the patient's condition, including symptoms the patient is experiencing, when the patient experiences symptoms,

how those symptoms impact the patient's functionality and activities of daily living, when the condition began, and if there is a family history of mental health issues. The practitioner must also seek to obtain any relevant prior medical records. Tr. 136-38.

ii. Physical examination: The practitioner must conduct a general examination, including heart, lungs, and vital signs. Tr. 138-39.

13. The practitioner must inquire into the patient's history of, and/or current use or abuse of, tobacco, drugs, or alcohol, as well as into any family history of use or abuse of tobacco, drugs, or alcohol. Tr. 120-21, 142.

14. On the basis of this evaluation, the practitioner must then assign a diagnosis to the patient. Tr. 103. An appropriate history and physical examination are crucial to arriving at an appropriate diagnosis. Tr. 121-22, 141. Without an appropriate diagnosis, a practitioner cannot establish a legitimate medical purpose to prescribe. 124, 141.

15. Next, the practitioner must determine the risk posed to a patient by controlled substances due to the patient's overall health history – as well as the potential for substance abuse or addiction – and then develop a customized treatment plan for the patient with goals and objectives. Tr. 103, 109. The practitioner must relay that plan to the patient, inform the patient of the risks and benefits of treatment with controlled substances, as well as potential alternative treatments, and obtain the patient's informed consent for the treatment. Tr. 103-04, 124-25. When prescribing high dosages of controlled substances, this discussion

of risks must include risks of addiction, overdose, and death. Tr. 126-27.

a. In the context of treating a patient with controlled substances for pain, the standard of care in the state of California requires that a treatment plan contain goals and objectives for pain management, such as maximizing benefit to function and minimizing pain, while also minimizing the risk to the patient from the controlled substances prescribed. Tr. 131.

b. In the context of treating a patient with controlled substances for mental health conditions, the standard of care in the state of California requires that the treatment plan contain goals and objectives for the patient. Tr. 143.

c. With respect to risks of medications, Dr. Munzing explained that practitioner should only co-prescribe opioids and benzodiazepines when "absolutely necessary," and should so for "[n]o longer than absolutely necessary and typically in as low doses as possible to . . . decrease the risk." Tr. 154-55.

16. As treatment progresses, a physician must monitor the patient. Tr. 104. A practitioner must periodically update the patient's medical history, conduct further physical examinations, and obtain updated information regarding the etiology of a patient's state of health. Tr. 106-08. The practitioner must periodically review the course of treatment, ascertain how the patient is responding thereto, determine if continued treatment is appropriate or if the treatment plan needs to be modified, and document the rationale for any modifications. Tr. 108-09, 206; GX 20 at 61.

The practitioner must also periodically re-inquire into the patient's use of abuse of, tobacco, drugs, or alcohol Tr. 259-60.

17. The practitioner must also periodically conduct updated physical examinations both brief general examinations to ensure that the patient is healthy enough to continue receiving controlled substances, as well as focused examinations of the area for which pain is being treated to help in determining how the patient is responding to treatment. Tr. 111-12.

18. When prescribing controlled substances, the standard of care in California also requires a practitioner to monitor medication compliance, including through reviews of CURES, Tr. 132:1-5, and periodic urine drug screening, Tr. 133. The practitioner must address any red flags of abuse or diversion. Tr. 112.

19. In addition, the practitioner must document all of these above steps (see PFF ¶¶ 12-18) in detail. *See*, *e.g.*, Tr. 104, 109, 110, 112, 122, 135, 144. Such documentation is critically important as it (1) enables the practitioner to recall important facts about the patient's state of health and treatment, Tr. 145, 146, and (2) allows other practitioners who may also see the patient to see these facts. Tr. 145-146.

20. Appropriate documentation is a well-known, fundamental requirement in the medical community. Tr. 146. Thus, it is not credible that a practitioner who consistently failed to document these basic elements for a patient actually performed them. Tr. 148-50.

21. The practitioner must also comply with all relevant California law.

11. IV. Respondent's Improper Prescribing of Controlled Substances

A. Patient S.B.

i. Patient S.B.'s initial visit

22. Between February 2, 2017 and January 30, 2019, Respondent issued Patient S.B. the controlled substance prescriptions listed in Joint Stipulation No. 10. *See* ALJ Ex. 3 at 2-3. During this time, Respondent diagnosed Patient S.B. with fibromyalgia, generalized anxiety disorder ("GAD"), and attention deficit disorder ("ADD"). GX 1 at 47-59.

23. Respondent's initial encounter with Patient S.B. took place on August 3, 2016. GX 1 at 62, 66; Tr. 164-65. At that visit, Respondent diagnosed Patient S.B. with fibromyalgia, GAD, and ADD. GX 1 at 62; Tr. 165. Respondent prescribed Patient S.B. Norco for fibromyalgia, Xanax for GAD, and Adderall for ADD. GX 1 at 62; Tr. 165. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 1 at 62; Tr. 166-68;

b. address Patient S.B.'s pain or functionality levels, GX 1 at 62; Tr. 171;

c. conduct an appropriate physical examination, GX 1 at 62; Tr. 166, 16871;

d. establish appropriate diagnoses, and therefore to establish legitimate medical purposes for Norco, Xanax, or Adderall, Tr. 171-72; or

e. establish and document a treatment plan with goals and objectives, GX 1 at 62; Tr.

172-73. ii. Continued Controlled Substance Prescribing Violations

24. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient S.B., never recorded Patient S.B.'s pain or functionality levels, never obtained prior medical records for Patient S.B. – nor does Patient S.B.'s medical file reflect Respondent requested such records – failed to periodically update Patient S.B.'s medical history as treatment progressed, and never conducted a sufficient physical examination for fibromyalgia. *See generally* GX 1; Tr. 241-43.

25. None of Respondent's diagnoses of Patient S.B. for which he prescribed controlled substances were based on sufficient clinical evidence. Tr. 243.

26. Over the course of his treatment of Patient S.B., Respondent's diagnoses of Patient S.B. for and GAD and fibromyalgia came and went without explanation or comment. *See generally* GX 1; Tr. 188, 193-95. Fibromyalgia and ADD are chronic diagnoses. Tr. 1888, 193. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between February 2, 2017 and January 30, 2019 – were likely not credible. Tr. 191-92; 195-97.

27. Respondent sometimes prescribed Patient S.B. both Norco and Soma, and sometimes only Norco, for fibromyalgia. See GX 1 at 47-59; Tr. 197:3-17. Respondent never documented any rationale for so changing Patient S.B.'s course of medication, in violation of the California standard of care. See GX 1 at 47-59; PFF ¶ 16; Tr. 199-200.

28. Respondent never documented an appropriate treatment plan with goals and objectives for Patient S.B., never documented an appropriate rationale for continued treatment of Patient S.B. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient S.B. *See generally* GX 1; Tr. 243.

29. Respondent also prescribed Patient S.B. the following dangerous combinations of controlled substances that put Patient S.B. at serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 203-05:

a. Norco, Adderall, and Soma on February 2, 2017; May 8, 2017; June 2, 2017; August 1, 2017; August 30, 2017; November 6, 2017; and January 23, 2018. ALJ Ex. 3 at 2-3.

b. Norco, Adderall, and Xanax on March 1, 2017; April 4, 2017; June 28, 2017. ALJ Ex. 3 at 2-3.

c. Norco and Adderall on September 29, 2017; July 2018; and in August 2018; September 2018; October 2018; and November 2018. ALJ Ex. 3 at 3.

30. Respondent's prescriptions to Patient S.B. for Xanax between February 2, 2017 and January 30, 2019 were all for 6 mg of Xanax per day. GX 1 at 5759; Tr. 212-13. The maximum recommended dosage for Xanax for treatment of GAD is 4 mg per day, according to the FDA label for Xanax. GX 22 at 59; Tr. 213. Prescribing such high dosages of Xanax placed Patient S.B. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 217, 21819. The fact that Respondent prescribed Xanax to Patient S.B.

concurrently with opioids, see ALJ Ex. 3 at 2-3, dramatically increased her risk of overdose and death. Tr. 217-18.

31. Respondent noted, on fifteen occasions between February 2, 2017 and December 21, 2018, that Patient S.B. was opioid dependent, and refusing detoxification. GX 1 at 49-59. Refusal to detoxify is a significant red flag of abuse or diversion, indicating the prescriber feels the patient needs to detoxify, but the patient refuses. Tr. 221-22. Respondent never addressed this red flag, but simply continued to prescribe the patient opioids on an as-needed basis. GX 1 at 49-59; Tr. 222. Prescribing opioids to the patient on an as-needed basis when a patient is refusing detoxification is particularly inappropriate because if opioids are prescribed at all to such a patient, it must be on a carefully controlled basis. Tr. 223.

32. Patient S.B. provided inconsistent information to other providers, including telling an orthopedic surgeon on a June 28, 2017 visit that she had only a past medical history of anxiety (with no mention of fibromyalgia or ADD), and did not disclose taking any medications, when she was receiving Norco, Soma, Adderall, and Xanax from Respondent. See GX 1 at 30, 57. Patient S.B. also informed the orthopedic surgeon that she had no history of trauma, see GX 1 at 30, but reported to the California Employment Development Department that she was disabled as a result of accident or trauma that had occurred on June 15, 2017, see GX 1 at 40. These inconsistent reports were significant red flags of abuse or diversion. Tr. 230, 231-32. Respondent, however, never addressed these red flags. Tr. 233, 235-37.

33. Respondent never conducted a urine drug screen on Patient S.B., in violation of the California standard of care. Tr. 219:13-16; PFF ¶ 18; *see generally* GX 1.

34. None of the controlled substance prescriptions Respondent issued to Patient S.B. between February 2, 2017 and January 30, 2018 were issued for a legitimate medical purpose, or by a practitioner acting within the usual course of professional practice. Tr. 244. Indeed, no patient should receive the drugs that Respondent prescribed to Patient S.B. in the dosages, durations, and combinations that Respondent prescribed. Tr. 211-12.

B. Patient M.B.

35. Between January 5, 2018 and November 20, 2019, Respondent issued to Patient M.B. the controlled substance prescriptions listed in Joint Stipulation No. 13. See ALJ Ex. 3 at 4-5. During this time, Respondent diagnosed Patient M.B. with back pain, ADD, and opioid dependency. GX 3 at 24-37.

i. Patient M.B.'s Initial Visit and the First Diagnosis for ADD

36. Respondent's initial encounter with Patient M.B. took place on April 19, 2006. GX 3 at 84, 91; Tr. 248-49. At that visit, Respondent diagnosed Patient M.B. with chronic back pain, chronic left knee pain, and dyslipidemia. GX 3 at 84; Tr. 250-51. Respondent prescribed Patient M.B. Norco for chronic back and left knee pain. GX 3 at 84. At this initial visit, Respondent failed to

a. take an appropriate medical history, GX 3 at 84; Tr. 252-54;

b. address Patient M.B.'s pain or functionality levels, GX 3 at 84; Tr. 257;

c. conduct an appropriate physical examination, GX 3 at 84; Tr. 254-56, 257;

d. establish appropriate diagnoses for back pain and knee pain and therefore to establish a legitimate medical purpose to prescribe Norco, Tr. 258; or

e. establish and document a treatment plan with goals and objectives, GX 3 at 84; Tr. 258.

37. Respondent first diagnosed Patient M.B. with ADD on July 9, 2013, and prescribed 30 mg of Adderall per day. GX 3 at 46. No history was taken, nor evaluations performed, for ADD other than a note saying Patient M.B. presented as a "40 yom with ADD, neck[]pain." GX 3 at 46; Tr. 262. Nothing supported Respondent's diagnosis for ADD, and he did not establish a legitimate medical purpose to prescribe Adderall. Tr. 263. Nor did he establish and document a treatment plan with goals and objectives for the Adderall. GX 3 at 46; Tr. 263. ii. Continued Controlled Substance Violations

38. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient M.B., recorded Patient M.B.'s pain or functionality levels, or obtained prior medical records for Patient M.B. – nor does Patient M.B.'s medical file reflect Respondent requested such records – failed to periodically update Patient M.B.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 3; Tr. 287-88.

39. None of Respondent's diagnoses of Patient M.B. for which he prescribed controlled substances between January 5, 2018 and November 20, 2019 were based on sufficient medical evidence. Tr. 288.

40. Over the course of his treatment of Patient M.B., Respondent frequently changed without comment the diagnoses for which he prescribed Patient M.B. Norco. *See generally* GX 3; Tr. 275-78. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 5, 2018 and November 20, 2019 – were likely not credible. Tr. 278-80.

41. Other than inquiring into smoking and alcohol use at Patient M.B.'s initial visit, see GX 3 at 84, Respondent did not inquire about current or past substance abuse until over three years later, on August 11, 2009, when he had Patient M.B. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 3 at 94. Patient M.B. was never asked about substance abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 261; *see generally* GX 3.

42. Respondent never documented an appropriate treatment plan with goals and objectives for Patient M.B., never documented an appropriate rationale for continued treatment of Patient M.B. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient M.B. *See generally* GX 3; Tr. 288-89.

43. Respondent also prescribed Patient M.B. dangerous combinations of Norco and Adderall approx-

imately monthly from January 2018 until July 2019, and once again on November 20, 2019. ALJ Ex. 3 at 4-5. These combinations put Patient M.B. at serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 105-06, 281.

44. Respondent noted, on at least 11 occasions between March 6, 2018 and February 4, 2019, that Patient M.B. was opioid dependent, and refusing detoxification. GX 3 at 30, 32-36. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 3 at 30, 32-36; *see also* Tr. 286-87.

45. Indeed, Respondent frequently prescribed Patient M.B. Norco as a treatment for the patient's opioid dependency, including on March 6, 2018; May 1, 2018; August 16, 2018; September 13, 2018; October 11, 2018; November 7, 2018; and January 2, 2019. GX 3 at 30, 32-36.

46. Opioid dependency does not create a legitimate medical purpose to prescribe Norco. To the contrary, treating a patient's opioid dependency with Norco is outside of the standard of care and outside the usual course of professional practice. Tr. 267-69.

47. Respondent never conducted a urine drug screen on Patient M.B., in violation of the California standard of care. Tr. 284; PFF ¶ 18; *see generally* GX 3.

48. None of the controlled substance prescriptions Respondent issued to Patient M.B. between January 5, 2018 and November 20, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 289-90. There is nearly no situation in which a patient

should receive the drugs that Respondent prescribed to Patient M.B. from January 5, 2018 to November 20, 2019 in those dosages, durations, and combinations, and Patient M.B. did not present any such situation. Tr. 28384.

C. Patient B.C.

49. Between January 25, 2017 and December 19, 2019, Respondent issued to Patient B.C. the controlled substance prescriptions listed in Joint Stipulation No. 16. See ALJ Ex. 3 at 5-7. During this time, Respondent diagnosed Patient B.C. with back pain, GAD, ADD, and opioid dependency. GX 5 at 17-33.

i. Patient B.C.'s Initial Visit and the First Diagnosis for ADD

50. Respondent's initial encounter with Patient B.C. took place on March 27, 2014. GX 5 at 48, 55; Tr. 293:1-16. At that visit, Respondent diagnosed Patient B.C. with GAD and back pain. GX 5 at 48; Tr. 294. Respondent prescribed Patient B.C. Norco for back pain and 6 mg of Xanax for GAD. GX 5 at 48; Tr. 294. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 5 at 84; Tr. 295:7-296:15;

b. address Patient B.C.'s pain or functionality levels, GX 5 at 84; Tr. 29798;

c. conduct an appropriate physical examination, GX 5 at 84; Tr. 296:16297;

d. establish an appropriate diagnosis for back pain or GAD, and so to establish a legitimate medical purpose to prescribe Norco or Xanax, Tr. 298-99; or

e. establish and document a treatment plan with goals and objectives, GX 5 at 85; Tr. 299.

51. Respondent only inquired about Patient B.C.'s substance abuse on March 27, 2014. *See* GX 5 at 48, 57; Tr. 296, 299. Patient B.C. was never asked about substance abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 300; *see generally* GX 5.

52. Respondent first diagnosed Patient B.C. with ADD on May 20, 2014, and prescribed 60 mg of Adderall per day. GX 5 at 47. He took no history, and performed no evaluations, for ADD, other than a note saying "Pt has ADD ¡ give [A]dderall 30mg bid (SED)." *Id.* Respondent's diagnosis for ADD was unsupported; he did not establish a legitimate medical purpose to prescribe Adderall, nor did he establish and document a treatment plan with goals and objectives. GX 5 at 47; Tr. 302. ii. Continued Controlled Substance Violations

53. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient B.C., never recorded Patient B.C.'s pain or functionality levels, failed to periodically update Patient B.C.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 5; Tr. 335-36.

54. None of Respondent's diagnoses of Patient B.C. for which he prescribed controlled substances between January 25, 2017 and December 19, 2019 were based on sufficient medical evidence. Tr. 336.

55. Over the course of his treatment of Patient B.C., Respondent's diagnoses for pain, GAD, and ADD

frequently came and went without comment or explanation. *See generally* GX 5; Tr. 316-19; 319-21; 322-25. Like chronic pain and GAD, ADD is a chronic condition. Tr. 167:13-16. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 25, 2017 and December 19, 2019 – were not credible. Tr. 318-19; 321-22; 325-26.

56. Respondent never documented an appropriate treatment plan with goals and objectives for Patient B.C., never documented an appropriate rationale for continued treatment of Patient B.C. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient B.C. *See generally* GX 5; Tr. 337.

57. Respondent also prescribed Patient B.C. the following dangerous combinations of controlled substances, that put Patient B.C. at serious risk of adverse medical consequences, including addiction, overdose and death, Tr. 326-30:

a. Norco, Adderall, and Xanax on January 25, 2017; April 18, 2017; June 19, 2017; and July 31, 2018. ALJ Ex. 3 at 5-6.

b. Norco and Xanax on May 19, 2017, and approximately monthly from February 16, 2018 until July 3, 2018. ALJ Ex. 3 at 5-6

c. Norco and Adderall on September 25, 2018; December 19, 2018; February 13, 2019; April 9, 2019; June 5, 2019; July 30, 2019; October 25, 2019; and December 19, 2019. ALJ Ex. 3 at 5-7.

58. Respondent's prescriptions to Patient B.C. for Xanax between January 25, 2017 and July 31, 2018

were all for 6 mg of Xanax per day. GX 5 at 28-33. Such high dosages of Xanax placed Patient B.C. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 294-95. The fact that Respondent prescribed Xanax to Patient B.C. concurrently with opioids, see ALJ Ex. 3 at 5-6, dramatically increased his risk of overdose and death. Tr. 295.

59. Respondent noted, on 19 occasions between January 25, 2017 and February 13, 2019, that Patient B.C. was opioid dependent, and refusing detoxification. GX 5 at 23, 25-33. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 5 at 23, 25-33; *see also* Tr. 333-34.

60. Indeed, Respondent frequently improperly and illegally prescribed Patient B.C. Norco as a treatment for the patient's opioid dependency, including on January 25, 2017; June 19, 2017; July 17, 2017; March 26, 2018; May 11, 2018; July 3, 2018; August 28, 2018; October 22; 2018; December 19, 2018; and February 13, 2019. GX 5 at 23, 25-33; Tr. 306-07.

61. Respondent never conducted a urine drug screen on Patient B.C., in violation of the California standard of care. Tr. 333; PFF ¶ 18; *see generally* GX 5.

62. None of the controlled substance prescriptions Respondent issued to Patient B.C. between January 25, 2017, and December 19, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 289-90. There is nearly no situation in which a patient should receive the drugs that Respondent prescribed to Patient B.C. from January 25, 2017, to December 19, 2019 in those dosages, durations, and combinations,

and Patient B.C. did not present any such situation. Tr. 337-38.

D. Patient J.C.

63. Between January 16, 2018 and December 30, 2019, Respondent issued to Patient J.C. the controlled substance prescriptions listed in Joint Stipulation No. 19. See ALJ Ex. 3 at 7-8. During this time, Respondent diagnosed Patient J.C. with back pain, GAD, and opioid dependency. GX 7 at 168-180.

i. Patient J.C.'s Initial Visit and the First Diagnosis for Back Pain

65. Respondent's initial encounter with Patient J.C. took place on May 18, 2009. GX 7 at 216, 233; Tr. 383:1-384:5. At that visit, Respondent diagnosed Patient J.C. with migraine headaches and GAD. GX 7 at 216; Tr. 384. Respondent prescribed Patient J.C. Norco for migraines and Xanax for GAD. GX 7 at 216; Tr. 384. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 7 at 216; Tr. 385-86;

b. address Patient J.C.'s pain or functionality levels, GX 7 at 216; Tr. 387;

c. conduct an appropriate physical examination, GX 7 at 216; Tr. 386:16387:3;

d. establish appropriate diagnoses for migraines or GAD and so establish a legitimate medical purpose to prescribe Norco or Xanax, Tr. 387-88; or

e. establish and document a treatment plan with goals and objectives, GX 7 at 216; Tr. 388.

65. Respondent first diagnosed Patient J.C. with back pain on July 21, 2016, and prescribed Norco. GX 7 at 189. There was no history taken, or evaluations performed, for back pain, other than a note saying Patient J.C. presented as a "39 yom with GAD, chronic back pain" *Id.* Respondent's diagnosis for back pain was unsupported, he did not establish a legitimate medical purpose to prescribe Norco, nor did he establish and document a treatment plan with goals and objectives. Tr. 391, 392-93, 393-94. ii. Continued Controlled Substance Violations

66. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient J.C., never recorded Patient J.C.'s pain or functionality levels, never obtained prior medical records for Patient J.C. – nor does Patient J.C.'s medical file reflect Respondent requested such records – failed to periodically update Patient J.C.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 7; Tr. 424-26.

67. None of Respondent's diagnoses of Patient J.C. for which he prescribed controlled substances between January 16, 2018, and December 30, 2019 were based on sufficient medical evidence. Tr. 426.

68. Over the course of his treatment of Patient J.C., Respondent frequently changed without comment the diagnoses for which he prescribed Patient J.C. opioids, as well as the opioids prescribed. *See generally* GX 7; Tr. 409-14. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 16, 2018 and December 30, 2019 – were not credible. Tr. 414-15.

69. Other than inquiring into smoking and alcohol use at Patient J.C.'s initial visit, see GX 7 at 216, Respondent did not inquire about current or past substance abuse until August 17, 2009, when he had Patient J.C. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 7 at 227. Patient J.C. was never asked about substance abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 359-60; *see generally* GX 7.

70. Respondent never documented an appropriate treatment plan with goals and objectives for Patient J.C., never documented an appropriate rationale for continued treatment of Patient J.C. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient J.C. *See generally* GX 7; Tr. 426-27.

71. Respondent also prescribed Patient J.C. dangerous combinations of Norco and Valium approximately monthly from January 16, 2018 until January 18, 2019, and once again on May 6, 2019. ALJ Ex. 3 at 7-8. These combinations put Patient J.C. at serious risk of adverse medical consequences, including addiction, overdose, and death. Tr. 417-18.

72. Respondent noted, on 14 occasions between January 16, 2018 and February 19, 2019, that Patient J.C. was opioid dependent, and refusing detoxification. GX 7 at 173, 175-180. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 7 at 173, 175-80; *see also* Tr. 423-24.

73. Indeed, Respondent frequently improperly and illegally prescribed Patient J.C. Norco as a treatment for the patient's opioid dependency, including on February 16, 2018; April 16, 2018; June 15, 2018; August 15, 2018; October 17, 2018; and December 13, 2018. GX 7 at 175-80; Tr. 398-400.

74. Respondent never conducted a urine drug screen on Patient J.C., in violation of the California standard of care. Tr. 421; PFF ¶ 18; *see generally* GX 7.

75. None of the controlled substance prescriptions Respondent issued to Patient J.C. between January 16, 2018 and December 30, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 427-28. There is nearly no situation in which a patient should receive the drugs that Respondent prescribed to Patient J.C. from January 16, 2018 to December 30, 2019 in those dosages, durations, and combinations, and Patient J.C. did not present any such situation. Tr. 418-19.

E. Patient D.D.

76. Between January 4, 2018 and February 12, 2019, Respondent issued to Patient D.D. the controlled substance prescriptions listed in Joint Stipulation No. 22. See ALJ Ex. 3 at 9. During this time, Respondent diagnosed Patient D.D. with back pain, GAD, and opioid dependency. GX 9 at 37-43.

i. Patient D.D.'s Initial Visit

77. Respondent's initial encounter with Patient D.D. took place on July 9, 2008. GX 9 at 74, 80; Tr. 430-31. At that visit, Respondent diagnosed Patient D.D. with GAD and back pain. GX 9 at 74; Tr. 431.

Respondent prescribed Patient D.D. Norco and Soma for back pain, and Valium for GAD. GX 9 at 74; Tr. 431. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 9 at 74; Tr. 433-34;

b. address Patient D.D.'s pain or functionality levels, GX 9 at 74; Tr. 43536;

c. conduct an appropriate physical examination, GX 9 at 74; Tr. 434-35;

d. establish appropriate diagnoses for back pain or GAD and so to establish a legitimate medical purpose to prescribe Norco, Soma, or a benzodiazepine, Tr. 436:3-21; or

e. establish and document a treatment plan with goals and objectives, GX 9 at 74; Tr. 436:22-25. ii. Continued Controlled Substance Violations

78. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient D.D., never recorded Patient D.D.'s pain or functionality levels, never obtained prior medical records for Patient D.D. – nor does Patient D.D.'s medical file reflect Respondent requested such records – failed to periodically update Patient D.D.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 9; Tr. 465-66.

79. None of Respondent's diagnoses of Patient D.D. for which he prescribed controlled substances between January 4, 2018 and February 12, 2019 were based on sufficient medical evidence. Tr. 467.

80. Over the course of his treatment of Patient D.D., Respondent frequently changed without comment the diagnoses for which he prescribed Patient D.D. opioids. *See generally* GX 9; Tr. 450-56. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 4, 2018 and February 12, 2019 – were not credible. Tr. 45356.

81. Other than inquiring into smoking and alcohol use at Patient D.D.'s initial visit, see GX 9 at 74, Respondent did not inquire about current or past substance abuse until over one year later, on August 28, 2009, when he had Patient D.D. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 9 at 77. Respondent never asked Patient D.D. about substance abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; *see generally* GX 9.

82. Respondent never documented an appropriate treatment plan with goals and objectives for Patient D.D., never documented an appropriate rationale for continued treatment of Patient D.D. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient D.D. *See generally* GX 9; Tr. 467.

83. Respondent also prescribed Patient D.D. the following dangerous combinations of controlled substances, that put Patient D.D. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 457-58:

a. Norco and Soma approximately monthly from January 4, 2018 through August 10,

2018, and October 16, 2018 through January 11, 2019. ALJ Ex. 3 at 9.

b. Norco and Xanax on September 19, 2018. ALJ Ex. 3 at 9.

84. Respondent noted, on 10 occasions between January 16, 2018 and February 12, 2019, that Patient D.D. was opioid dependent, and refusing detoxification. GX 9 at 37, 39-43. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 9 at 37, 39-43.; *see also* Tr. 463-65.

85. Indeed, Respondent frequently illegally and improperly prescribed Patient D.D. Norco as a treatment for the patient's opioid dependency, including on March 23, 2018; July 6, 2018; August 10, 2018; October 16, 2018; December 13, 2018; and February 12, 2019. GX 9 at 37, 39-43; Tr. 454. Moreover, on all of those occasions except February 12, 2019, Respondent also prescribed Patient D.D. Soma for his opioid dependency. Soma is not indicated as a treatment for opioid dependency, and prescribing it to treat opioid dependency is not within the standard of care. GX 9 at 39-43; Tr. 454-55.

86. Although Patient D.D. presented a risk of abuse or diversion, Respondent never conducted a urine drug screen on Patient D.D., in violation of the California standard of care. Tr. 461-62; PFF ¶ 18; *see generally* GX 9.

87. None of the controlled substance prescriptions Respondent issued to Patient D.D. between January 4, 2018 and February 12, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr.

468:4-16. There is nearly no situation in which any patient should receive the drugs that Respondent prescribed to Patient D.D. between January 4, 2018 and February 12, 2019 in those dosages, durations, and combinations, and Patient D.D. did not present any such situation. Tr. 460-61.

F. Patient J.M.

88. Between January 10, 2017 and December 31, 2019, Respondent issued to Patient J.M. the controlled substance prescriptions listed in Joint Stipulation No. 25. See ALJ Ex. 3 at 10-12. During this time, Respondent diagnosed Patient J.M. with back pain, GAD, and opioid dependency. GX 11 at 18-42.

i. Patient J.M.'s Initial Visit

89. Respondent's initial encounter with Patient J.M. took place on May 14, 2007. GX 11 at 104, 111; Tr. 471. At that visit, Respondent diagnosed Patient J.M. with, inter alia, back pain and GAD. GX 11 at 104; Tr. 472. Respondent prescribed Patient J.M. Norco for back pain and 6 mg of Xanax per day for GAD. GX 11 at 104; 472. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 11 at 104; Tr. 473-74

b. address Patient K.S.'s pain or functionality levels, GX 11 at 104; Tr. 474-75;

c. conduct an appropriate physical examination, GX 11 at 104; Tr. 474;

d. establish an appropriate diagnosis for back pain and so establish a legitimate medical purpose to prescribe Norco or Soma, Tr. 475; or

e. establish and document a treatment plan with goals and objectives, GX 11 at 104; Tr. 475-76. ii. Controlled Substance Violations

90. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient J.M., never recorded Patient J.M.'s pain or functionality levels, never obtained prior medical records for Patient J.M. – nor does Patient J.M.'s medical file reflect Respondent requested such records – failed to periodically update Patient J.M.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 11; Tr. 564-66.

91. None of Respondent's diagnoses of Patient J.M. for which he prescribed controlled substances between January 10, 2017 and December 31, 2019 were based on sufficient medical evidence. Tr. 566.

92. Over the course of his treatment of Patient J.M., Respondent frequently changed without comment the diagnoses for which he prescribed Patient J.M. Norco. *See generally* GX 11; Tr. 502-03, 504. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 10, 2017 and December 31, 2019 – were not credible. Tr. 503-04.

93. Other than inquiring into smoking and alcohol use at Patient J.M.'s initial visit, see GX 11 at 104; Tr. 475, Respondent did not inquire about substance abuse until over two years later, on September 21, 2009, when he had Patient J.M. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 11 at 115. Respondent never asked Patient J.M. about substance

abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 481-82; *see generally* GX 11.

94. Respondent never documented an appropriate treatment plan with goals and objectives for Patient J.M., never documented an appropriate rationale for continued treatment of Patient J.M. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient J.M. *See generally* GX 11; Tr. 566-67.

95. Respondent also prescribed Patient J.M. the following dangerous combinations of controlled substances, that put Patient J.M. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 505-10:

a. Norco, Xanax, and Soma (a combination referred to by illicit users as "the Holy Trinity," Tr. 506) in May of 2018 and November of 2018. ALJ Ex. 3 at 11.

b. Norco and Xanax on 26 occasions between January 25, 2017 and February 20, 2019. ALJ Ex. 3 at 10-11.

96. These combinations of drugs are highly sought after for abuse and diversion. Tr. 505-06, 510. Indeed, there is almost never any medical justification for prescribing a combination of Norco, Xanax, and Soma. Tr. 507-08.

Specifically, on January 25, 2017; June 19, 2017; August 14, 2017; September 14, 2017; October 17, 2017; November 6, 2017; November 20, 2017; January 25, 2018; February 7, 2018; February 23, 2018; March of 2018; April 9, 2018; April 25, 2018; May 23, 2018;

June 11, 2018; June 27, 2018; July 11, 2018; July 25, 2018; August 29, 2018; September 17, 2018; October 17, 2018; December 5, 2018; December 21, 2018; January of 2019; February 6, 2019; and February 20, 2019.

97. Respondent's prescriptions to Patient J.M. for Xanax between January 10, 2017 and February 20, 2019 were repeatedly for at least 6 mg of Xanax per day. GX 11 at 26-42; ALJ Ex. 3 at 10-11. Prescribing such high dosages of Xanax placed Patient J.M. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 217, 218-19. The fact that Respondent often prescribed Xanax to Patient J.M. concurrently with opioids, see ALJ Ex. 3 at 10-11, dramatically increased his risk of overdose and death. Tr. 217-18.

98. Indeed, between January 10, 2017 and November 2, 2018 Respondent repeatedly issued Patient J.M. substantially early prescriptions for Xanax – issuing Patient J.M. 40 prescriptions for 90 units of Xanax 2 mg, or a prescription approximately every 17 days. ALJ Ex. 3 at 10-11. This provided Patient J.M. with over 10.5 mg of Xanax per day, or more than double the maximum recommended daily dose of 4 mg. *Id.*; Tr. 513-15.

99. Further, between January 10, 2017 and November 2, 2018, Patient J.M. alternated filling his Xanax prescriptions at one of two different pharmacies. Tr. 520-21; GX 17; GX 18. This was a significant red flag or abuse and diversion, indicating that Patient J.M. was seeking to avoid these pharmacies recognizing how much Xanax he was being prescribed, but Respondent did nothing to address this. Tr. 521-22.

100. Instead, Respondent actually assisted Patient J.M. in obtaining controlled substances Patient J.M. might not otherwise have been able to have filled. Respondent frequently issued Patient J.M. a written prescription for Norco which Patient J.M. would fill at one pharmacy, and that same day, Respondent would call in a prescription for Xanax to another pharmacy. Tr. 528-547, 55058. Respondent did this on at least the following dates:

a. January 25, 2017, *see* GX 11 at 42; GX 12 at 1-2; GX 17 at rows 425, 575;

b. June 19, 2017, *see* GX 11 at 41; GX 12 at 5-6; GX 17 at rows 1,746, 1,825; 28

c. November 6, 2017, *see* GX 11 at 40; GX 12 at 10-11; GX 17 at rows 2,764, 2,788;

d. February 7, 2018, *see* GX 11 at 38; GX 12 at 14; GX 13 at 20; GX 18 at rows 473, 474;

e. May 11, 2018, *see* GX 11 at 36; GX 12 at 22; GX 13 at 25; GX 18 at rows 994, 1,120;

f. June 11, 2018, *see* GX 11 at 36; GX 12 at 24; GX 13 at 27; GX 18 at rows 1,228, 1,386;

g. July 11, 2018, *see* GX 11 at 35; GX 12 at 26-27; GX 18 at rows 1,472, 1,553;

h. September 17, 2018, *see* GX 11 at 33; GX 12 at 33; GX 13 at 32; GX 18 at rows 2,102, 2,229; and

i. October 17, 2018, *see* GX 11 at 32; GX 12 at 34; GX 13 at 34; GX 18 at rows 2,341, 2,342.

101. This was a "bright red flag" indicating that both Patient J.M. and Respondent were seeking to avoid having a pharmacy potentially refuse to fill con-

current prescriptions for opioids and benzodiazepines. Tr. 558-59.

102. Between November 20, 2017 and February 20, 2019, Respondent noted 17 times in Patient J.M.'s medical file that Patient J.M. was opioid dependent, and refusing detoxification. GX 11 at 26-39. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 11 at 26-39; *see also* Tr. 561-64.

103. Indeed, Respondent frequently improperly and illegally prescribed Patient J.M. Norco as a treatment for the patient's opioid dependency, including on at least April 25, 2018; May 23, 2018; June 27, 2018; August 29, 2018; October 17, 2018; and December 21, 2018. GX 11 at 30, 32, 34-37; Tr. 48688.

104. Further, Respondent's prescribing of Norco was sporadic. *See*, *e.g.*, GX 11 at 3942; Tr. 500:5-501:13. However, Respondent never documented any rationale for changing Patient J.M.'s course of medication with respect to Norco. *See* GX 1 at 18-42; Tr. 501.

105. Although Patient J.M. presented significant risks of abuse or diversion, Respondent never conducted a urine drug screen on Patient J.M., in violation of the California standard of care. Tr. 560-61:12; PFF ¶ 18; *see generally* GX 11.

106. None of the controlled substance prescriptions Respondent issued to Patient J.M. between January 10, 2017 and December 31, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 567-68. There is no situation in which any patient should receive the drugs that Respondent prescribed to Patient J.M. between January 10, 2017 and December

31, 2019 in those dosages, durations, and combinations. Tr. 507-08.

G. Patient K.S.

107. Between January 19, 2018 and January 31, 2019, Respondent issued to Patient K.S. the controlled substance prescriptions listed in Joint Stipulation No. 29. See ALJ Ex. 3 at 12-13. During this time period, Respondent diagnosed Patient K.S. with back pain, GAD, ADD, and opioid dependency. GX 14 at 31-41.

i. Patient K.S.'s Initial Visit and the First Prescriptions for Xanax and Adderall

108. Respondent's initial encounter with Patient K.S. took place on June 21, 2007. GX 14 at 110, 117; Tr. 570:8-571:3. At that visit, Respondent diagnosed Patient K.S. with back pain. GX 14 at 110; Tr. 571. Respondent prescribed Patient K.S. Norco and Soma for back pain. GX 14 at 110; Tr. 571. At this initial visit, Respondent failed to:

a. take an appropriate medical history, GX 14 at 110; Tr. 572:4-23;

b. address Patient K.S.'s pain or functionality levels, GX 14 at 110; Tr. 573:1823;

c. conduct an appropriate physical examination, GX 14 at 110; Tr. 57273

d. establish an appropriate diagnosis for back pain and so establish a legitimate medical purpose to prescribe Norco or Soma, Tr. 574; or

e. establish and document a treatment plan with goals and objectives, GX 14 at 110; Tr. 574:16-21.

109. Respondent first diagnosed Patient K.S. with GAD on May 1, 2012, and prescribed 6 mg of Xanax per day. GX 14 at 80; Tr. 577. There was no history taken, or evaluations performed, for GAD, other than a note saying Patient K.S. presented as a "28 yom with GAD, neck pain" GX 14 at 80. Respondent's diagnosis for GAD was completely unsupported, he did not establish a legitimate medical purpose to prescribe Xanax, nor did he establish and document a treatment plan with goals and objectives. *Id.*; Tr. 579-81.

110. Respondent first prescribed Patient K.S. Adderall on November 18, 2013. GX 14 at 70. There was no history taken, evaluations performed, or even any diagnosis made, only a note saying "Adderall 30 mg #60, [one] bid (SED)." *Id.*; Tr. 581. Respondent did not establish a legitimate medical purpose to prescribe Adderall, nor did he establish and document a treatment plan with goals and objectives. Tr. 582:16-23. Respondent later diagnosed Patient K.S. with ADD, *see*, *e.g.*, GX 14 at 41, but had never obtained sufficient medical evidence for such a diagnosis. Tr. 583-84.

ii. Continued Controlled Substance Violations

111. Throughout the entire course of treatment, Respondent never obtained a proper medical history of Patient K.S., never recorded Patient K.S.'s pain or functionality levels, never obtained prior medical records for Patient K.S. – nor does Patient K.S.'s medical file reflect Respondent requested such records – failed to periodically update Patient K.S.'s medical history as treatment progressed, and never conducted a sufficient physical examination for pain. *See generally* GX 14; Tr. 617-19.

112. None of Respondent's diagnoses of Patient K.S. for which he prescribed controlled substances between January 19, 2018 and January 31, 2019 were based on sufficient medical evidence. Tr. 619:6-13.

113. Over the course of his treatment of Patient K.S., Respondent's diagnoses for pain, GAD, and ADD frequently came and went without comment or explanation. *See generally* GX 14; Tr. 598-601; 602-05; 605-08. These erratic diagnoses were outside of the standard of care, and indicate these diagnoses – including those made between January 19, 2018 and January 31, 2019 – were not credible. Tr. 601-02; 604-05; 608-09.

114. Other than inquiring into smoking and alcohol use at Patient K.S.'s initial visit, see GX 14 at 110; Tr. 573-74, Respondent did not inquire about current or past substance abuse until over two years later, on August 5, 2009, when he had Patient K.S. sign a form stating "I have no history of drug abuse, nor was I treated for drug or substance abuse in the past." GX 14 at 119. Respondent never asked Patient K.S. about substance abuse again – something the California standard of care required Respondent to do. PFF ¶ 16; Tr. 574-75; *see generally* GX 14.

115. Respondent never documented an appropriate treatment plan with goals and objectives for Patient K.S., never documented an appropriate rationale for continued treatment of Patient K.S. with controlled substances, and failed to properly discuss the risks and benefits of the controlled substances he prescribed to Patient K.S. *See generally* GX 14; Tr. 619-20.

116. Respondent also prescribed Patient K.S. the following dangerous combinations of controlled substances, that put Patient K.S. at serious risk of adverse medical consequences, including addiction, overdose, and death, Tr. 609-11:

a. Norco, Adderall, and Xanax approximately monthly from January 19, 2018 through August of 2018, and again in November of 2018. ALJ Ex. 3 at 12-13.

b. Norco and Xanax on August 29, 2018, October 2, 2018, October 31, 2018, and November 28, 2018. ALJ Ex. 3 at 13.

117. Respondent's prescriptions to Patient K.S. for Xanax between January 19, 2018 and January 31, 2019 were all for 6 mg of Xanax per day. GX 14 at 33-41; ALJ Ex. 3 at 12-13. Prescribing such high dosages of Xanax placed Patient K.S. at risk of potentially lethal withdrawal, and presented risks of diversion. Tr. 577-78. The fact that Respondent prescribed Xanax to Patient K.S. concurrently with opioids, *see* ALJ Ex. 3 at 12-13, dramatically increased his risk of overdose and death. Tr. 579.

118. Respondent noted, on 13 occasions between January 19, 2018 and January 31, 2019, that Patient K.S. was opioid dependent, and refusing detoxification. GX 14 at 31-41. Respondent never addressed this red flag, but simply continued to prescribe the patient Norco on an as-needed basis. GX 14 at 31-41; *see also* Tr. 615-17.

119. Indeed, Respondent frequently improperly and illegally prescribed Patient K.S. Norco as a treatment for the patient's opioid dependency, including on February 27, 2018; April 30, 2018; July 3, 2018;

August 3, 2018; October 2, 2018; November 28, 2018; and January 2, 2019. GX 14 at 31, 33, 35-37, 3940; Tr. 586-88.

120. Although Patient K.S. presented significant risks of abuse or diversion, Respondent never conducted a urine drug screen on Patient K.S., in violation of the California standard of care. Tr. 614; PFF ¶ 18; *see generally* GX 14.

121. None of the controlled substance prescriptions Respondent issued to Patient K.S. between January 19, 2018 and January 31, 2019 were issued for a legitimate medical purpose or by a practitioner acting within the usual course of professional practice. Tr. 620. There is no situation in which a patient should receive the drugs that Respondent prescribed to Patient K.S. between January 19, 2018 and January 31, 2019 in those dosages, durations, and combinations. Tr. 613.

122. Respondent's prescribing of controlled substances to Patients S.B., M.B., B.C., J.C., D.D., J.M., K.S. constituted clearly excessive prescribing. Tr. 621.

ANALYSIS

FINDINGS AS TO ALLEGATIONS

The Government alleges that the Respondent's COR should be revoked, and any applications should be denied, because the Respondent violated federal and California law, by issuing numerous prescriptions for Schedule II through IV controlled substances outside the usual course of professional practice and not for a legitimate medical purpose to seven individuals as recently as December 31, 2019. These prescriptions fell below minimal medical standards applicable to the practice of medicine in California. Therefore, these

prescriptions violated federal and California state law.

In the adjudication of a revocation or suspension of a DEA COR, DEA bears the burden of proving that the requirements for such revocation or suspension are satisfied. 21 C.F.R. § 1301.44(e). Where the Government has sustained its burden and established that a registrant has committed acts inconsistent with the public interest, to rebut the Government's *prima facie* case, a respondent must both accept responsibility for his actions and demonstrate that he will not engage in future misconduct. *Patrick W. Stodola, M.D.*, 74 Fed. Reg. 20727, 20734 (2009).

Acceptance of responsibility and remedial measures are assessed in the context of the "egregiousness of the violations and the [DEA's] interest in deterring similar misconduct by [the] Respondent in the future as well as on the part of others." *David A. Ruben, M.D.*, 78 Fed. Reg. 38363, 38364 (2013). Where the Government has sustained its burden and established that a registrant has committed acts inconsistent with the public interest, that registrant must present sufficient mitigating evidence to assure the Acting Administrator that he can be entrusted with the responsibility commensurate with such a registration. *Medicine Shoppe-Jonesborough*, 73 Fed. Reg. 364, 387 (2008).

The Agency's conclusion that "past performance is the best predictor of future performance" has been sustained on review, *Alra Labs., Inc. v. DEA*, 54 F.3d 450, 452 (7th Cir. 1995), as has the Agency's consistent policy of strongly weighing whether a registrant who has committed acts inconsistent with the public interest has accepted responsibility and demonstrated

that he or she will not engage in future misconduct. *Hoxie v. DEA*, 419 F.3d 477, 482-83 (6th Cir. 2005); *see also Ronald Lynch, M.D.*, 75 Fed. Reg. 78745, 78754 (2010) (holding that the Respondent's attempts to minimize misconduct undermined acceptance of responsibility); *George C. Aycock, M.D.*, 74 Fed. Reg. 17529, 17543 (2009) (finding that much of the respondent's testimony undermined his initial acceptance that he was "probably at fault" for some misconduct); *Jayam Krishna-Iyer, M.D.*, 74 Fed. Reg. 459, 463 (2009) (noting, on remand, that despite the respondent's having undertaken measures to reform her practice, revocation had been appropriate because the respondent had refused to acknowledge her responsibility under the law); *Medicine Shoppe–Jonesborough*, 73 Fed. Reg. at 387 (noting that the respondent did not acknowledge recordkeeping problems, let alone more serious violations of federal law, and concluding that revocation was warranted).

The burden of proof at this administrative hearing is a preponderance-of-the-evidence standard. *Steadman v. SEC*, 450 U.S. 91, 100-01 (1981). The Acting Administrator's factual findings will be sustained on review to the extent they are supported by "substantial evidence." *Hoxie*, 419 F.3d at 481. The Supreme Court has defined "substantial evidence" as such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Consolidated Edison Co. of New York v. NLRB*, 305 U.S. 197, 229 (1938). While "the possibility of drawing two inconsistent conclusions from the evidence" does not limit the Acting Administrator's ability to find facts on either side of the contested issues in the case, *Shatz v. U.S. Dep't of Justice*, 873 F.2d 1089, 1092 (8th Cir. 1989); *Trawick v. DEA*, 861 F.2d 72, 77 (4th Cir. 1988), all "important

aspect[s] of the problem," such as a respondent's defense or explanation that runs counter to the Government's evidence, must be considered. *Wedgewood Vill. Pharmacy v. DEA*, 509 F.3d 541, 549 (D.C. Cir. 2007); *Humphreys v. DEA*, 96 F.3d 658, 663 (3rd Cir. 1996).

Regarding the exercise of discretionary authority, the courts have recognized that gross deviations from past Agency precedent must be adequately supported, *Morall v. DEA*, 412 F.3d 165, 183 (D.C. Cir. 2005), but mere unevenness in application does not, standing alone, render a particular discretionary action unwarranted. *Chein v. DEA*, 533 F.3d 828, 835 (D.C. Cir. 2008) (citing *Butz v. Glover Livestock Comm'n Co.*, 411 U.S. 182, 188 (1973)). It is well-settled that since the Administrative Law Judge has had the opportunity to observe the demeanor and conduct of hearing witnesses, the factual findings set forth in this recommended decision are entitled to significant deference, *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 496 (1951), and that this recommended decision constitutes an important part of the record that must be considered in the Acting Administrator's decision. *Morall*, 412 F.3d at 179. However, any recommendations set forth herein regarding the exercise of discretion are by no means binding on the Acting Administrator and do not limit the exercise of that discretion. 5 U.S.C. § 557 (b); *River Forest Pharmacy, Inc. v. DEA*, 501 F.2d 1202, 1206 (7th Cir. 1974); *Attorney General's Manual on the Administrative Procedure Act* § 8 (1947).

California Law

The applicable California Codes are:

1. Cal. Health & Safety Code § 1153(a), requiring that a "prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice";
2. Cal. Health & Safety Code § 1154(a), directing that "no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person . . . not under his or her treatment for a pathology or condition . . . . ;
3. Cal. Bus.& Prof. Code § 2242, prohibiting the "[p]rescribing, dispensing, or furnishing [of controlled substances] . . . without an appropriate prior examination and a medical indication," the violation of which constitutes unprofessional conduct;
4. Cal. Bus. & Prof. Code § 2234, defining unprofessional conduct to include: "[g]ross negligence"; "[r]epeated negligent acts"; "[i]ncompetence"; or "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon"; and
5. Cal. Bus. & Prof. Code § 725, further defining unprofessional conduct to include "[r]epeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs . . . ."

ALJ Ex. 1.

12. Allegations Common to Multiple Patients

There were allegations common to many or all of the subject patients. They will be discussed here generally. They may be discussed in detail in the context of the particular patients as well, and as needed.

13. Failure to Maintain Accurate and Complete Patient Charts

There was a recurring theme throughout the patient files of the Respondent, failure to maintain accurate and complete patient charts. This failing itself is contrary to the "Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons," Medical Board of California, 7th ed. 2013, which requires the practitioner to "keep accurate and complete records, including but not limited to, records of the patient's medical history, physical examinations of the patient, the treatment plan objectives and the treatments given, and the rationale for any changes in treatment." *Id.* at 59. Not surprisingly, the failure to maintain accurate and complete patient records itself represents a violation of the California standard of care.

Dr. Munzing also cited this failure in documentation in support of his opinion that it often rendered any resulting treatment or diagnosis unjustified and inappropriate. Tr. 241-44. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44.

The Respondent conceded repeatedly that there were matters discussed with the patients, information gathered from them, evaluation of treatment and

changes in treatment, and determinations regarding treatment, which he did not record in the patient chart.[24] He gave various reasons for not documenting the missing information, including his 41-years of clinical experience, his busy practice, his practice of maintaining paper records, which prevents the degree of detail permitted by electronic record-keeping, and results in him keeping his notes as brief as possible and only recording the "main ideas". Finally, he defended his limited documentation as unnecessary due to his photographic memory.[25] Although the Res-

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[24] The Respondent conceded he did not document the rationale for the change in medication for J.M. and K.S. Tr. 885. On February 2, 2017, the Respondent prescribed Soma to S.B. Tr. 875; GX 1 at 59. By March 1, 2017, Soma had been discontinued, yet the chart reflected no rationale for that change in medication regimen. Tr. 876-77. As the Respondent varied his prescribing between Soma and Xanax, he conceded he did not document the reason for the variation in medication. Tr. 878-83. Similarly, the Respondent conceded he did not document pain level, function level and quality of life in the seven charged patients. Tr. 885-87; GX 20 at 61.

[25] The list of prior therapies was not in his progress notes. Tr. 805-06, 808. The Respondent explained its absence as maybe he did not feel it was crucial to document them, as he memorizes what the patient tells him. Tr. 806. Including references to prior, concluded treatment, the Respondent found to be irrelevant as the prior treatment was concluded and the patient had moved on to the new treatment. Tr. 807-08. The Respondent testified to S.B.'s prior treatment from memory. Tr. 808. The Respondent explained that, as he still maintained handwritten records, seeing up to 20 patients a day, with new patients taking an hour and returning patients taking up to 20 minutes each, he did not have the luxury of documenting in detail. Tr. 807, 849. So, the basic information is reflected in his written notes, while the rest he remembers, as he has a photographic memory. Tr. 808-09. The Respondent conceded that "maybe" it was "inappropriate" of him not to more thoroughly detail this information in the charts. Tr.

pondent sometimes displayed an extraordinary memory[26], it was not always infallible.

Although the Respondent indicated he was essentially testifying from memory regarding appointments and treatment from sometimes up to fourteen years ago, the Government was permitted to test the Respondent's memory. The Respondent's memory may not be as good as he believes.[27] Of course, even an

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809. But with handwritten charts he was only able to include the "main ideas". His notes are simply to remind him of the matters. Tr. 810-11. He keeps his notes as brief as possible to remind him in the future. Tr. 815. Although the Respondent testified he developed a treatment plan for each of his patients, the Government pointed out S.B.'s treatment plan and objectives were not documented in her chart. Tr. 813-14. M.B. had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827.

[26] The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit (in 2009). Tr. 840. The Respondent added that he probably prescribed Valium to J.C., as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent added that he may have also prescribed Xanax to K.S., but it is difficult to be sure with hundreds of patients and treatment dating back 15 years. Tr. 859. Even with a good memory, sometimes the Respondent may just miss something. Tr. 859.

[27] The Government sought to test the Respondent's memory by asking to confirm that, consistent with his direct testimony, he only treated S.B. with hydrocodone, Xanax and Adderall. Tr. 810-13. The Respondent confirmed his direct testimony. Tr. 812. The Government reminded the Respondent that he prescribed Soma as well. Tr. 813. Although the Respondent testified he did not introduce any of his subject patients to controlled substances, the chart reflects he did prescribe S.B. Soma to her for the first time. Tr. 816-17; GX 1 at 61, 62. The Respondent remembered during cross-examination that, although not in the chart, S.B. told him she had been on Soma previously. Tr. 817-19.

extraordinary memory by the Respondent will not help another practitioner who may treat one of the Respondent's patients and expect to rely on the Respondent's chart.

Of course, none of these reasons justifies the Respondent's failure to maintain accurate and complete patient files. Unless the records otherwise provide justification for the actions taken, or inaction, by the Respondent, I find the Respondent violated the California professional standards by failing to maintain complete and accurate medical charts as to each of the subject patients.

In his Post-hearing Brief (PHB), the Respondent argues that Dr. Munzing's assertions that deficient medical charts demonstrate treatment outside the standard of care, is faulty, as Dr. Munzing failed to speak with the subject patients to determine if the prescriptions were justified. Only then, he argues, could Dr. Munzing convincingly opine regarding whether the actual treatment was consistent with the standard of care. The Respondent misses the point. Although certainly the extent of Dr. Munzing's review of relevant material is normally critical to the conclusions he draws, the focus of Dr. Munzing's opinions relate to whether the Respondent complied with his obligations under the standard of care prior to prescribing the subject medications, and to documenting that obligation within the file. It is neither here nor there that Dr. Munzing could have resolved his own concerns regarding the subject prescriptions by speaking to the patients years later. Nor is it dispositive that Dr. Munzing could have determined, through his own investigation, that the prescriptions were justified at the time they were issued, if the Respondent

failed to satisfy his own obligations at the time the prescriptions were issued. So, I do not view the fact that Dr. Munzing did not speak with the subject patients as diminishing the probity of his relevant opinions as to the Respondent's acts or omissions, at all. The instant evaluation relates to whether the Respondent provided appropriate treatment on the basis of the information developed by the Respondent up until the time the subject prescriptions were issued.

Although the Respondent argues in his PHB that he testified credibly that he fully complied with his obligations under the standard of care, as detailed in my credibility analysis of the Respondent, the Respondent was not fully credible. In the Government's Supplemental Pre-hearing Statement (GSPHS), the Government argues that the failure to document procedures or findings within the chart justifies a finding that the procedures, evaluation or findings did not occur. On the basis of the instant record, I concur. I further adopt Dr. Munzing's conclusions that without sufficient documentation of procedures or evaluation required by the standard of care, resulting diagnoses are deemed inappropriate, there is no legitimate medical purpose established for treatment and any resulting controlled substance prescriptions were outside the usual course of professional practice.

14. Patients were left on their original medication protocols despite being at high MME and with dangerous combinations.

Patients were permitted to remain on the medications and dosages they were previously prescribed if the Respondent found them to be doing well, that their pain level was low enough that they could

work full time, and they could complete their ADLs. This was the case even with patients at dangerous levels of medication and in dangerous combinations, and popular for abuse and diversion.

The Respondent maintained this *laissez faire* attitude despite being confronted with significant red flags suggesting abuse and or diversion.[28] Even patients the Respondent acknowledged as opioid dependent and refusing detox were continued on these dangerous medications and combinations without even UDS monitoring.[29] In fact, the Respondent treated opioid dependence with opioids, which is clearly outside the California standard of care. It is actually illegal in California. Tr. 267-68, 306, 398-400. The Respondent failed to make any attempt at titration, even for patients who attempted to titrate on their own, who skipped pain medication, when they could tolerate it. As Dr. Munzing observed, the standard of care would require an attempt at titration.

I find the Respondent's failures to sufficiently monitor, and to attempt titration from dangerous

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[28] S.B. further reported to Dr. Falakassa that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription evidence. Tr. 231-32. CURES records disclosing his patients were being prescribed Suboxone by another physician.

[29] *See Holloway Distrib.*, 72 Fed. Reg. 42118, 42124 (2007) (a policy of "see no evil, hear no evil" is fundamentally inconsistent with the obligations of a DEA registrant). Agency precedent has long recognized that "[l]egally, there is absolutely no difference between the sale of an illicit drug on the street and the illicit dispensing of a licit drug by means of a physician's prescription." *EZRX, L.L.C.*, 69 Fed. Reg. 63178, 63181 (1988); *Floyd A. Santner, M.D.*, 55 Fed. Reg. 37581 (1988); *Michael J. Aruta, M.D.*, 76 Fed. Reg. 19420, 19434 (2011).

levels of medication and in dangerous combinations were outside the California standard of care.

15. Patient S.B.

Allegations

From at least February 2, 2017, through January 30, 2019, the Respondent issued prescriptions for controlled substances to Patient S.B. approximately on a monthly basis. These prescriptions included at least seventeen prescriptions ranging from 170 to 200 dosage units of Hydrocodone-acetaminophen 10-325 mg (a Schedule II opioid), 22 prescriptions for 60 dosage units of amphetamine salts 30 mg (a Schedule II stimulant), three prescriptions for 90 dosage units of alprazolam 2 mg (a Schedule IV benzodiazepine), and seven prescriptions for 90 dosage units of Carisoprodol 350 mg (a Schedule IV muscle relaxant). Each of the controlled substance prescriptions the Respondent wrote for Patient S.B. from at least February 2, 2017, through January 30, 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose. The Respondent failed to perform any appropriate physical examination of the areas in which pain was purportedly being treated, nor did the Respondent record Patient S.B.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient S.B., including medical history, mental health history, or any history of past or current illegal drug abuse. The Respondent also failed to obtain any prior medical records for Patient S.B. There was no medically legitimate basis established for the multiple controlled substance medications prescribed for Patient S.B. The Respondent repeatedly issued prescriptions to

Patient S.B. for dangerous combinations of controlled substances. These included widely-abused drug cocktails.

On at least three occasions, the Respondent prescribed Patient S.B. combinations of Hydrocodone-acetaminophen, amphetamine salts, and alprazolam. The combination of an opioid, a stimulant, and a benzodiazepine is often referred to as the "new Holy Trinity." This drug combination is highly addictive and carries a significant risk of diversion, as well as a significant risk of serious adverse medical consequences, including death.

On at least seven other occasions, the Respondent prescribed Patient S.B. a cocktail comprised of Hydrocodone-acetaminophen, amphetamine salts, and Carisoprodol. Carisoprodol is frequently abused in combination with other controlled substances, especially opioids, and that concurrent use of Carisoprodol and opioids carries a risk of profound sedation, respiratory depression, and death. On at least six other occasions, the Respondent prescribed Patient S.B. a cocktail comprised of Hydrocodone-acetaminophen and amphetamine salts. There is a significant risk of addiction and diversion from using these two dangerous drugs concurrently.

The Respondent refilled, added, and/or changed Patient S.B.'s controlled substance prescriptions without documenting any legitimate medical purpose for doing so. These actions appear to be arbitrary and unrelated to any clinical observations, which indicates that these prescriptions were issued outside the standard of care and not for a legitimate medical purpose. For example, on February 2, 2017, the Respondent prescribed Patient S.B. 90 dosage units of Cariso-

prodol 350 mg together with amphetamine salts and Hydrocodone. On March 1, 2017 and April 4, 2017, the Respondent instead prescribed Patient S.B. 90 dosage units of alprazolam 30 mg together with amphetamine salts and Hydrocodone. On May 8, 2017, the Respondent discontinued alprazolam and returned Patient S.B. to Carisoprodol 350 mg.

Despite the danger of addiction and harm to Patient S.B. from these controlled substance prescriptions, the Respondent maintained Patient S.B. on doses of controlled substances for at least two years. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient S.B. These failures included: no continuing assessments of the potential risks and benefits to Patient S.B. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies other than these dangerous medications.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient S.B., and there is no evidence that the Respondent attempted to address them. For example, as discussed *supra*, the Respondent prescribed Patient S.B. drugs popular for abuse and diversion for a long period of time. Further, the Respondent's own records reflect that Patient S.B. had an opioid dependency and refused detoxification. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient S.B.'s medication compliance, for example, by not conducting even a single urine drug screen.

Accordingly, the Respondent's controlled substance prescriptions to Patient S.B. from at least February 2, 2017, through January 30, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Discussion as to Patient S.B.

As per the parties' stipulations, between February 2, 2017 and January 30, 2019, S.B. was prescribed Hydrocodone, Carisoprodol, Adderall and alprazolam. Tr. 162-63; GDX 1. Patient S.B. remains a patient of Dr. Rabadi. Tr. 708-09. She was prescribed Hydrocodone, Xanax and Adderall. Tr. 709. Dr. Rabadi believed his prescription practice concerning S.B. was within the California standard of care. Tr. 709. Dr. Rabadi began his treatment of S.B. on August 3, 2016. Tr. 718. She presented as a 29 year-old female to establish care for the treatment of ongoing conditions of GAD, fibromyalgia and ADD. Tr. 719. Dr. Rabadi noted that patients with ADD are six times more likely to have other psychiatric conditions as people without ADD. Ultimately, Dr. Rabadi concurred with the previous physician's diagnoses of ADD, GAD, and fibromyalgia. Tr. 724, 728.

As per Dr. Rabadi's policy, and detailed in his earlier testimony, he took a complete history. Tr. 719-20. He performed a complete physical exam, reviewed her existing diagnoses of GAD and ADD, and her medication history in general, and specifically for those diagnoses. Tr. 720, 722-24. He obtained her pain level with and without medication. Without medication her subjective pain level was eight. With medication,

it was one to two, which permitted her to function and perform daily activities. Tr. 721.

Dr. Munzing disagreed, characterizing the controlled substance prescriptions as outside the standard of care. Tr. 163, 207, 241-44. For S.B.'s initial visit on August 3, 2016, she was diagnosed with GAD, ADD, and fibromyalgia. Tr. 16365; GX1 at 62, 66. However, there was no supporting findings or history for the fibromyalgia diagnosis, which typically is reached after a certain number of tender points are determined. Tr. 166. Similarly, there was no supporting findings or history to support the GAD or ADD diagnoses. Tr. 166-71, 241-44. There is no physical functioning level documented nor mental functioning level. Tr. 171. Without sufficient evaluation and supporting documentation for the three diagnoses, Dr. Munzing deemed the diagnoses inappropriate. Tr. 241-44. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescriptions. Tr. 172, 207, 241-44. The Respondent conceded that the detailed findings of the complete physical exam are not reflected in his chart, but noted he was a clinician with 41-years of experience, and not a medical student. Tr. 810.

Consistent with Dr. Munzing's opinions, the Respondent misperceives the purpose of these medical records. The documentation is necessary without regard to the skill level of the treating practitioner. It reminds the treating practitioner of the basis and ongoing treatment strategy. It also provides an accurate history of symptoms, ongoing treatment and medication protocol for other practitioners who may treat the patient in the future.

Dr. Munzing highlights that there is no documented treatment plan. Tr. 24144. On February 2, 2017, S.B. presented to the clinic suffering from fibromyalgia and ADD. Tr. 173; GX 1 at 59. The Respondent diagnosed her Fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed Hydrocodone, Carisoprodol, and Adderall. Tr. 173-74. Again, there was no medical history justifying the diagnoses. The physical exam conducted on February 2, 2017, consisted of blood pressure, cardiovascular, heart and lung, which were normal, which is insufficient to justify the fibromyalgia and ADD diagnosis. Tr. 175. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 175-76. For the progress notes of June 28, 2017, the Respondent diagnosed her with Fibromyalgia-opioid dependent, refusing detox, and ADD. He prescribed Hydrocodone, Carisoprodol, and Adderall. Tr. 177.

Again, there was no medical history justifying the diagnoses. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr. 177-78; GX 1 at 57. Again, only a blood pressure and heart and lung exams were performed. Tr. 177. There was insufficient medical evidence to justify the three diagnoses. Tr. 177-78. For the progress noted of December 21, 2018, S.B. presented with eczema and fibromyalgia. Tr. 179; GX 1 at 49. The Respondent diagnosed her with Fibromyalgia-opioid dependent, refusing detox. She was prescribed Hydrocodone. No history was recorded. Again, only a blood pressure and heart and lung exams were performed. Tr. 180. There was no documentation of the pain level, or functionality level, to justify continued controlled substance prescribing. Tr.

180. There was insufficient medical evidence to justify the fibromyalgia diagnosis. Tr. 181. In the progress notes for January 30, 2019, S.B. reported to the clinic with ADD and rhinitis. Tr. 181; GX1 at 47. She was prescribed Adderall for the ADD. No medical history was taken. ADD patient progress was reported as "stable". There was insufficient medical evidence to justify the ADD diagnosis. Tr. 183. Dr. Munzing deemed the ADD diagnoses inappropriate. Without an appropriate diagnosis, there is no legitimate medical purpose for the controlled substance prescription. Tr. 185-86.

During the subject period of the Respondent's treatment of S.B., he never obtained any prior medical records. Tr. 184. He never recorded a history, which would justify his diagnoses for fibromyalgia, GAD or ADD. He never reported a sufficient physical or mental exam to justify the fibromyalgia, GAD or ADD diagnoses. He never reported a sufficient evaluation to justify his diagnoses for fibromyalgia, GAD or ADD. Tr. 184-85. The controlled substance prescriptions for S.B. were not issued within the California standard of care, nor were they issued within the usual course of professional practice. Tr. 187, 244.

Dr. Munzing observed that the diagnoses would come and go in the records, were inconsistently reported, which is atypical for chronic diagnoses. Tr. 188-97. A chronic disease, with symptoms which appear to come and go would question whether the patient had the disease at all. Tr. 192. Even a lessening of symptoms should cause evaluation of whether tapering of medication was appropriate. Tr. 196.

Dr. Munzing noted that the Respondent prescribed S.B. both Hydrocodone and Soma to treat fibromyalgia on numerous occasions. Tr. 197-98. On other occasions he prescribed the Hydrocodone without Soma, without any explanation for changing the medication protocol, contrary to the California standard of care for documentation. Tr. 198-201; GX 20 at 61. Dr. Munzing noted that S.B. was on a dangerous, highly addictive, combination of medications, popular for abuse, Hydrocodone and Soma, which are respiratory depressants, and Adderall, a Schedule II medication. Tr. 202. Another dangerous combination, Hydrocodone, Adderall and Xanax was prescribed on 1, 2017, in April 2017 and June 2017. Tr. 203; GDX 1. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity". Tr. 204. It includes the depressants, Hydrocodone and Soma, and is followed by the stimulant, Adderall, to counteract the effects of the depressants. Again, the combination of Hydrocodone and Soma are the subject of the FDA "black box" warning. Tr. 205. The high dosage of Xanax, 6 mg per day, heightens the risk of this already dangerous combination. With Xanax and Adderall prescribed at their highest commercially available dosage units, the danger and risk of addiction are further increased. Tr. 205. Additionally, two mg tablets of Xanax are popular for abuse and diversion. Tr. 217-18. On September 29, 2017, and monthly from July 2018 to July, 2019, S.B. was prescribed Hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the Hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition

in which this combination would be appropriate. Tr. 211-12.

The Respondent defended his keeping S.B. on this medication protocol, noting that if the Respondent objected to every patient's choice of treatment, there would be no medical care. If a patient says they are on medication and it permits them to function, the Respondent will continue that treatment. Tr. 729-30. S.B. indicated she had been through several alternate treatments, including, occupational therapy, physical therapy, hydrotherapy, yoga and meditation. Tr. 731, 805.

She further reported that she had been on the same dosage of medications for several years to good effect. Tr. 731-32. To reduce her from those dosages would have to be done gradually, lest the patient have withdrawal and suffer severe pain. Tr. 732. Prior to each prescription, the Respondent discussed side effects, and changes in status. Tr. 733. However, the record discloses that the patient was not always taking the medications as prescribed. There were a number of notations that the patient refused detox.

The Respondent misperceives his role as an independent practitioner. He has a responsibility to independently determine the course of treatment, even in patients he inherits from other prescribers. Completely deferring to his patients' wishes in determining appropriate treatment is contrary to his role within the California standard of care. He concedes titration would have to be done gradually. However, he kept this patient on high levels of dangerous medication, in dangerous combinations, for two years, without attempting titration. This treatment is below the California standard of care. The Respondent's failure to obtain prior

medical records and failure to document the patient's history, and to even order a single UDS, is consistent with this relinquishment of his responsibility to independently evaluate and to monitor the patients' condition and to develop an appropriate treatment plan.

The Respondent explained his process to obtain informed consent to prescribe controlled substances to S.B. The Respondent executed the "pain management contract". Tr. 728-29. The patient reads it and signs it. The Respondent then goes over the contract in detail with the patient. The Respondent then explains that the medications are meant to help the patient, not to cause side effects or addiction, although they tend to cause chemical dependence. Tr. 729. The Respondent then goes over all the alternative treatments, but in the end, it is the patient's decision as to the treatment he will receive. Tr. 729.

Dr. Munzing noted that the medical records failed to disclose any indication that the Respondent warned S.B. regarding the risks associated with these dangerous combinations of medications. This failure precludes any informed consent by S.B. Tr. 207. The Declaration of Pain Medication Use document in the file, dated August 3, 2016, which requires the patient to alert the Respondent if the patient takes additional medications which could result in drug interactions, does not put the patient on notice of the dangerous combinations prescribed by the Respondent. Tr. 207-10; GX 1 at 67. Similarly, Dr. Munzing noted the repeated notation within the patient records of "SED", which Dr. Munzing assumed meant, "side effects discussed", was insufficient documentation within the standard of care for discussing the various risks of

these medication combinations. Tr. 210-11; GX 1 at 59.

I agree with Dr. Munzing's assessment that, on the basis of the above lapses, the Respondent failed to obtain informed consent under the California standard. The Respondent's failure to document the details of his informed consent process itself renders his process below the California standard of care.

In March, April and June of 2017, the Respondent prescribed S.B. Xanax at 6 mg per day, in excess of the FDA recommended daily limit of 4 mg per day. Tr. 212-15; GX 1 at 57, 58, 59; GX 22 at 40, 59-61. In May of 2017, the Xanax is abruptly stopped, Tr. 216-17; GDX 1, and abruptly restarted in June of 2017, and again stopped. Tr. 217. This is very dangerous as the abrupt stoppage of Xanax, especially at this high dosage, can cause seizures, and restarting at this high dosage can trigger an overdose, especially in conjunction with the prescribed opioid. Tr. 212-18.

Regarding the monitoring of S.B., there were no urine drug screens evident in the records, which the standard of care would have required at least quarterly. Tr. 218-21; GX 1 at 44. In the progress notes for February, March, April 2017, all the way to January 30, 2019, the Respondent noted "refusal to detox". Tr. 220-21, 22729; GX 1 at 58, 59. This is a huge red flag for opioid use disorder and for diversion. However, the chart suggests the Respondent did not take any necessary action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 222-23. The Respondent's course of action was outside the California standard of care. Tr. 223, 229.

In a June 2017 report from Dr. Falakassa, an orthopedic surgeon, who saw S.B. for reported neck and back pain, S.B. reported her past medical history as only "anxiety". Tr. 229; GX 1, p. 30, 32, 36-42, 56. She did not report fibromyalgia, ADD or GAD. Tr. 229-30. S.B. further reported to Dr. Falakassa that she was not then taking any medication for pain, which is contrary to the Respondent's medical records and prescription evidence. Tr. 231-32. Dr. Falakassa's report was part of S.B.'s disability application, claiming disability as of June 15, 2017. A report from Chiropractor, Bruce Hall is included in the disability packet. Tr. 235. Dr. Hall reports the disability was caused by "accident or trauma", which is inconsistent with what the patient reported to Dr. Falkassa and to the Respondent. Tr. 236. There is no indication within the Respondent's records for S.B. that he ever discussed, with S.B. or with Dr. Falkassa, the discrepancies revealed by Dr. Falkassa's report. Tr. 233-37.

Contemporaneous to the preparation of the disability claim, Dr. Rabadi ordered a series of radiologic tests on S.B., none of which were related to the Respondent's diagnosis of fibromyalgia. The progress notes from August 17, 2017, S.B. presented with "overactive thyroid, gait disturbance". Tr. 237-40; GX 1 at 5, 7, 9, 11, 13, 16, 17, 56. Dr. Ramadi ordered an MRI of the brain to rule out MS, a thyroid ultrasound to rule out hyperthyroidism, an MRI of the lumbar spine, and an MRI of the thoracic spine. The MRI of the cervical spine was ordered by Dr. Falkassa. Tr. 241.

In the context of S.B.'s disability claim, the Respondent ordered a series of tests in support of the disability claim, but neglected to order any tests related

to the fibromyalgia, for which the Respondent was treating S.B. This further calls the Respondent's treatment into question.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient S.B. from at least February 2, 2017, through January 30, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

16. Patient M.B.

Allegations

From at least January 5, 2018, through November 2019, the Respondent issued prescriptions for controlled substances to Patient M.B. approximately on a monthly basis. These prescriptions included at least nineteen prescriptions ranging from 90 to 240 dosage units of Hydrocodone-acetaminophen 10-325 mg (a Schedule II opioid), and at least 20 prescriptions for 60 dosage units of amphetamine salts 30 mg (a Schedule II stimulant). Each of the controlled substance prescriptions the Respondent wrote for Patient M.B. from at least January 5, 2018, through November 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas in which pain purportedly was being treated, nor did the Respondent record Patient M.B.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient M.B., including medical history, mental health history, or any history of past or current illegal drug abuse. The

Respondent also failed to obtain any prior medical records for Patient M.B.

There was no medically legitimate basis established for the multiple controlled substance medications prescribed for Patient M.B. The Respondent repeatedly prescribed Patient M.B. a dangerous combination of controlled substances. Specifically, on at least nineteen occasions, the Respondent issued prescriptions to Patient M.B. for Hydrocodone-acetaminophen and amphetamine salts, despite the significant risk of addiction and diversion from using these two dangerous drugs concurrently.

Despite the danger of addiction and harm to Patient M.B. from these controlled substance prescriptions, the Respondent maintained Patient M.B. on these doses of controlled substances for at least twenty-one months. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient M.B. These failures included: no continuing assessments of the potential risks and benefits to Patient M.B. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies other than these dangerous medications.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient M.B., and there is no evidence that the Respondent attempted to address them. For example, as detailed above, the Respondent prescribed Patient M.B. drugs popular for abuse and diversion for a long period of time. Further, the Respondent's own records reflect that Patient M.B. had an opioid dependency and refused detoxification. Despite such red flags of

drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient M.B.'s medication compliance, for example, by conducting even a single urine drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient M.B., which was an improper "treatment" for Patient M.B.'s opioid dependency, and in violation of 21 C.F.R. § 1306.04(c).

Accordingly, the Respondent's controlled substance prescriptions to Patient M.B. from at least January 5, 2018, through November 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Discussion at to Patient M.B.

The Respondent testified that Patient M.B. presented on April 19, 2006 with severe back pain, left knee pain, and history of dyslipidemia. Tr. 782. The Respondent obtained a full medical history, medication history, pain level, performed a complete head to toe physical exam. Tr. 783. The Respondent discovered M.B. had chronic back pain related to an injury, a knee injury, which was manageable, and dyslipidemia. Tr. 784. Although the Respondent maintains he obtained a complete medical history as to the back pain, and chronic knee pain, he concedes it is not detailed in the chart. Tr. 820-23. He was already on Hydrocodone, previously prescribed, when M.B. first saw the Respondent. The Respondent obtained informed consent in the same manner as described for his earlier patients. Tr. 784. He discussed alternative forms of treatment with M.B., however M.B. had exhausted

those. M.B. had physical therapy, and perhaps acupuncture, but the Respondent could not quite remember. Tr. 827. The Respondent conceded he did not document these therapies in the chart. Tr. 828.

Dr. Munzing observed that between January 5, 2018 and November 20, 2019, the Respondent prescribed Hydrocodone and Adderall. Tr. 245. As with patient S.B., Dr. Munzing characterized the patient file as meager. Tr. 245-47. The Respondent never obtained prior medical records of M.B. Tr. 288. Dr. Munzing observed that none of the subject prescriptions were within the California standard of care. Tr. 248, 289. On April 19, 2006, M.B. presented for his first visit. Tr. 24849; GX 3 at 88, 91. In his "Comprehensive History and Physical Examination", the Respondent reported that M.B. presented with symptoms of "chronic back pain, left knee pain, dyslipidemia". Tr. 249-50. However, there are no diagnoses relating to the back and knee pain. Tr. 250-51, 258. To address the reported pain, the Respondent prescribed Hydrocodone. Tr. 252. The file fails to evidence sufficient history to justify the pain prescriptions under the standard of care. Tr. 252-54. The file fails to evidence any physical exam to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287. The file fails to evidence any treatment plan or goals, past drug abuse to justify the pain prescriptions under the standard of care. Tr. 254-55, 258, 287. Although M.B. declared on a "Declaration of Pain medication Use" form that he had no prior drug abuse in August 2009, which was three years after his first visit, such static declaration does not satisfy the physician's ongoing responsibility under the standard of care to monitor this issue. Tr. 259-61; GX 3 at 93.

On July 9, 2013, M.B. presented with ADD and neck pain. Tr. 261-62; GX 3 at 46. He was prescribed Adderall for the ADD. Tr. 262. Again, the records reveal there was no history taken to support the diagnosis or prescriptions for Adderall. Tr. 262. There was no evident evaluation done by the Respondent. Tr. 287. There was no treatment plan. Tr. 263. Although there was a diagnosis related to the neck pain, there was no history or physical exam evident in the file. Tr. 263-64. The Respondent never established a legitimate medical purpose for Hydrocodone. Tr. 264. On September 6, 2013, M.B. presented with ADD. Tr. 264-65; GX 3 at 46. He was prescribed Adderall for the ADD, but at double the dosage of the previous visit, yet without any reported justification. Tr. 264-65. On January 5, 2018, M.B. presented to the clinic. Tr. 265-66; GX 3 at 37. He was prescribed Hydrocodone and Adderall. There was no medical history, no discussion of M.B.'s response to treatment, evaluation of pain or functioning, substance abuse history, diagnoses, or rationale for establishing a legitimate medical purpose to justify continuing the medication regimen. Tr. 265-66. On March 6, 2018, M.B. presented to the clinic with "ADD and opioid dependency". Tr. 266-67; GX 3 at 36. Absent was any report of pain. He was diagnosed with "Opioid dependency, refusing detox". Tr. 267. He was prescribed Hydrocodone, which is not only outside the standard of care, but is illegal in California. Tr. 267-68. Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 268. Dr. Munzing observed that the Respondent prescribed Hydrocodone repeatedly to address his diagnosis of opioid dependency until November 20, 2019. Tr. 268-69. On November 20, 2019, M.B. presen-

ted with ADD and back pain. Tr. 269; GX 3 at 27. He was prescribed Adderall, and his Hydrocodone was increased. Tr. 270. No medical history was taken or updated. No response to treatment or patient functionality was included. Although vital signs were taken, no physical exam was performed. Tr. 270-71. There was no appropriate diagnosis for the back pain. Tr. 272. There was no evaluation for ADD, such as mental functioning. Tr. 271, 274, 287-88. The Respondent never obtained a sufficient history to support the diagnosis for ADD. Tr. 273. There was no appropriate diagnosis for ADD. Tr. 272. The Respondent never established a legitimate medical purpose to prescribe either Hydrocodone or Adderall to M.B. throughout the reported treatment. Tr. 274. Such prescriptions were not in the usual course of professional practice, were not for a legitimate medical purpose and were outside the standard of care. Tr. 274-75.

Dr. Munzing noted the inconsistency of the various diagnoses. Diagnoses would come and go within the records. Tr. 275-278; GX 3 at 35, 37, 43, 67. Although the reported pain was always treated with Hydrocodone, the source of the pain varied greatly, yet no explanation for this is included in the file, as required by the standard of care. Tr. 278-80.

Dr. Munzing noted the serious dangers occasioned by the combination of Adderall and Hydrocodone, by reference to his testimony regarding S.B.'s similar prescriptions.[30] Tr. 281. Dr. Munzing deemed this

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[30] On September 29, 2017, and monthly from July 2018 to July, 2019, S.B. was prescribed hydrocodone and Adderall. Besides the serious risk of addiction posed by these two Schedule II medications, the hydrocodone was prescribed at a daily dosage of 60 mg MME, which significantly increases the risk of overdose

combination of medications for over ten years inappropriate and unsafe. Tr. 284. The only semblance of a warning to M.B. regarding these dangerous combinations appeared in a 2009 "Controlled Substance Therapy Agreement". For the same reasons voiced as to Patient S.B., Dr. Munzing deemed the signed form wholly insufficient to satisfy the California standard of care in this regard. Tr. 281-82; GX 3 at 92. Similarly, the notation within the file, "SED" was insufficient to satisfy the standard of care. Tr. 283. There was never a UDS ordered for M.B., necessary under the standard of care for any patient receiving opioids, but especially for a patient who has refused opioid detox. Tr. 284-85. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was not addressed by the Respondent repeatedly as to M.B. Tr. 285-87; GX 3 at 36.

The Respondent defended his treatment of M.B. by noting that he monitored M.B. throughout his treatment. Tr. 785. The Respondent believed his prescribing was justified on the basis of M.B.'s medical conditions, level of chronic pain and present level of functioning, working in a welding factory, and in the movie business. Tr. 786, 832. The Respondent conceded that he did not document M.B.'s degree of pain, but minimized the value of the subjective pain scale. Tr. 823-24. The Respondent conceded there were no imaging reports in M.B.'s chart, but explained that these patients were from the movie business. They were

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and death. This risk was increased by its combination with Adderall. Tr. 206-07. Dr. Munzing could not foresee a medical condition in which this combination would be appropriate. Tr. 211-12.

treated by an HMO, from which is almost impossible to obtain records. Tr. 829.

It is true the Respondent monitored M.B. during treatment, and not all this monitoring found its way into M.B.'s chart. Alarming evidence revealed the Respondent was aware M.B. was receiving Suboxone from Dr. Stark during the period the Respondent was prescribing high levels of dangerous medications and in dangerous combinations. DI Johnson identified GX 25, which is a CURES Audit Report run on the DEA Registration of Dr. Bruce Stark, which included the patient M.B., a patient common to the Respondent. Tr. 904. Between October 10, 2018 and September 11, 2020, Dr. Stark prescribed Suboxone[31] to M.B. Tr. 909; GX 24, 25, 25B. On March 15, 2019, the Respondent accessed CURES and would have observed M.B. was receiving Suboxone from Dr. Starks. Tr. 910; GX 24. Despite discovering the Suboxone prescriptions, the Respondent continued prescribing these dangerous medications, and like his other patients, without any UDS.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient M.B. from at least January 5, 2018, through November 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

17. Patient B.C.

Allegations

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[31] Buprenorphine.

From at least January 25, 2017, through December 19, 2019, the Respondent issued prescriptions for controlled substances to Patient B.C. approximately on a monthly basis. These prescriptions included at least 30 prescriptions ranging from 90 to 200 dosage units of Hydrocodone-acetaminophen 10-325 mg (a Schedule Il opioid), at least 12 prescriptions for 60 dosage units of amphetamine salts 30 mg (a Schedule Il stimulant), and at least 11 prescriptions for 90 dosage units of alprazolam 2 mg (a Schedule IV benzodiazepine). Each of the controlled substance prescriptions the Respondent wrote for Patient B.C. from at least January 25, 2017, through December 19, 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas in which pain purportedly was being treated, nor did the Respondent record Patient B.C.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient B.C., including medical history, mental health history, or any history of past or current illegal drug abuse. The Respondent also failed to obtain any prior medical records for Patient B.C.

There was no medically legitimate basis established for the multiple controlled substance medications prescribed for Patient B.C.

The Respondent repeatedly issued prescriptions to Patient B.C. for highly dangerous combinations of controlled substances. On at least four occasions, the Respondent prescribed Patient B.C. a combination of Hydrocodone-acetaminophen, amphetamine salts, and alprazolam. The combination of an opioid, a stimulant,

and a benzodiazepine is a widely-abused drug cocktail often referred to as the "new Holy Trinity." This drug combination is highly addictive and carries a significant risk of diversion, as well as a significant risk of serious adverse medical consequences, including death. On at least seven occasions, the Respondent prescribed Patient B.C. a combination of Hydrocodone-acetaminophen and alprazolam. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death. On at least eight occasions, the Respondent prescribed Patient B.C. a combination of Hydrocodone-acetaminophen and amphetamine salts, despite the significant risk of addiction and diversion from concurrent use of these two dangerous drugs.

The Respondent refilled, added, and/or changed Patient B.C.'s controlled substance prescriptions without documenting any legitimate medical purpose. These actions appear to be arbitrary and unrelated to any clinical observations, and so further indicate that these prescriptions were issued outside the standard of care and not for a legitimate medical purpose.

For example, on July 3, 2018, the Respondent prescribed Patient B.C. 180 dosage units of Hydrocodone-acetaminophen and 90 dosage units of alprazolam. On July 31, 2018, the Respondent prescribed Patient B.C. 180 dosage units of Hydrocodone-acetaminophen, 90 dosage units of alprazolam, and 60 dosage units of amphetamine salts.

On August 28, 2018, the Respondent prescribed Patient B.C. 180 dosage units of Hydrocodone-acetaminophen. On September 25, 2018, the Respondent prescribed Patient BC. 180 dosage units of Hydro-

codone-acetaminophen and 60 dosage units of amphetamine salts.

Despite the danger of addiction and harm to Patient B.C. from these controlled substance prescriptions, the Respondent maintained Patient B.C. on doses of controlled substances for over two years. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient B.C. These failures included: no continuing assessments of the potential risks and benefits to Patient B.C. from the controlled substances the Respondent prescribed; and no assessments of the ongoing need to prescribe these controlled substances.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient B.C., and there is no evidence that the Respondent attempted to address them. For example, as detailed above, the Respondent prescribed Patient B.C. drugs popular for abuse and diversion for a long period of time. Further, the Respondent's own records reflect that Patient B.C. had an opioid dependency and refused detoxification. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient B.C.'s medication compliance, for example, by conducting even a single urine drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient B.C., which was an improper "treatment" for Patient B.C.'s opioid dependency.

Accordingly, the Respondent's controlled substance prescriptions to Patient B.C. from at least January 25, 2017, through December 19, 2019, were not issued "for a legitimate medical purpose by an individual prac-

titioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Additionally, as noted above, during this time period the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient B.C. as "treatment" for Patient B.C. 's opioid dependency, in violation of 21 C.F.R. § 1306.04(c).

Discussion as to Patient B.C.

The Respondent explained his treatment of Patient B.C. He has been a patient of the Respondent since March 27, 2014. Tr. 750-51. Patient B.C. has been prescribed Hydrocodone, Xanax and Adderall. Tr. 749. The Respondent obtained a complete history, a complete physical exam and then probed the complaint which brought him to the Respondent, which was right shoulder and chronic back pain. Tr. 751. Without medication, B.C. reported pain at seven or eight, with medication, one or two. Tr. 752. As far as his medication history, B.C. had been on pain medication for years following a neurosurgical procedure to treat a herniated disc with radiculopathy.[32] Tr. 752.

To obtain informed consent, the Respondent discussed the pain management contract, which B.C. read and signed. Tr. 752-53. The Respondent then discussed side effects of the medication. B.C. is a married man with three children. He works full time.

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[32] The Government objected to B.C.'s prior treatment history, which was not noticed in the RPHS. Although I ruled it was reasonably anticipated. The Respondent cited to specific treatment from a prior physician. The contested evidence is reflected in GX 5 at 14, so the Government was certainly not surprised by the evidence.

He gave the Respondent no indication he was a risk of diversion. Tr. 753. Regarding prior alternate treatment, B.C. reported that he has tried surgery, physical therapy and acupuncture, but that only pain medication therapy alleviates his pain to the extent he can function. Tr. 754. At each visit, the Respondent reviewed B.C.'s progress and believed B.C.'s condition warranted the medication he was prescribed. Tr. 754, 757. Although the Respondent remembered discussing B.C.'s pain levels on March 27, 2014, that it was one or two on medication, he conceded it was not documented in the chart. Tr. 832-34; GX 5 at 48. Although the Respondent remembered B.C. reporting he had a herniated disc, this report was not documented in the chart. Tr. 836. Neither were B.C.'s reported prior therapies documented. Tr. 837.

Dr. Munzing reviewed the subject prescriptions, patient file and CURES report for Patient B.C, which he described as lean. Tr. 290-92; GDX 3. He opined that the subject controlled substance prescriptions issued for Hydrocodone, Xanax and Adderall, from January 25, 2017 to December 19, 2019, were all issued outside the California standard of care. Tr. 290-92, 335-38. B.C. presented on March 27, 2014, with GAD and back pain. Tr. 293-94; GX 5 at 48, 55. B.C. was diagnosed as GAD and back pain, refusing detox. He was prescribed Xanax (6 mg per day) for the GAD, and Hydrocodone for the back pain, refusing detox. Tr. 294. Dr. Munzing reiterated the risks involved in prescribing 6 mg of Xanax per day. Tr. 294.

The records failed to disclose the minimum history necessary under the standard of care to appropriately diagnose "back pain" and GAD. Tr. 295-96. Other than limited vital signs, the records failed to disclose the

minimum physical examination necessary under the standard of care to appropriately diagnose "back pain", or to justify a Hydrocodone prescription. Tr. 296-97. Dr. Munzing could not remember seeing any prior medical records in the Respondent's subject files. Tr. 297. There were no entries in B.C.'s file indicating physical or mental functioning. Tr. 298, 335-38. There is no treatment plan indicated. The Declaration of Pain Medication Use, signed by B.C. at his first visit, as discussed *supra*, is insufficient to evaluate B.C., and to establish informed consent for the controlled substances prescribed. Tr. 299-300. There was insufficient medical evidence to support either diagnosis. Tr. 298, 335-38. So, there was no legitimate medical purpose for either controlled substance prescription. Tr. 299, 335-38. B.C. presented on May 20, 2014 with ADD, and was prescribed Adderall. Tr. 301-02; GX 5 at 47. The ADD diagnosis was deficient, as no history was developed, no mental functioning was assessed, the medical evidence was deficient, and a treatment plan was lacking. The Respondent failed to establish a legitimate medical purpose for the Adderall. Tr. 302. Additionally, starting B.C. on 30 mg of Adderall twice daily is a very high dosage, and extremely inappropriate to an Adderall naive patient, which is not developed within the patient file. Tr. 302-03. B.C. presented on January 25, 2017, with ADD, opioid dependency and GAD. Tr. 303; GX 5 at 33. He was diagnosed with ADD, for which he was prescribed Adderall, and GAD, for which he was prescribed Xanax (6 mg per day). Tr. 304. Pain levels were not reported at this visit. The diagnoses were unsupported by sufficient, medical history, medical evaluation, response to treatment, patient functionality, and medical evidence. Tr. 304-06. He failed to estab-

lish a legitimate medical purpose for both Adderall and Xanax. Tr. 306, 335-38. The Respondent further diagnosed, "Opioid dependency, refusing detox, to which the Respondent again prescribed Hydrocodone. Tr. 306. Prescribing Hydrocodone for opioid dependence is not only not within the standard of care, but it is illegal in California. Tr. 307. Hydrocodone as treatment for opioid dependency is not a legitimate medical purpose and is outside the usual course of professional practice. Tr. 307. A patient diagnosed with opioid dependency and refusing detox is also a red flag of abuse and diversion. Such red flag was repeatedly left unaddressed by the Respondent as to B.C. Tr. 306-07; GX 5 at 33.

On July 31, 2018, B.C. presented with ADD, back pain and GAD. Tr. 308; GX 5 at 28. He was diagnosed with ADD, for which he was prescribed Adderall (60 mg per day), "back pain, opiate dependent, refusing detox", for which he was prescribed Hydrocodone, GAD, for which he was prescribed Xanax (6 mg per day). Tr. 308. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment and no indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 30809, 335-38. There was no reference to pain levels or physical functionality. Tr. 309-10. There was no reference to mental functioning with respect to the ADD and GAD diagnoses. There was no appropriate diagnosis for the three diagnoses. Tr. 309-10.

Neither did he establish a legitimate medical purpose for the three controlled substance prescriptions. Tr. 311. B.C. presented on December 19, 2019, with ADD and back pain, which was also his diagnosis, and

for which he was prescribed Adderall (60 mg per day) and Hydrocodone. Tr. 311-12; GX 5 at 20. The record is absent medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. Tr. 312-13, 335-38. As a result, the three diagnoses are without sufficient medical evidence. Tr. 313. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, are outside the usual course of professional practice, and are contrary to the standard of care. Tr. 313-16, 335-38.

Dr. Munzing noted the inconsistency of diagnoses throughout B.C.'s records, and the dual prescribing of Hydrocodone for opioid abuse and for skeletal pain, without explanation in the record. Tr. 316-19; GX 5, p. 31, 32, 33. Dr. Munzing noted the GAD and ADD diagnoses appears and disappears within the record, as did their treatment medications. Tr. 319-24; GX 5 at 27, 31, 32, 33. Dr. Munzing deemed it highly unlikely that ADD and GAD were appropriate diagnoses. Tr. 322, 324. The Respondent prescribed B.C. a combination of Hydrocodone, Adderall and Xanax. Tr. 327; GDX 3. Dr. Munzing could not conceive of a medical condition warranting this dosage, duration and combination of medications, noting Adderall is counter-indicated for GAD, and combining Xanax with an opioid represents a dangerous combination and is contrary to an FDA black box warning and CDC guidance. Tr. 327-29, 332-33; GDX 3. A further concern, as detailed earlier in his testimony, is reflected by the repeated combination of Hydrocodone and Adderall by the Respondent. Tr. 329-30; GDX 3. These dangerous combinations were without an established legitimate

medical purpose, outside the usual course of professional practice, prescribed without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 330-35.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient B.C. from at least January 25, 2017, through December 19, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

18. Patient J. C.

Allegations

From at least January 16, 2018, through December 2019, the Respondent issued prescriptions for controlled substances to Patient J.C. approximately on a monthly basis. These prescriptions included at least 17 prescriptions ranging from 45 to 100 dosage units of Hydrocodone-acetaminophen 10-325 mg (a Schedule II opioid), and at least 22 prescriptions ranging from 45 to 90 dosage units of diazepam 5 mg or 10 mg (a Schedule IV benzodiazepine). Each of the controlled substance prescriptions the Respondent wrote for Patient J.C. from at least January 16, 2018, through December 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas which were the purported sources of the pain, nor did the Respondent record Patient J.C.'s pain level or functionality level. At no point in time did the Respondent record an

appropriate patient history for Patient J.C., including medical history, mental health history, or any history of past or current illegal drug abuse. The Respondent also failed to obtain any prior medical records for Patient J.C. No medically legitimate basis was established for the multiple controlled substance medications prescribed for Patient J.C.

The Respondent repeatedly issued prescriptions to Patient J.C. for a highly dangerous combination of controlled substances. Specifically, on at least 14 occasions, the Respondent prescribed Patient J.C. a combination of Hydrocodone-acetaminophen and diazepam. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death.

Despite the danger of addiction and harm to Patient J.C. from these controlled substances, the Respondent maintained Patient J.C. on doses of controlled substances for at least two years. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient J.C. These failures included: no continuing assessments of the potential risks and benefits to Patient J.C. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies other than these dangerous medications.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient J.C., and there is no evidence that the Respondent attempted to address them. For example, as detailed above, the Respondent prescribed Patient J.C. drugs popular for abuse and diversion for a long

period of time. Further, the Respondent's own records reflect that Patient J.C. had an opioid dependency and refused detoxification. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient J.C.'s medication compliance, for example, by conducting even a single urine drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient J.C., which was an improper "treatment" for Patient J.C.'s opioid dependency, and in violation of 21 C.F.R. § 1306.04(c).

Accordingly, the Respondent's controlled substance prescriptions to Patient J.C. from at least January 16, 2018, through December 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore are also a violation of 21 C.F.R. § 1306.04(a).

Discussion as to Patient J.C.

The Respondent discussed his treatment of Patient J.C. He presented on May 18, 2009 with chronic back pain, ulcerative colitis, and GAD. Tr. 759-60, 761-62. He was prescribed Hydrocodone, and Xanax, sometimes substituted with Valium. Tr. 759. The Government prompted the Respondent to visits in which several other controlled substances were prescribed. Tr. 842-46; GX 7 at 181, 214, 215.

The Respondent explained J.C. had suffered multiple injuries, and had been immobile for some time. However, the Respondent did not document the injuries, nor the immobility in the chart, nor did the

file contain any prior medical records.[33] Tr. 839, 842; GX 7 at 216. He had undergone physical therapy, occupational therapy and finally pain management, which permitted him to resume working full-time. These alternate treatments and therapies and prior surgeries were not documented within the chart. Tr. 840. The Respondent could not remember if J.C. mentioned his prior surgeries at the first or second visit. Tr. 840. The Respondent performed a full exam on J.C. Tr. 760-61. His GAD resulted from his ulcerative colitis. Tr. 762. The Respondent obtained informed consent to prescribe controlled substances by explaining the pain contract, after J.C. read it and signed it. Tr. 763. The Respondent explained the dangers of overdose. Tr. 764. The Respondent had no concerns over J.C. diverting his medication. Tr. 764-65. On the basis of J.C.'s considerable injuries and condition, the Respondent felt J.C.'s medication protocol was fully justified. Tr. 765. Although the Respondent remembered J.C. reporting that he had seen two previous doctors, including a pain physician, that report was not reflected in the chart. Tr. 841-42. Although the Respondent remembered performing a complete mental health evaluation on J.C., it is not documented in the chart. Tr. 842. The Respondent denied ever intentionally misspelling J.C.'s first name. Tr. 765-66.

Dr. Munzing reviewed the subject prescriptions issued from January 16, 2018 to December 30, 2019, patient records and CURES data relating to Patient J.C. Tr. 381-82; GDX 4. Dr. Munzing opined that none of the subject prescriptions issued to J.C. were within the California standard of care. Tr. 382. J.C. presen-

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[33] The Respondent again explained the difficulty in obtaining prior medical records. Tr. 842.

ted to the Respondent's clinic on May 18, 2009 with headache and GAD. Tr. 383-384; GX 7, at 216, 233. He was prescribed Hydrocodone for migraine and Xanax for GAD, and remained on this medication regimen for a long period. As to the migraines, insufficient medical history was obtained, symptom evaluation was absent, no neurological exam was conducted, no evaluation of functioning level, no treatment plan evident, and no evaluation of possible drug abuse. Tr. 384-90.

In short, there was insufficient medical evidence to support the diagnosis of migraines and GAD, nor was there a legitimate medical purpose to prescribe Hydrocodone and Xanax. TR. 386-88. J.C. presented on July 21, 2016 with "GAD, chronic back pain, consented for H&P". Tr. 390; GX 7, p. 189. He was diagnosed with GAD, back pain – refusing detox, for which he was prescribed Xanax and Hydrocodone, respectively. Tr. 390-91. There was no updated history taken for either diagnosis, no physical exam, no treatment plan, no response to treatment, no pain of functioning level evaluation, no discussion regarding drug abuse, and no rationale for continued treatment, as required by the standard of care. Tr. 390-94. According there was deficient medical evidence to support either diagnosis. The Respondent did not establish a legitimate medical purpose to prescribe the controlled substances. Tr. 393-94. J.C. presented on January 16, 2018 with GAD and back pain, for which he was diagnosed with GAD and back pain, opiate dependent, refused detox. Tr. 394-95; GX 7 at 180. He was prescribed Valium for the GAD, discontinue Klonopin, and Hydrocodone for back pain, although no explanation was giving for substituting the Valium for the Klonopin. Tr. 395. There was no medical history included in the records, no response to treatment, no physical exam, no pain

or functioning evaluation, no drug abuse history, rendering each diagnosis inappropriate. Tr. 395-97. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 396-

98. J.C. presented on February 16, 2018, with "opioid dependency, GAD", yet without the previously noted back pain. Tr. 198; GX 7, 9. There is no reference to pain. He was diagnosed with "Opioid dependency, refusing detox", for which he was prescribed Hydrocodone, which again, is outside the standard of care and usual course of professional practice, and illegal in California. Tr. 398-400. The diagnosis for opioid dependency being treated with Hydrocodone appeared repeatedly in the records. Tr. 399. J.C. presented on May 6, 2019, however no treatment notes for this visit are evident in the file. Tr. 401; GDX 4, GX 7 at 168.

On April 9, 2019, J.C. presented with GERD, and back pain, for which he was prescribed Hydrocodone. Tr. 402. However, there was no medical history included in the records, no response to treatment, no physical exam, no pain or functioning evaluation, no mental health history, no drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 402-04. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 40204. On December 30, 2019, J.C. presented with GERD and GAD. Tr. 404; GX 7 at 171. He was prescribed Valium for the GAD. However, there was no appropriate medical history included in the records, no response to treatment, no physical exam, no evaluation for GAD, or functioning evaluation, no mental health history, no drug abuse history, rendering the GAD diagnosis inappropriate from January 16,

2018 to December 30, 2019. Tr. 404-08, 425-28. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 408, 425-28. Such prescriptions, from January 16, 2018 to December 30, 2019, were outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice. Tr. 408, 425-28.

Dr. Munzing noted the inconsistency of diagnoses throughout J.C.'s records, and the dual prescribing of Hydrocodone for opioid abuse, migraines and for skeletal pain, without explanation in the record. Tr. 410-14; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the skeletal pain diagnoses appears and disappears within the record. Tr. 414-15. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 415; GX 7 at 188, 189, 205, 214, 215. Dr. Munzing noted the Respondent had prescribed the combination of Hydrocodone and Valium monthly between January 2018 and January 2019, without a legitimate medical purpose. Tr. 416-17; GX 4. Combining Valium with an opioid represents a dangerous combination and is contrary to an FDA black box warning and to CDC guidance, especially with the Valium at its highest available strength. Tr. 417. Dr. Munzing could not envision a condition in which this medication regimen would be appropriate. Tr. 418. These dangerous combinations were without an established legitimate medical purpose, outside the usual course of professional practice, prescribed without sufficient warnings and informed consent, without sufficient patient monitoring, and without regard to obvious red flags. Tr. 418-23; GX 7 at 19, 25, 27, 180, 225.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient J.C. from at least January 16, 2018, through December 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore are also a violation of 21 C.F.R. § 1306.04(a).

19. Patient D.D.

Allegations

From at least January 4, 2018, through February 12, 2019, the Respondent issued prescriptions for controlled substances to Patient D.D. approximately on a monthly basis. These prescriptions included at least 13 prescriptions ranging from 150 to 240 dosage units of Hydrocodone-acetaminophen 10-325 mg (a Schedule Il opioid), at least 11 prescriptions for 90 dosage units of Carisoprodol 350 mg (a Schedule IV muscle relaxant), and at least one prescription for 90 dosage units of alprazolam 2 mg (a Schedule IV benzodiazepine). Each of the controlled substance prescriptions the Respondent wrote for Patient D.D. from at least January 4, 2018, through February 12, 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas for which pain purportedly was being treated, nor did the Respondent record Patient D.D.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient D.D., including medical history, mental health history, or any history of past or current illegal drug abuse. The Res-

pondent also failed to obtain any prior medical records for Patient D.D.

No medically legitimate basis was established for the multiple controlled substance medications prescribed for Patient D.D. The Respondent repeatedly issued prescriptions to Patient D.D. for highly dangerous combinations of controlled substances. On at least 11 occasions, the Respondent prescribed Patient D.D. a combination of Hydrocodone-acetaminophen and Carisoprodol. The combination of an opioid and a muscle relaxant is highly dangerous, and also a red flag for potential diversion. Concurrent use of opioids and Carisoprodol carries a significant risk of profound sedation, respiratory depression, coma, and death. On at least one occasion, the Respondent prescribed Patient D.D. a combination of Hydrocodone-acetaminophen and alprazolam. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death.

Despite the danger of addiction and harm to Patient D.D. from these controlled substance prescriptions, the Respondent maintained Patient D.D. on doses of controlled substances for over a year. During this time the Respondent failed to conduct appropriate ongoing monitoring of Patient D.D. These failures included: no continuing assessments of the potential risks and benefits to Patient D.D. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies other than these dangerous medications. There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient

D.D., and there is no evidence that the Respondent attempted to address them. For example, as discussed *supra*, the Respondent prescribed Patient D.D. drugs popular for abuse and diversion for a long period of time. Further, the Respondent's own records reflect that Patient D.D. had an opioid dependency and refused detoxification. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient D.D.'s medication compliance, for example, by conducting even a single urine drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient D.D., which was an improper "treatment" for Patient D.D.'s opioid dependency.

Accordingly, the Respondent's controlled substance prescriptions to Patient D.D. from at least January 4, 2018, through February 12, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Additionally, as noted above, during this time period the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient D.D. as "treatment" for Patient DD.'s opioid dependency, in violation of 21 C.F.R. § 1306.04(c).

Discussion as to Patient D.D.

The Respondent explained his treatment of Patient D.D. He first presented on July 9, 2008 with GAD and severe back pain, although the source of the back injury was not documented. Tr. 767-68, 850; GX 9 at 74. Over the course of treatment, the Respondent pre-

scribed Hydrocodone, Xanax, and Soma. Tr. 850. The Respondent added that he probably prescribed Valium, as well, explaining he was remembering from 13 years ago. Tr. 850. The Respondent remembered D.D. was prescribed Valium, Hydrocodone and Soma the first visit. Tr. 851-52. The Respondent believes his treatment was within the standard of care in California. The Respondent took a complete medical history, family history, personal history and medication history. Tr. 768. The family history was not documented in the chart. Tr. 848. The Respondent explained that the family history was not documented because it was non-contributory to his assessment. Tr. 848. There was no heart conditions in his family, etc. Tr. 849. The Respondent did document that D.D. was married, which he deemed contributory. Tr. 849. D.D. had a dirt bike accident, which shattered his shoulder and fractured several ribs, although the accident source of the injury was not documented. Tr. 850. He underwent physical therapy, occupational therapy after treatment by an orthopedic surgeon, although it was not documented within the chart. Tr. 769, 771, 850-51. It was several years before he reached the medication regimen he was on when he first reported to the Respondent. The Respondent performed a full physical exam. He established informed consent with the pain contract and discussion of side effects and overdose, as with all his patients. Tr. 770. He cautioned D.D. regarding diversion and other red flags. Again, D.D. gave no indication of diversion. Tr. 771.

Dr. Munzing reviewed the subject prescriptions issued from January 4, 2018 to February 12, 2019, patient records and CURES data relating to Patient D.D. Tr. 428-29; GDX 5. Again, the records were very lean. D.D. presented on July 9, 2008, with GAD and

back pain. Tr. 430-31 GX 9 at 74. For the GAD, he was prescribed Valium. For back pain, Hydrocodone and Soma. Tr. 431. D.D. refused MRI, refused referral to orthopedist or pain specialist. Tr. 431. Each refusal is a red flag, and suggestive of drug-seeking behavior. Tr. 432. Instead of addressing the red flags, the Respondent prescribed opioids. Tr. 432. The Respondent's response was the same throughout the subject treatment of D.D., a total of nine and a half years. Tr. 433. There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, or functioning evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from July 9, 2008 to January 4, 2019. Tr. 433-38; GX 9 at 37, 39, 41, 43, 44. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances. Tr. 434-48. Such prescriptions, from July 9, 2008 to January 4, 2019, were outside the standard of care, without legitimate medical purpose and outside the usual course of professional practice. Tr. 434-48. Dr. Munzing noted a period of over a year when no diagnosis for GAD appeared in D.D.'s records, from May 10, 2017 to September 19, 2018, and the 30 mg daily dose of Valium was stopped. Tr. 447-48. Then on September 19, 2018, the Respondent was placed on 6 mg of Xanax, a very high dosage, especially for the beginning dosage. Compounding this dangerous dosage, D.D. was prescribed Hydrocodone in combination, heightening the risk of overdose. Tr. 448-50.

Dr. Munzing noted the inconsistency of diagnoses throughout D.D.'s records, and the dual prescribing of

Hydrocodone and Soma for Fibromyalgia, opioid abuse, migraines and for skeletal pain, without explanation in the record. Tr. 450-56; GX 9, p. 43, 51, 64, 70, GDX 5. Prescribing Soma with Hydrocodone presents considerable risks to the patient. Each are respiratory depressants, which present a significant risk of overdose. Tr. 458. Dr. Munzing noted the skeletal pain diagnoses appears and disappears within the record. Tr. 450-56. Dr. Munzing suspected the skeletal pain complaints were not legitimate. Tr. 456; GX 9 at 43, 51, 64, 70.

D.D. presented on March 23, 2019 with opioid dependency, refusing detox. He was again prescribed Hydrocodone and Soma. Tr. 463; GX 9 at 42, 43. The Respondent failed to address this red flag repeatedly, instead prescribing Soma and Hydrocodone. Tr. 465.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient D.D. from at least January 4, 2018, through February 12, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

20. Patient J.M.

Allegations

From at least January 10, 2017, through December 31, 2019, the Respondent issued prescriptions for controlled substances to Patient J.M. approximately on a monthly basis. These prescriptions included at least 28 prescriptions ranging from 50 to 60 dosage of Hydrocodone-acetaminophen 10-325 mg (a Schedule Il opioid), at least four prescriptions ranging from 30 to 50 dosage units of Carisoprodol 350 mg (a Schedule IV

muscle relaxant), and at least 59 prescriptions ranging from 60 to 90 dosage units of alprazolam 2 mg (a Schedule IV benzodiazepine). Each of the controlled substance prescriptions the Respondent wrote for Patient J.M. from at least January 10, 2017, through December 31, 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas in which pain purportedly is being treated, nor did the Respondent record Patient J.M.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient J.M., including medical history, mental health history, or any history of past or current illegal drug abuse.

The Respondent also failed to obtain any prior medical records for Patient J.M. No medically legitimate basis was established for the multiple controlled substance medications prescribed for Patient J.M.

The Respondent repeatedly issued prescriptions to Patient J.M. for highly dangerous combinations of controlled substances. On at least two occasions, the Respondent prescribed Patient J.M. a combination of Hydrocodone-acetaminophen, alprazolam, and Carisoprodol. The combination of an opioid, a benzodiazepine, and Carisoprodol is a widely-abused drug cocktail often referred to by illicit drug users as the "Holy Trinity." This drug combination is highly addictive and carries a significant risk of diversion, as well as a significant risk of serious adverse medical consequences, including death.

On at least 24 occasions, the Respondent prescribed Patient J.M. a combination of Hydrocodone-acetaminophen and alprazolam. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death. On one of these occasions, the Respondent prescribed Patient J.M. a 15-day supply of Hydrocodone, and 13 days later prescribed him alprazolam and Carisoprodol. However, assuming that Patient J.M. took these medications as prescribed, Patient J.M. still was receiving the "Holy Trinity" for two days on this occasion. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death.

Despite the danger of addiction and harm to Patient J.M. from these controlled substances, the Respondent maintained Patient J.M. on controlled substances for at least three years. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient J.M. These failures included: no continuing assessments of the potential risks and benefits to Patient J.M. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies than these dangerous medications.

From at least January 10, 2017, through November 2, 2018, the Respondent repeatedly issued substantially early prescriptions to Patient J.M. for alprazolam. During this time period, the Respondent issued at least 25 prescriptions to Patient J.M. for alprazolam. Including refills, these prescriptions provided Patient J.M. with 40 fills for 90 tablets of alprazolam 2 mg. Patient J.M. filled these prescriptions early at least 38

times. Of these fills, over 30 were at least five days early, which the DEA's medical expert opined makes it highly likely that Patient J.M. was abusing or diverting this controlled substance. The cumulative effect of providing Patient J.M. these early prescriptions was to provide Patient J.M. with approximately 300 extra days of alprazolam over this approximate 23-month period. These early prescriptions were issued outside the usual course of professional practice. The manufacturer's highest recommended dosage of alprazolam is 4 mg per day. Each prescription the Respondent issued during this time period was for a daily dosage ranging from 6 mg to 8 mg of alprazolam. By regularly issuing Patient J.M.'s prescriptions substantially early, however, the Respondent provided Patient J.M. with over 10 mg of alprazolam per day — more than two-and-a-half times the highest recommended daily dosage — for this approximate 23-month period.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient J.M., and there is no evidence that the Respondent attempted to address them. For example, as detailed above, the Respondent prescribed Patient J.M. drugs popular for abuse and diversion for a long period of time, and Patient J.M. often used a variant spelling of Patient J.M.'s first name, together with a false birth date when filling Patient J.M.'s prescriptions. Further, the Respondent's own records reflect that Patient J.M. had an opioid dependency, refused detoxification, and refused to see a pain specialist or orthopedist for Patient J.M.'s back pain. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient J.M.'s medication

compliance, for example, by conducting even a single urine drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient J.M., which was an improper "treatment" for Patient J.M.'s opioid dependency.

Accordingly, the Respondent's controlled substance prescriptions to Patient J.M. from at least January 10, 2017, through December 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Additionally, as noted above, during this time period the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient J.M. as "treatment" for Patient J.M.'s opioid dependency, in violation of 21 C.F.R. § 1306.04(c). Discussion as to Patient J.M.

The Respondent explained his treatment of J.M. He has been a patient for 13 years. Tr. 734. The Respondent has prescribed him Xanax, Soma, and Hydrocodone. The Respondent believed his treatment of J.M. was within the California standard of care. J.M. first presented on May 14, 2007 with chronic pain syndrome, which sometimes manifests as back pain, and neck pain, and GAD. Tr. 735; GX 11 at 104. The Respondent took a history. J.M. had been involved in a motor vehicle accident injuring his back, neck and lumbar spine. Additionally, he suffered from GAD and hypertension. Tr. 736. The motor vehicle accident source of the injury was not documented. Tr. 853. He had seen an orthopedic surgeon, although it was not documented in the chart. Tr. 853. Without medication, J.M. reported severe pain, 10 or 11 out of 10. With medication, he reported three of ten, permitting him

to function and to work full time, although the pain levels were not documented in the chart. Tr. 736, 854-55. J.M. reported prior treatments and medication. He had received physical therapy, occupational therapy, hypnosis and acupuncture to no avail, prior to turning to chronic pain management, although these previous therapies were not documented in the chart. Tr. 737, 854. His present medication protocol delivered the best results with the least side effects he had. Tr. 737. The Respondent probed his psychological history, which included an all-consuming fear.

The Respondent performed a comprehensive physical exam. Tr. 739. To obtain informed consent to prescribe J.M. controlled substances, the Respondent went over the pain management contract, which J.M. also read and signed. The Respondent cautioned J.M. about diversion and red flags of doctor shopping and pharmacy hopping, which would result in discharge. Tr. 739-40. The Respondent noted that J.M. is a very well-respected man. He is very well-known in the community. Tr. 740.[34] The Respondent then discussed the beneficial aspects of the pain medication and potential negative effects if abused. J.M. never gave any indication he represented a risk of diversion. Tr. 741. Prior to seeing the Respondent, J.M. was on a higher MME of opioids. He was able to reduce the dosages to the level he was on when he first saw the Respondent. He remains on that dosage. Again, he is able to function, to work full-time on this dosage. Tr. 742. The Respondent noted that J.M. would sometimes try to

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[34] J.M.'s prestigious background will not be considered. It is an unnoticed matter that the government would have no way of checking or countering.

avoid taking his medication, even if he suffered pain, as explanation for the breaks in prescribing. Tr. 743.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 10, 2017 to December 31, 2019, patient records and CURES data relating to Patient J.M. Tr. 469-70; GDX 6. Dr. Munzing opined that none of the subject prescriptions issued to J.C. were within the California standard of care. Tr. 470-71.

On May 13, 2007, J.M. presented with hypertension, back pain, GAD, dyslipidemia and insomnia. Tr. 470-72; GX 7 at 104, 111. He was diagnosed with hypertension, back pain, GAD, dyslipidemia and insomnia. He was prescribed Hydrocodone for back pain, Xanax (6 mg per day) for GAD. Tr. 472. Xanax was a recurring prescription. As discussed earlier, its high dosage was a concern, as well as its combination with an opioid. Tr. 473.

There was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, no treatment plan, no pain or functioning evaluation, no mental health history, no ongoing drug abuse history or monitoring, no discussion of risk factors and informed consent, and no patient monitoring, rendering the GAD and back pain diagnoses inappropriate from May 13, 2007 to January 13, 2017. Tr. 473-76, 478, 481-83, 485-500. The MRI of May 30, 2007, and its mild findings, did not satisfy the Respondent's related obligations or justify the subject prescriptions. Tr. 479-80, 485-87; GX 11 at 14, 16, 17, 22, 26, 31, 37, 41, 42, 115. Without legitimate medical purpose, there was no appropriate rationale for the controlled substance prescriptions, or to continue

treatment with controlled substances. Tr. 473-76, 478, 485-500, 505; GDX 7. There were red flags left unaddressed by the Respondent. J.M. refused to see a pain specialist, which gives rise to the suspicion that he is not concerned about getting better, but just getting medicated. Tr. 476-77. On May 29, 2007, J.M. presented with back pain and insomnia. Tr. 477-78; GX 11 at 103. He was prescribed Hydrocodone and Soma for back pain, a recurring prescription for this malady. Tr. 477-78. Dr. Munzing noted gaps in prescribing the Hydrocodone and Soma, without any required explanation for changes to the medication regimen. Tr. 500-04; GX 11 at 36, 37, 40, 41, 42, 76. He observed that the Hydrocodone was prescribed either for back pain or for opioid dependence. Tr. 504. However, the required evaluation for the diagnoses coming and going and explanation for treatment is lacking. This further diminishes any medical legitimacy for the Hydrocodone. Tr. 504.

Additionally, the Respondent prescribed a very addictive and dangerous combination of medications, an opioid, and a benzodiazepine. Tr. 558-60. Even more concerning, he added a muscle relaxant, to this already dangerous combination to form the "Holy Trinity", a favorite drug combination of abuse by the drug-abusing community. Tr. 505-10. Dr. Munzing could not conceive of a medical condition in which the trinity combination would represent appropriate treatment. Tr. 512. This trinity of medications was prescribed to J.M. repeatedly. GDX 6. The file fails to reveal appropriate warnings were given to J.M. in connection with these dangerous combinations. Tr. Tr. 511; GX 11 at 113. The CURES report reveals 40 Xanax prescriptions (3600 dosage units and 7200 mgs) were issued to J.M. between January 2017 and

November 2018, a period of 22 months, which averages 10.5 mgs per day. Tr. 512-17; GX 7, 17, 18. This averaged a prescription every 16 days. Tr. 527-28. Ten and a half mgs per day is considerably greater than the maximum 4 mg per day recommended for treatment of anxiety.

DI Johnson identified GX 26, an additional CURES Audit Report, one for Dr. Steinberg, which spanned from January 2017 to September 2020, and which shared a common patient with the Respondent, J.M. Tr. 911-13; GX 26, 26B. Dr. Steinberg prescribed Suboxone to J.M. from January 2017 to August 2020. Tr. 913. The CURES Audit of the Respondent demonstrated he accessed the CURES database during the period J.M. was prescribed Suboxone by Dr. Steinberg, which would have been evident by this review. Tr. 914. The Respondent testified he cautioned D.D. regarding diversion and other red flags and D.D. gave no indication of diversion. Tr. 771. But the CURES report belies the Respondent's assurances. The Respondent was aware J.M. was obtaining Suboxone from Dr. Stenberg, yet the Respondent did not mention that critical fact in J.M.'s chart. And incredibly, the Respondent continued prescribing controlled substances to J.M. This action exceeds the bounds of benign neglect and crosses into the realm of intentional diversion.

The Respondent denied ever using a different first name for J.M., or using a different birth date for him. Tr. 778-82. However, the CURES report lists two different dates of birth for J.M., as well as two different spellings of his first name. Tr. 517-18, 547-49; GX 18. A CURES search would be name and date of birth specific. So that a search by one name and

date of birth would not reveal prescriptions filed under the alternate name and date of birth. Tr. 526. The main sources of the CURES report information are two pharmacies, Reliable Rexall and Northridge Pharmacy. Tr. 518-19. Despite the presence of two dates of birth and alternate first names, a considerable red flag suggesting abuse or diversion, the respondent did not address these issues. Tr. 519-20, 525-26. Even if J.M. or the pharmacies were the source of the alternate dates of birth and alternate first names, with due diligence, the Respondent would have discovered a search by a single name and date of birth would only include half of the Xanax prescriptions the Respondent issued to J.M. Tr. 521-26, 549-50. Additionally, a review of two prescriptions, one written by the Respondent and one called in by the Respondent on the same day contain two different dates of birth. Tr. 533-34.

Of further suspicion, the CURES report reveals J.M. is alternating the filling of the Xanax prescriptions between the two pharmacies, apparently trying to hide the bi-monthly frequency of the prescriptions. Tr. 520; GX 17, 18. Dr. Munzing noted a suspicious prescribing practice by the Respondent. Tr. 530; GX 17, # 425 & 575.[35] He would issue two prescriptions on the same day to J.M., one for Hydrocodone and one for Xanax. He would issue a written prescription for Hydrocodone, which J.M. would invariably fill at Northridge Pharmacy, but call in to Reliable pharmacy the prescription for Xanax. Tr. 531-33, 535-45, 550-58; GX 11 at 32, 33, 35, 36, 38, 40, 41, GX 12 at 5, 6, 10, 11, 14, 22, 24, 27, 33, 34; GX 13,p. 20, 25, 27, 32, 34;

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[35] These are prescription numbers.

GX 17, 18 # 473, 474, #994, 1120, # 1228, 1386, # 1472, 1553,# 2102, 2229, # 2341, 2342. This appears to be an attempt to avoid the suspicion generated by the opioid/benzodiazepine combination if filled at a single pharmacy. Tr. 532-33, 557-60. There was an additional suspicious circumstance related to a Xanax prescription. The Respondent wrote in his medical notes that the medication should be taken once every eight hours, while the call-in information to the pharmacy was once every six hours. Tr. 543-45, 554, 556-57.

In light of the Respondent's knowledge of the Suboxone prescriptions by Dr. Steinberg and this prescribing strategy remaining unaddressed or unexplained by the Respondent in his testimony, on the basis of this record, drawing all rational inferences warranted by the evidence, it is more believable than not that the Respondent was involved in this sophisticated attempt to avoid detection by J.M.

The red flag of refusing to detox was repeatedly evident within J.M.'s patient file. Tr. 562; GX 11 at 37. He was diagnosed with "Opioid dependency, refusing detox", for which he was prescribed Hydrocodone, which again, is outside the standard of care and usual course of professional practice, and illegal in California. Tr. 563-64. The diagnosis for opioid dependency being treated with Hydrocodone appeared repeatedly in the records. The Respondent never addressed this red flag. Tr. 564.

A review of the entirety of J.M.'s file and related records revealed there was no appropriate medical history included in the records, no response to treatment, no physical exam, insufficient patient monitoring, no evaluation for GAD, or pain level/functioning

evaluation, no mental health history, no drug abuse history, no discussion of risk factors and informed consent, no patient monitoring, no resolution of the multiple red flags noted, rendering the GAD and back pain diagnoses inappropriate from January 10, 2017 to December 31, 2019, and outside the California standard of care. Each was without legitimate medical purpose and outside the usual course of professional practice. Tr. 565-68.

I find, as alleged, the Respondent's controlled substance prescriptions to Patient J.M. from at least January 10, 2017, through December 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

21. Patient K.S.

Allegations

From at least January 19, 2018, through January 31, 2019, the Respondent issued prescriptions for controlled substances to Patient K.S. approximately on a monthly basis. These included at least 14 prescriptions ranging from 170 to 200 dosage units of Hydrocodone acetaminophen 10-325 mg (a Schedule Il opioid), at least ten prescriptions for 60 dosage units of amphetamine salts 30 mg (a Schedule Il stimulant), and at least 12 prescriptions for 90 dosage units alprazolam 2 mg (a Schedule IV benzodiazepine). Each of the controlled substance prescriptions the Respondent wrote for Patient K.S. from at least January 19, 2018, through January 31, 2019, were issued outside the usual course of professional practice and not for a legitimate medical purpose.

The Respondent failed to perform any appropriate physical examination of the areas for which pain purportedly was being treated, nor did the Respondent record Patient K.S.'s pain level or functionality level. At no point in time did the Respondent record an appropriate patient history for Patient K.S., including medical history, mental health history, or any history of past or current illegal drug abuse. The Respondent also failed to obtain any prior medical records for Patient KS.

No medically legitimate basis was established for the multiple controlled substance medications prescribed for Patient K.S.

The Respondent repeatedly issued prescriptions to Patient K.S. for highly dangerous combinations of controlled substances. On at least eight occasions, the Respondent prescribed Patient KS. a combination of Hydrocodone-acetaminophen, amphetamine salts, and alprazolam. The combination of an opioid, a stimulant, and a benzodiazepine is a widely abused drug cocktail often referred to as the "new Holy Trinity." DEA's medical expert opined that this drug combination is highly addictive and carries a significant risk of diversion, as well as a significant risk of serious adverse medical consequences, including death.

On at least four occasions, the Respondent prescribed Patient K.S. a combination of Hydrocodone-acetaminophen and alprazolam. The concurrent use of opioids and benzodiazepines carries a significant risk of profound sedation, respiratory depression, coma, and death.

Despite the danger of addiction and harm to Patient KS. from these controlled substances, the Res-

pondent maintained Patient K.S. on these controlled substances for at least a year. During this time, the Respondent failed to conduct appropriate ongoing monitoring of Patient K.S. These failures included: no continuing assessments of the potential risks and benefits to Patient K.S. from the controlled substances the Respondent prescribed; no assessments of the ongoing need to prescribe these controlled substances; and no efforts to seek safer alternative management strategies than these dangerous medications.

There were several red flags of abuse and/or diversion associated with the Respondent's treatment of Patient K.S., and there is no evidence that the Respondent attempted to address them. For example, as detailed above, the Respondent prescribed Patient K.S. drugs popular for abuse and diversion for a long period of time. Further, the Respondent's own records reflect that Patient K.S. had an opioid dependency and refused detoxification. Despite such red flags of drug abuse and/or diversion, the Respondent's medical charts indicate that the Respondent did not appropriately monitor Patient K.S.'s medication compliance, for example, by conducting even a single urine Drug screen. To the contrary, the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient K.S., which was an improper "treatment" for Patient K.S.'s opioid dependency.

Accordingly, the Respondent's controlled substance prescriptions to Patient K.S. from at least January 19, 2018, through January 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

Discussion as to Patient K.S.

The Respondent explained Patient K.S.'s treatment. K.S. presented on June 21, 2007 with chronic back pain. He was later diagnosed with ADD. He was prescribed Hydrocodone, Soma, and sometimes Adderall. Tr. 788-89, 861; GX 14 at 110. The Respondent added that he may have also prescribed Xanax, but it is difficult to be sure with hundreds of patients and treatment dating back 15 years. Tr. 859. Even with a good memory, sometimes the Respondent just misses something. Tr. 859. Additionally, he noted that many times patients do not disclose all of their medications at the initial visit, if they have plenty and do not then need them to be refilled. So, he is not always aware of all of their medications at the initial visit. Tr. 860-62.

The Respondent believed his treatment was within the standard of care for California. The Respondent obtained a full medical history, medication history, pain level, and performed a complete head to toe physical exam. Tr. 789. The Respondent discovered K.S. had chronic back pain related to a bike accident, for which he had been treated by several doctors for several years, although the bike accident source of the injury and treatment by other doctors was not documented. Tr. 856-57, 859. Additionally, there were no records from prior treatment in the patient's records. Tr. 857. Although the Respondent explained that he requested the prior medical records, none were provided. The Respondent explained that his request for records is simply faxed to the previous physician's office. Tr. 857-58. Its absence from the file probably resulted in a staffer forgetting to file it. Tr. 858. The Respondent did not contest the Govern-

ment's observation that no requests for previous medical records were in any of the seven patient files. Tr. 859. He was already on Hydrocodone, when K.S. first saw the Respondent. The Respondent obtained informed consent in the same manner as described for his earlier patients. Tr. 790. He discussed alternative forms of treatment with K.S. K.S. was obtaining physical therapy prior to seeing the Respondent. He continued physical therapy after beginning treatment with the Respondent. Tr. 791. The Respondent monitored K.S. throughout his treatment. Tr. 791. K.S. presented no indications of diversion. The Respondent has treated K.S. for thirteen years, during which time K.S. got married and had three children. Tr. 790-91.

Dr. Munzing reviewed the subject prescriptions and fill stickers issued from January 19, 2018 to January 31, 2019, patient records, and CURES data relating to Patient K.S. Tr. 469-70; GDX 8. Dr. Munzing opined that none of the subject prescriptions issued to K.S. were within the California standard of care. Tr. 568-70. K.S. presented on June 21, 2007 with "back pain", for which he was prescribed Hydrocodone and Soma. Tr. 570; GX 13 at 117. Although the Respondent noted he would get an MRI for the lumbar spine, no such MRI appears in the records. Tr. 271. However, there was no medical history included in this record, no treatment plan, no response to treatment, no physical exam, no pain or functioning evaluation, no ongoing drug abuse history, rendering the back pain diagnosis inappropriate. Tr. 570. Without legitimate medical purpose, there was no appropriate rationale for continued treatment with controlled substances of back pain. Tr. 571-76. On May 1, 2012, K.S. presented with GAD and neck pain. Tr. 576; GX 14 at 80. He was diagnosed with GAD and neck pain, and prescribed

Xanax for GAD and Hydrocodone for the neck pain, refusing detox. Tr. 577. K.S. was prescribed the combination of Hydrocodone and Xanax frequently throughout his treatment. This combination of opioid and benzodiazepine is dangerous, outside the standard of care and represents a red flag, unresolved by the Respondent throughout the records. Tr. 578-79. There was no medical history supporting the prescriptions. There was no indication how the patient was responding to treatment. There was no treatment plan, and no indication a physical exam was performed to support the diagnoses or justify the prescriptions. Tr. 579-81. There was no reference to pain levels or physical functionality. There was no reference to mental functioning with respect to the GAD diagnosis. There was no appropriate diagnosis for the GAD and neck pain. Neither did he establish a legitimate medical purpose for the controlled substance prescriptions. Tr. 580-81.

K.S. presented on November 18, 2013, with ADD, but with no diagnosis, and for which he was prescribed Adderall (60 mg per day). Tr. 581-82; GX 14 at 70. The record is absent medical history, any updated medical history, the patient's state of health, how he is responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 582. Accordingly, the subject charged prescription is without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 582.

On January 19, 2018, K.S. presented with GAD, back pain, and ADD. Tr. 583, 599; GX 14 at 41. For GAD, the Respondent prescribed Xanax. For back pain – opioid dependent, refusing detox, the Respondent prescribed Hydrocodone. And for ADD, Adderall. Tr. 584. The record is absent medical history, any updated medical history, an explanation why back pain has returned, the patient's state of health, how he's responding to treatment, a physical exam, pain levels, mental or physical functioning, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 584-86. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 586.

On February 27, 2018, K.S. presented with ADD, opioid dependency, and GAD. Tr. 586-87, 599-600; GX 14 at 39, 40. He was diagnosed with ADD, opioid dependency-refusing detox, and GAD. Back pain was not reported, nor was any report of pain made. At the April 30, 2018 visit, again, back pain was not reported, nor was any report of pain made. Tr. 601. Throughout the records, the Respondent failed to explain the appearance and disappearance of back pain. Tr. 601-02. Again, contrary to the standard of care and the law in California, K.S. was prescribed Hydrocodone for opioid dependency. Tr. 587-88. On November 28, 2018, K.S. presented with opioid dependency and GAD, for which he was diagnosed with opioid dependency-refusing detox and GAD, and for which he was prescribed Hydrocodone and Xanax respectively. Tr. 588-589; GX 14 at 33; GDX 8. Again, contrary to the standard of care and the law in California, K.S.

was prescribed Hydrocodone for opioid dependency. Tr. 588-89. And again the medication regimen included the dangerous combination of an opioid and benzodiazepine. The record is absent medical history, any updated medical history, the patient's state of health, how he was responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 588-89. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 590.

On December 11, 2018, K.S. presented with ADD and eczema, for which he was diagnosed with ADD and eczema. Tr. 591; GX 14 at 33. For ADD he was prescribed Adderall. K.S. presented with back pain and stomatitis. Tr. 593-94; GX 14 at 31. For the back pain he was prescribed Hydrocodone.

A review of the entirety of K.S.'s subject medical records reveals the Respondent never obtained any prior medical records. Tr. 596, 619. The record is absent medical history, any updated medical history, the patient's state of health, how he was responding to treatment, a physical exam, pain levels, mental or physical functioning, any evaluation for GAD, appropriate rationale for continued treatment, and information relating to drug abuse. As a result, the treatment is without sufficient medical evidence. Tr. 598-99, 620. Accordingly, the subject charged prescriptions are without a legitimate medical purpose, is outside the usual course of professional practice, and are contrary to the standard of care. Tr. 598, 619-20.

Dr. Munzing noted the inconsistency of the GAD diagnoses throughout the records. Tr. 602-05; GX 14 at 31, 42, 47, 48. With the GAD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 605-09; GX 8. Similarly, ADD was inconsistently diagnosed with Adderall inconsistently prescribed. Tr. 605-06; GX 14 at 34, 35; GX 8. With the ADD diagnoses appearing and disappearing within the records and without any explanation, Dr. Munzing observed there is no medical evidence it was a medically legitimate diagnosis. Tr. 609.

Dr. Munzing noted the Respondent prescribed a dangerous combination of medications, including Hydrocodone, Adderall and Xanax, which was prescribed from January 2018 through August 2018. Tr. 609-10. Dr. Munzing noted it is referred to by drug abusers as the "new Holy Trinity". Tr. 610. Additionally, the combination of an opioid and a benzodiazepine is present in August, October and November 2018. Tr. 610-11. The records fail to reveal the appropriate warnings were conveyed to K.S., nor was informed consent obtained. Tr. 611-13; GX 8. Dr. Munzing could not conceive of a medical condition warranting the dangerous combinations of medications prescribed. Tr. 614.

Dr. Munzing noted the Respondent's failure to resolve red flags, including K.S.'s refusal to detox, the dangerous combinations of medications, and high dosages of controlled medications. Tr. 615-18, 620; GX 14 at 39, 40, 41. The refusal to detox is a major red flag for opioid use disorder and for diversion. However, the Respondent did not take any necessary

action, such as CURES monitoring, UDS, counseling, or titration. Rather, he simply prescribed the same levels of medications she was on, PRN. Tr. 615-17. The Respondent's course of action was outside the California standard of care.

Additionally, as noted above, during this time period the Respondent repeatedly prescribed Hydrocodone-acetaminophen to Patient K.S. as "treatment" for Patient K.S.'s opioid dependency, in violation of 21 C.F.R. § 1306.04(c).

I find, as alleged, the Respondent's controlled substance prescriptions to Patient K.S. from at least January 19, 2018, through January 31, 2019, were not issued "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice," and therefore also are a violation of 21 C.F.R. § 1306.04(a).

22. The Respondent's General Denial

The Respondent noted that, to the best of his knowledge, none of his thousands of patients have suffered any harm from his medication treatment. Tr. 793. The Respondent disagreed with Dr. Munzing's assertion that he could perceive of no medical condition justifying the dangerous combinations of medications identified herein. Tr. 794-800.

The Respondent conceded the potential danger of individual pain medications, and the potential increase in risk in combination with other medications. However, he further stated that if patients are responsible and take the medications as prescribed for the

indications intended, these combinations are fairly safe. Tr. 800.[36]

The Respondent recognized his obligations to follow all federal and state rules concerning the practice of medicine, including the directives of the California Board of Medicine. Tr. 862. Compliance with Controlled Substance Laws and Regulations, includes a provision on records. Tr. 864; GX 20 at 61. It mandates, "[t]he physician and surgeon should keep accurate and complete records according to the items above between the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan". Tr. 86465. The provision further requires, "[a] medical history and physical examination must be accomplished . . . this includes an assessment of the pain, physical and psychological function". Tr. 866; GX 20 at 59. The Respondent assured that the necessary assessments were made, but not fully documented. Tr. 866-67. The Respondent made the same assurances for the requirement as to "Treatment Plan Objectives", "Informed

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[36] Although the government objected to this opinion by the Respondent, I overruled their objection. A general disagreement by the Respondent of the government expert's opinion is certainly reasonably anticipated. The Respondent does not cite to any unnoticed medical practice guide, medical theories or other basis for his contrary opinion. The government was readily able to confront the Respondent's opinion.

Consent", "Periodic Review", noting these Guidelines were published in 2013.[37] Tr. 867-72.

The Respondent reiterated that, to his knowledge, none of his patients exhibited red flags, or violated the pain agreement. Tr. 888-89.

23. Credibility Analysis of the Respondent

In his testimony, the Respondent came off as very sincere and credible. Accepting his testimony as true and accurate, although his perception of the standard of care was, in several instances, unfounded, and his treatment was, in many cases, outside the standard of care, his explanations seemed to present that of a caring, dedicated practitioner, who may be guilty of benign neglect in his treatment and failure to maintain complete and accurate records.

However, the discovery during rebuttal of his monitoring the CURES report for S.B. and J.M., dramatically changed that perception. The Respondent was fully aware of those patients being treated by other physicians with Suboxone, and opioid abuse medication, which violated his own controlled substance agreements with those patients. Yet the Respondent failed to note that significant fact in the charts, and even more alarmingly, continued them on opioid and other controlled substance medications. Additionally, the Respondent failed to address the results of his CURES monitoring in his testimony. The Respondent has lost a great deal of credibility.

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37 *See* Tr. 950-52. Dr. Munzing testified credibly that the 2013 version was the 7th edition and the basic requirement have not changed over the years.

I was willing to give the Respondent the benefit of the doubt regarding the alias used by J.M. in filling opioid/benzodiazepine prescriptions, the unexplained simultaneous dispensing of the opioid and benzodiazepine prescriptions to two separate pharmacies by the Respondent and the inconsistent instructions for usage of the benzodiazepine to the pharmacy and as recorded in the Respondent's chart notes. But it appears more believable than not that the Respondent was a knowing participant in what appears to be a sophisticated attempt to abuse or divert medication by J.M.[38]

The Respondent's testimony that he performed all of the procedures, undocumented in the charts, and fully complied with the California standard of care suffers the same loss of credibility.

24. Dr. Munzing's Credibility

Conversely, Dr. Munzing was fully credible. His opinion regarding the California standard of care was consistent with the relevant California and federal

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38 "While proof of intentional or knowing diversion is highly consequential in these proceedings, the Agency's authority to act is not limited to those instances in which a practitioner is shown to have engaged in such acts. . . . Accordingly, under the public interest standard, DEA has authority to consider those prescribing practices of a physician, which, while not rising to the level of intentional or knowing misconduct, nonetheless create a substantial risk of diversion." *Dewey C. Mackay, M.D.*, 75 Fed. Reg. 49956, 49974-75 n.35 (2010) (citing *Paul J. Caragine, Jr.*, 63 Fed. Reg. at 51601 ("Just because misconduct is unintentional, innocent or devoid of improper motivation, does not preclude revocation or denial [of a registration]. Careless or negligent handling of controlled substances creates the opportunity for diversion and could justify revocation or denial.")).

regulations, the practitioner Guides issued by the California Medical Board and by federal agencies, such as the CDC, FDA and DEA. His specific opinions that the Respondent's subject treatment fell below the minimum California standard of care were factually well-founded, and were based on clear edicts of the standard. As the Government notes in its PHB, the Respondent did not credibly contest Dr. Munzing's opinions regarding the specific parameters of the standard of care.

Accordingly, I adopt each of Dr. Munzing's opinions regarding the Respondent's treatment falling below the California standard of care.

25. Government's Burden of Proof and Establishment of a *Prima Facie* Case

Based upon my review of each of the allegations by the Government, it is necessary to determine if it has met its *prima facie* burden of proving the requirements for a sanction pursuant to 21 U.S.C. § 824(a)(4). At the outset, I find that the Government has demonstrated and met its burden of proof in support of its allegations relating to the prescribing of controlled substances to patients S.B., M.B., B.C., J.C., D.D., J.M., and K.S.

PUBLIC INTEREST DETERMINATION: THE STANDARD

Pursuant to 21 U.S.C. § 823(f) (2006 & Supp. III 2010), the Acting Administrator[39] may revoke a DEA Certificate of Registration if persuaded that maintaining such registration would be inconsistent with the public interest. Evaluation of the following factors have been mandated by Congress in determiningwhether maintaining such registration would be inconsistent with the "the public interest":

(1) The recommendation of the appropriate State licensing board or professional disciplinary authority.

(2) The [registrant's] experience in dispensing, or conducting research with respect to controlled substances.

(3) The [registrant's] conviction record under Federal or State laws relating to the manufacture, distribution, or dispensing of controlled substances.

(4) Compliance with applicable State, Federal, or local laws relating to controlled substances.

(5) Such other conduct which may threaten the public health and safety.

21 U.S.C. § 823(f).

"These factors are . . . considered in the disjunctive." *Robert A. Leslie, M.D.*, 68 Fed. Reg. 15227, 15230 (2003). Any one or a combination of factors may

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[39] This authority has been delegated pursuant to 28 C.F.R. §§ 0.100(b) and 0.104 (2008).

be relied upon, and when exercising authority as an impartial adjudicator, the Agency may properly give each factor whatever weight it deems appropriate in determining whether a registrant's registration should be revoked. *Id.* (citation omitted); *David H. Gillis, M.D.*, 58 Fed. Reg. 37507, 37508 (1993); *see also Morall v. DEA*, 412 F.3d at 173-74; *Henry J. Schwarz, Jr., M.D.*, 54 Fed. Reg. 16422, 16424 (1989). Moreover, the Agency is "not required to make findings as to all of the factors," *Hoxie v. DEA*, 419 F.3d 477, 482 (6th Cir. 2005); *see also Morall*, 412 F.3d at 173. The Agency also is not required to discuss consideration of each factor in equal detail, or even every factor in any given level of detail. *Trawick v. DEA*, 861 F.2d 72, 76 (4th Cir. 1988) (holding that the Administrator's obligation to explain the decision rationale may be satisfied even if only minimal consideration is given tothe relevant factors, and that remand is required only when it is unclear whether the relevant factors were considered at all). The balancing of the public interest factors "is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest . . . ." *Jayam Krishna-Iyer, M.D.*, 74 Fed. Reg. 459, 462 (2009).

The Government's case invoking the public interest factors of 21 U.S.C. § 823(f) seeks the revocation of the Respondent's COR based primarily on conduct most aptly considered under Public Interest Factors Two, and Four.[40]

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[40] 21 U.S.C. §§ 823(f)(2), and (4). There is nothing in the record to suggest that a state licensing board made any recommenda-

FACTOR TWO: EXPERIENCE IN DISPENSING CONTROLLED SUBSTANCES

Factor Two requires consideration of the Respondent's experience in dispensing controlled substances. The plain language of Factor Two dictates that a registrant's prior experience in the regulated activity must be considered. The Agency has acknowledged that even a considerable level of benign or even commendable experience could be easily outweighed by evidence demonstrating that continued registration was inconsistent with the public interest.[41]

Although the Respondent testified that, to the best of his knowledge, none of his thousands of patients have suffered any harm from his medication treatment. Tr. 793. The Respondent did not offer specific direct evidence, either documentary or testimonial, relating to any patients outside those who are the subject of this proceeding. The Government did not offer any evidence relating to patients other than the charged patients herein.

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tion regarding the disposition of the Respondent's DEA COR (Factor One). Likewise, the record contains no evidence that the Respondent has been convicted of (or charged with) a crime related to controlled substances (Factor Three). The Government does not allege Factor Five as relevant.

41 *See, e.g.*, *Paul J. Caragine, Jr.*, 63 Fed. Reg. at 51560 ([E]ven though the patients at issue are only a small portion of Respondent Pharmacy's patient population, his prescribing of controlled substances to these individuals raises serious concerns regarding [his] ability to responsibly handle controlled substances in the future."); *Med. Shoppe-Jonesborough*, 73 Fed. Reg. at 386 (finding that the misconduct outweighed the fact that only a relatively small portion of the respondent's patient population was involved).

Although this is evidence of positive experience in prescribing, based on the egregiousness of the Respondent's charged actions, it will be assessed limited or no weight.[42] I will assess this factor in equipoise.

Although the Government has proved misconduct which could be considered under Factor Two and Factor Four, I will only weigh that misconduct under Factor Four to avoid double-counting the same violations under multiple factors.

FACTOR 4: COMPLIANCE WITH APPLICABLE FEDERAL, STATE, OR LOCAL LAWS RELATING TO CONTROLLED SUBSTANCES

Evidence is considered under Factor Four when it reflects a respondent's compliance (or non-compliance) with laws related to controlled substances. Established violations of the CSA, DEA regulations, or other laws regulating controlled substances at the state or local level are cognizable under Factor Four. As DEA has held in the past, a registrant's "ignorance of the law is no excuse" for actions that are inconsistent with responsibilities attendant upon a registration. *Daniel A. Glick, D.D.S.*, 80 Fed. Reg. 74800, 74809 (2015) (quoting *Sigrid Sanchez, M.D.*, 78 Fed. Reg. 39331, 39336 (2013) (citing *Patrick W. Stodola*, 74 Fed. Reg. 20727, 20735 (2009) and *Hageseth v. Superior Ct.*, 59 Cal. Rptr. 3d 385, 403 (Ct. App. 2007) (a "licensed health care provider cannot 'reasonably claim ignorance' of state provisions regulating medical

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[42] Where a respondent has committed egregious acts, whether intentional or not, that likely resulted in diversion, evidence of the respondent's prior good acts and prior compliance with the Controlled Substances Act is entitled to no weight. *Surinder Dang, M.D.*, 76 Fed. Reg. 51417, 51423 (2011) (citing *Jayam Krishna-Iyer, M.D.*, 74 Fed. Reg. 459, 463 (2009)).

practice"))). Under Agency precedent, "[a]ll registrants are charged with knowledge of the CSA, its implementing regulations, as well as applicable state laws and rules." *Id*. at 74809 (internal citations omitted).

The Respondent has violated the charged federal and California regulations, related to controlled substances. He has violated the California standard of care, as alleged. This Factor weighs heavily in favor of revocation.

26. Acceptance of Responsibility

With the Government's *prima facie* burden having been met, an unequivocal acceptance of responsibility stands as a condition precedent for the Respondent to prevail. *George Mathew, M.D.*, 75 Fed. Reg. 66138, 66148 (2010). This feature of the Agency's interpretation of its statutory mandate on the exercise of its discretionary function under the CSA has been sustained on review. *MacKay v. DEA*, 664 F.3d 808, 822 (10th Cir. 2011*)*. Accordingly, the Respondent must present sufficient mitigating evidence to assure the Administrator that he can be entrusted with the responsibility incumbent with such registration. *Medicine Shoppe-Jonesborough*, 73 Fed. Reg at 387; *Samuel S. Jackson*, 72 Fed. Reg. 23848, 23853 (2007). As past performance is the best predictor of future performance, DEA has repeatedly held that where an applicant has committed acts inconsistent with the public interest, the applicant must accept responsibility for his actions and demonstrate that she will not engage in future misconduct. *ALRA Labs, Inc. v. DEA*, 54 F.3d at 452; *Medicine Shoppe*, 73 Fed. Reg. at 387; *see also Hoxie v. DEA*, 419 F.3d at 483 ("admitting fault" is "properly consider[ed]" by DEA to be an "important factor[]" in

the public interest determination). So too, in making the public interest determination, "this Agency places great weight on an [applicant's] candor, both during an investigation and in [a] subsequent proceeding." *Robert F. Hunt*, 75 Fed. Reg. 49995, 50004 (2010); *Hoxie*, 419 F.3d at 483.

As I have found, the Respondent's testimony was less than credible, as evidenced by the Government's rebuttal evidence. The Respondent cannot credibly claim that he forgot the alarming discoveries he made as to Patients S.B. and J.M., when he monitored their CURES reports. The Respondent's failure to discuss this critical information in describing the justification for their treatment during testimony constitutes a significant lack of candor.[43]

I therefore find that the Respondent has not unequivocally accepted responsibility.[44]

27. Egregiousness and Deterrence

While a registrant must accept responsibility and demonstrate that he will not engage in future misconduct in order to establish that his continued registration is consistent with the public interest, DEA has repeatedly held these are not the only factors

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[43] The degree of candor displayed by a registrant during a hearing is "an important factor to be considered in determining . . . whether [the registrant] has accepted responsibility" and in formulating an appropriate sanction. *Hills Pharmacy, LLC*, 81 Fed. Reg. 49816, 49845 (2016) (citing *Michael S. Moore*, 76 Fed. Reg. 45867, 45868 (2011)).

[44] A registrant's acceptance of responsibility must be unequivocal, or relief for sanction is not available, and where there is equivocation any evidence of remedial measures is irrelevant. *Daniel A. Glick, D.D.S.*, 80 Fed. Reg. 74800, 74801, 74810 (2015).

that are relevant in determining the appropriate sanction. *See, e.g.*, *Joseph Gaudio*, 74 Fed. Reg. 10083, 10094 (2009); *Southwood Pharm., Inc.*, 72 Fed. Reg. 36487, 36504 (2007). The egregiousness and extent of a registrant's misconduct are significant factors in determining the appropriate sanction. *See Jacobo Dreszer*, 76 Fed. Reg. 19386, 19387-88 (2011) (explaining that a respondent can "argue that even though the Government has made out a *prima facie* case, his conduct was not so egregious as to warrant revocation"); *Paul H. Volkman*, 73 Fed. Reg. 30630, 30644 (2008); *see also Gregory D. Owens*, 74 Fed. Reg. 36751, 36757 n.22 (2009).

I find that the proven misconduct is egregious and that deterrence considerations weigh in favor of revocation. In addition to the myriad of treatment falling below the California standard of care, the proven misconduct involved being directly aware of two patients' apparent abuse or diversion of controlled substances, and being an apparent party to one of those patient's abuse or diversion. He treated opioid abuse with opioids, an illegal action under state federal regulations. Beyond that, his actions unnecessarily exposed his patients to dangerous levels of medication and to dangerous combinations of those medications.

Finding that the Respondent's proven misconduct is egregious is warranted despite the fact that I only weighed the Government's evidence under Factor Four. The public interest factors are considered separately and any one or combination of factors may be considered when weighing the evidence. *Robert A. Leslie, M.D.*, 68 Fed. Reg. at 15230 (citation omitted). It is not necessary that a sanction be supported by findings under each factor. *Hoxie v. DEA*, 419 F.3d at

482; *Morall*, 412 F.3d at 173. It is also not required to discuss consideration of each factor in equal detail, or even every factor in any given level of detail. *Trawick v. DEA*, 861 F.2d at 76. The balancing of the public interest factors "is not a contest in which score is kept; the Agency is not required to mechanically count up the factors and determine how many favor the Government and how many favor the registrant. Rather, it is an inquiry which focuses on protecting the public interest." *Jayam Krishna-Iyer, M.D.*, 74 Fed. Reg. at 462. Thus, I find that sanction is justified and that the Respondent's conduct was egregious even though the evidence was only weighed under a single factor.

I further find that deterrence considerations weigh in favor of revocation. Allowing the Respondent to retain his COR despite the proven misconduct would send the wrong message to the regulated community. Imposing a sanction less than revocation would create the impression that registrants can maintain DEA registration despite ongoing treatment below the California standard of care, knowledge and acquiescence of the abuse or diversion demonstrated herein, the repeated prescribing of dangerous combinations of medications, and the wholesale failure to maintain complete and accurate medical charts. Revoking the Respondent's COR communicates to registrants that the DEA takes all failings under the CSA seriously and that severe violations will result in severe sanctions.

RECOMMENDATION

Considering the entire record before me, the conduct of the hearing, and observation of the testimony of the witnesses presented, I find that the Government has met its burden of proof and has estab-

lished a *prima facie* case for revocation. In evaluating Factors Two, and Four of 21 U.S.C. § 823(f), I find that the Respondent's COR is inconsistent with the public interest. Furthermore, I find that the Respondent has failed to overcome the Government's *prima facie* case by unequivocally accepting responsibility.

Therefore, I recommend that the Respondent's DEA COR No. BW7210759 should be REVOKED, and that any pending applications for modification or renewal of the existing registration, and any applications for additional registrations, be DENIED.

Signed: December 22, 2020

/s/ Mark M. Dowd
Mark M. Dowd
U.S. Administrative Law Judge