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

In the Matter of the Accusation Against: )
) )
NARINDER SINGH GREWAL, M.D. ) Case No. 05-2011-215032
) )
Physician's and Surgeon's )
Certificate No. C 42572 )
) )
Respondent )

DECISION AND ORDER

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

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

IT IS SO ORDERED January 8, 2016.

MEDICAL BOARD OF CALIFORNIA

By: ________________________________

Jamie Wright, J.D., Chair
Panel A
BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA 

In the Matter of the Accusation Against:  
NARINDER GREWAL, M.D.,  
Physician and Surgeon’s Certificate No. C42572,  
Respondent.  

Case No. 05-2011-215032  
OAH No. 2013030956 

PROPOSED DECISION 

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on October 21, 22, 23, 26, 27, 28, and 29, and December 17, 2015, in Los Angeles, California. Complainant was represented by Randall R. Murphy, Deputy Attorney General. Narinder Grewal, M.D. (Respondent) was represented by Raymond J. McMahon, with Doyle Schafer McMahon. 

Oral and documentary evidence was received, and argument was heard. The record closed, and the matter was submitted for decision on December 17, 2015. 

FACTUAL FINDINGS 

1. On February 28, 2013, an Accusation was filed against Respondent in this matter. On October 31, 2014, Complainant Kimberly Kirchmeyer filed the First Amended Accusation (FAC) while acting in her official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. 

2. On May 30, 1989, the Board issued Physician and Surgeon’s Certificate Number C42572 to Respondent. Respondent’s Certificate was in full force and effect at all relevant times and will expire on November 30, 2016, unless renewed. 

Respondent’s Education, Certifications and Area of Practice 

3. Respondent was born in Punjabi, India and earned his medical degree in 1978 from the Medical College Patiala in India. He moved to the United States in September 1978. In 1979, he passed the certification examination administered by the Educational
Commission on Foreign Medical Graduates, and in 1983, he completed a three-year residency in anesthesia at the Medical College of Toledo, in Ohio.

4. Respondent practiced as an anesthesiologist from 1983 through 1989 at the Heartland Hospitals in Missouri, where he also served as Medical Director of the Department of Anesthesia for three years. While practicing in Missouri, Respondent became involved in pain management, and his services as an anesthesiologist included performing nerve blocks and epidural injections at the request of orthopedic surgeons.

5. Respondent moved to California in 1989. He became a staff anesthesiologist at Henry Mayo Newhall Memorial Hospital (HMNMH) in Valencia, California, where he began providing pain management services at the request of orthopedic surgeons, neuro-surgeons and other surgeons on staff. Although he initially worked primarily in anesthesia, with one to two days in pain management, he was eventually asked to provide pain management services on a full-time basis. Respondent operates a private practice, Advanced Pain Management, which has sites in Valencia and Lancaster. Respondent also serves as Medical Director for the Santa Clarita Surgery Center for Advanced Pain Management in Valencia.

6. Respondent has held hospital privileges at HMNMH and at Antelope Valley Hospital in Lancaster, California since 1989. He is board certified by the American Board of Anesthesiology. He also holds a certification with the American Academy of Pain Management and is an active member of the American Society of Interventional Pain Physicians (ASIPP) and the International Spine Intervention Society (SIS).

7. Respondent has never had his hospital privileges restricted, revoked or denied. He has held medical licenses in jurisdictions other than California, including Missouri and Ohio, and he has no prior discipline against any of his medical licenses.

Board Request for Records and Respondent Interview

8. In 2012, the Board sent Respondent a letter instructing him to produce certain records for three patients, K.B., C.P. and A.K.1 The letter requested records for the limited time period of December 2, 2010, through December 2, 2011, and the Board provided signed patient authorizations for release of those time-specific records.

9. Respondent made copies of the requested records and hand delivered them to the Board office in Valencia, California. Respondent provided only the records requested by the Board and authorized by the signed patient releases.

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1 Patient’s initials are used in lieu of full names in order to protect their privacy.
10. Although Respondent began treating all three patients prior to December 2, 2010, the Board never requested production of the complete records for any of the three patients. The Board never requested copies of the delegation of service agreements for Respondent’s physician assistants or any pain management contracts for the patients.

11. Thereafter, the Board asked Respondent to submit to an interview with a Board Investigator, and Respondent agreed. On September 27, 2012, Respondent submitted to an interview with Board Investigator Julie Escat and Board Medical Consultant Shoaiib Naqvi, M.D. He did not retain an attorney to accompany him to the interview, and he answered all of the questions he was asked.²

12. At the interview, all of the participants understood that the requested records had been limited to a one-year period, but that Respondent’s care of the three patients began before December 2, 2010, and continued after December 2, 2011.

13. Following the filing of the Accusation in February 2013, Respondent sought to provide the Board with the three patients’ complete medical records. He was able to obtain a signed release from patient A.K., authorizing release of her complete medical records. Respondent submitted those records to the Board. However, he was unable to obtain signed releases from patients C.P. and K.B.

Respondent’s Practice in 2010-2011

14. From the end of 2010 through the end of 2011, Respondent’s practice included two licensed Physician Assistants (PA’s), Adolfo Salcido and Cherylynn Jones, and another anesthesiologist, Devinder S. Kumar, M.D.

15. Both PA Salcido and PA Jones were working pursuant to Delegation of Services Agreements signed by Respondent and each PA. According to the Delegation of Services Agreements, both PA Salcido and PA Jones had Drug Enforcement Administration (DEA) numbers under which they were able to write and sign prescriptions.

16. PA Salcido completed a Controlled Substances Education Course on January 24, 2009, and his certificate of completion was admitted into evidence at the administrative hearing.

² The transcript of the September 27, 2012 Board interview was admitted into evidence without objection. Respondent’s interview statements are consistent with his testimony at the administrative hearing. Since Complainant did not offer the testimony of any percipient witnesses, Respondent’s interview statements, along with the credible testimonies of Respondent and Physician Assistant Adolfo Salcido, established the facts regarding Respondent’s custom and practice and the interactions with the three patients.
17. At the time PA Jones worked for Respondent, Respondent understood that PA Jones had taken the prescribing course for PA’s. However, Respondent could not locate her certificate of completion for submission as evidence at the administrative hearing. PA Jones no longer works for Respondent.

18. In addition to their licensure and certifications, PA Salcido and PA Jones had hands-on training on a daily basis while working for Respondent. He trained his PA’s on many subjects, including: how to examine patients and take their histories; the criteria for diagnosing facet pain and radicular pain; which medications to start prescribing and how to slowly progress to stronger medications if anti-inflammatory medications are ineffective; and how to determine diversion, addiction and side effects. He also expected them to read the Pain Physician journals (periodical publications of ASIPP) and interventional pain management treatises he brought to the office.

19. In 2010 and 2011, Respondent did not have detailed written protocols for the PA’s regarding the specific criteria for prescribing particular medications. He had practice guidelines in place (e.g. the requirement of a delegation of service agreement; the requirement that a physician must see patients on their initial visit and any time a procedure was recommended; guidelines for PA’s seeing patients and physicians supervising PA’s), along with a one-page formulary of the medications (including narcotics and muscle relaxants) commonly prescribed by his office. Respondent’s office also had an updated Physician’s Desk Reference (PDR) which the PA’s were instructed to use, along with Internet research, when prescribing medications.

20(a). In 2010 and 2011, Respondent’s practice had four providers (two PA’s and two physicians) seeing patients for consultations. Respondent’s policy dictated, and it was his custom and practice, that any new patient must be seen by a physician, either Respondent or Dr. Kumar. The PA’s were authorized to take histories, conduct physical examinations, review any diagnostic studies, and formulate recommended treatment plans, including ordering diagnostic studies, prescribing medications, or ordering interventional procedures such as spinal injections. One of the physicians would also review the history with the patient, examine the patient, review any diagnostic studies and determine whether to accept or change the recommended treatment plan. For follow-up consultations, patients were seen by a PA or a physician. If a patient was seen by a PA and there was no change in the patient’s physical status and no change in medications, the physician would review the PA’s consultation note and co-sign the consultation note on the same day as the patient visit. If a PA recommended a procedure, pursuant to office policy, a physician would examine the patient and confirm the order for the procedure. Additionally, only the physicians performed any procedures.
20(b). At the administrative hearing, PA Salcido and Respondent testified credibly regarding Respondent’s custom and practice regarding patient visits, PA supervision, and consultation/progress notes as follows:

(1) Respondent was always involved in care of new patients. PA Salcido would document the patient’s history (including medical history and comorbidities, medication history, social history, family history), conduct a physical examination directed toward the patient’s current complaint, and review any prior diagnostic imaging which the patient sent or brought in. PA Salcido would talk to the patient about possible treatment recommendations and then bring Respondent into the examination room. When Respondent came in, PA Salcido would provide Respondent with the information PA Salcido had obtained, and Respondent would ask questions, conduct his own physical examination, and review prior diagnostic imaging. After a discussion, Respondent would either agree with PA Salcido’s recommendation or consider another plan. Respondent would sign the initial consultation note written by PA Salcido on the same date as the consultation.

(2) For follow up visits, PA Salcido would go through the same sequence of taking the history, including the patient’s response to treatment (determined by the patient’s pain level with and without medications and the patient’s level of functioning by way of increased activities of daily living) and any side effects, conducting the physical examination, and formulating a recommended treatment plan. If the patient was stable, the PA could refill medications and leave the patient on the current regimen, or he could recommend additional treatment and bring in Respondent to review the note and see if he agreed with the recommendation. Any time a procedure was recommended, Respondent saw the patient, because he was responsible for making the determination of whether the procedure was indicated. Respondent did not see patients on follow-up visits if the patient was stable on the current regimen, pain was being controlled by medications, there was no evidence of diversion or side effects, and the patient was able to perform the activities of daily living (ADL).

(3) If Respondent saw the patient on his own without PA Salcido, Respondent would write his own note. Otherwise, PA Salcido would write the progress notes when he saw the patients in follow-up. Per office protocol, PA Salcido would always review his progress notes with Respondent on the same day as the patient visit. PA Salcido would explain any changes to the patient’s history or physical examination and discuss his treatment plan. PA Salcido always documented the date of the visit in the progress note, and Respondent would sign the note on that same date. Respondent always signed at the bottom of the note on the same day as indicated in the upper left portion of note. If he signed the note on a different day than indicated at the top of the note, he would write in the signature date next to his signature.

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21. All of the progress notes for the three patients in this case were in SOAP (subjective, objective, assessment, and plan) format.

22. Respondent personally ordered all of the procedures which he performed on K.B., C.P., and AK.

23(a). Prior to 2010, Respondent began utilizing Pain Management Agreements which the patient signed at the initial visit, wherein the patient agreed to certain parameters for use of prescribed pain medications during treatment.

23(b). A.K.’s Pain Management Agreement contained the following parameters:

- I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medications.
- I will communicate fully with my doctor about the character of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medications with anyone.
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled, stimulants, or antianxiety medicines from any other doctor.
- I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I agree to use _____ Pharmacy, located at _____, telephone number _____ for filling prescriptions for all of my pain medicine. [¶] . . . [¶]
- I agree that I will submit to a blood or urine test is [sic] requested by my doctor to determine my compliance with my programs of pain control medicine.
I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

(Exhibit B, p. 10.)

23(c). Regarding the blank space in the form where a pharmacy name was to be placed, Respondent did not necessarily require the patient to name an exclusive pharmacy for filling their pain medicine prescriptions. Respondent noted that, prior to 2010, some physicians were requiring the name of a single pharmacy on their pain medicine contracts, but Respondent believed that “nailing the patient down to one pharmacy did not work” for patients because it curtailed their ability to go to a different pharmacy if one did not have the medications stocked or if the patient needed to refill their prescription while out of town. Respondent believed there were other means to monitor patient compliance.

24. Respondent testified credibly that: he had three pain management agreements for K.B., two of which were similar to A.K.’s with the pharmacy left blank; he had one similar pain management agreement for C.P.; and that all of the pain management agreements had similar language regarding compliance testing. However, the specific language of K.B.’s and C.P.’s pain management agreements was not established by the evidence. Their pain management agreements were not submitted as evidence at the administrative hearing because these documents were never requested as part of the records to be produced by Respondent, and they apparently pre-dated the scope of the records request and the patients’ authorizations for disclosure of their records.

25. In addition to the Pain Management Agreement, Respondent included a multi-page Consent for Chronic Opioid Therapy form in the new patient packet for review and signature. The Consent for Chronic Opioid Therapy detailed the risks and side effects associated with the use of opioids, the negative interactions with certain other medicines, the possibility of physical dependence and addiction, potential withdrawal symptoms, and the possibility of tolerance or failure to respond to opioids. The Consent for Chronic Opioid Therapy contained a Summary of Guidelines for prescribed Opiates, which listed expectations similar to but expanding on those listed in the Pain Management Agreement.

26. In 2010 and 2011, Respondent did not conduct urine testing on his patients as a means of monitoring any misuse of pain medications. He believed that it was not necessary for most patients who by all other indications were not misusing their medications. Additionally, he believed that the urinalysis was not covered by Medi-Care and Medi-Cal and did not want to place an undue expense on the patients.
27(a). In 2010 and 2011, Respondent was not registered to use the California Controlled Substance Utilization Review and Evaluation System (CURES).³

27(b). In 2009, CURES had converted to an online system, replacing its prior system which had required written requests for prescription histories by mail or facsimile. Following the conversion in 2009, prospective enrollees encountered difficulties registering for online access to CURES. Registration required submission of notarized documents to Sacramento, and due to budgetary constraints, the CURES staff had been reduced to one to two people. Respondent made several attempts to enroll in the newly-electronic system and contacted the CURES Sacramento headquarters but was unable to gain electronic access to CURES. Consequently, Respondent did not use CURES in 2010 and 2011.

28. In 2010 and 2011, Respondent did not request any CURES reports or conduct any urinalysis on the three patients at issue in this case (K.B., C.P, and A.K.).

29. In 2010 and 2011, Respondent’s PA’s had clear directions from him regarding how to assess patients for adverse reactions to medications and any signs of abuse or diversion. PA’s listened for patient complaints (including nausea, constipation or rash) to determine any adverse reaction to medications. PA’s were instructed to ask patients several specific questions to determine any evidence of addiction or diversion. Additionally, PA’s were instructed to look at the patient’s demeanor and physical condition on examination (e.g. slurred speech, unsteady gait, excessively dilated or pinpoint pupils) and to do pill counts for medication compliance at each visit. (Patients were instructed to bring their medication bottles to each visit for pill counts.) PA’s were also taught to note certain warning signs of addiction or diversion, such as patients requesting early refills and concerned calls from pharmacies or patients’ family members. PA’s were expected to specifically document any positive findings of addiction or diversion and to document negative findings as “no evidence of addiction or diversion.” They were not expected to document the actual pill count numbers unless there was a shortage.

30. PA’s were also expected to counsel patients regarding how to take their medications (e.g. correct dosages, never exceeding dosages) and the potential risks.

31(a). In 2010 and 2011, Respondent and his PA’s did not take or record patients’ vital signs during any office consultations. This included the office consultations of patients K.B., C.P. and A.K. Respondent believed pain management physicians need not consider vital signs at consultations, where their primary focus was the patients’ pain complaints. He

³ CURES allows healthcare prescribers, pharmacists, law enforcement, and regulatory boards to access patients’ and providers’ controlled substance prescription histories. CURES is intended to assist in the reduction of prescription drug abuse in California.
believed that, because the pain management physicians were not primary care physicians, internists or cardiologists, they were not looking at the patients’ blood pressure, heart rate or other medical conditions.

31(b). However, patients’ vital signs were always taken several times on procedure dates, including pre-operatively, during the procedures and after the procedures. Respondent understood that recording of vital signs during procedures at his surgery center was required by the Department of Health and by the applicable standard of care. Additionally, monitoring of vital signs by an anesthesiologist or certified nurse anesthetist (CRNA) was necessary when patients were receiving monitored anesthesia care (MAC) wherein the anesthesiologist/CRNA might administer intravenous (IV) propofol and other sedating medications which could alter the patient’s blood pressure.

32. Before each procedure, as was Respondent’s custom, each of the three patients (K.B., C.P., and A.K.) was given a package which included an informed consent document discussing the risks/complications and alternatives (including physical therapy, medication, and surgical options) of the listed procedure. The packet also contained a pain diagram for patients to indicate the area(s) of their bodies where they felt pain and their level of pain on a scale of 0 to 10 (0 being no pain, and 10 being the worst pain).

33. The two types of procedures Respondent performed in this case were transforaminal epidural steroid injections and facet injections. Both procedures could be performed on either the cervical or lumbar spine. Respondent has performed thousands of these procedures over the past 20 years.

34. A transforaminal epidural steroid injection (TFESI) is an injection into the epidural space going through the foramen (i.e., the opening at the side of the spine where the nerve root exits). The procedure is performed with the use of fluoroscopy/x-ray.4 Viewing the fluoroscopy monitor, Respondent locates the level of the spine where the procedure will be performed. Local/skin anesthesia is administered and Respondent inserts the needle and confirms its positioning using the fluoroscopy. Respondent then injects dye into the area to confirm proper placement of the needle (i.e. that the dye spreads as required and is not injecting into an artery). Respondent will then inject the anesthetic mixed with the steroid into the epidural space where treatment is indicated.

35. Once the patient has been readied for the procedure and the fluoroscopy has commenced, the TFESI procedure takes only a couple of minutes.

4 Fluoroscopy is a continuous x-ray to allow viewing of internal body structures, inserted medical instruments, or injected contrast dye.
36(a). In 2010-2011, Respondent used Kenalog, a particulate steroid, for his TFESI’s. Specifically, he used a solution of Marcaine mixed with 10 mg of Kenalog.

36(b). A particulate steroid is a solution containing particulates of a steroid, making the solution thicker than a non-particulate steroid solution. Respondent understood that injected steroid particulates remain in the area near the inflamed nerve for a longer time period, while non-particulate steroids spread much faster, generating the then-current theory that particulate steroids have greater efficacy than non-particulate steroids.

36(c). Although particulate steroids had been used for several decades in epidural injections, Respondent was aware that, in 2010-2011, there was “great controversy” involved in their use. (Respondent’s testimony.) Respondent knew that there had been rare cases of catastrophic injury (e.g. paralysis) and death with TFESI’s and that critics were blaming particulate steroids for clogging the artery to the spinal cord and causing paralysis. However, Respondent reasoned that those procedures involved larger needles than those he used and that those patients had been more prone to complications. He noted that catastrophic injuries such as paralysis also occurred with injections of non-particulate steroids or just a local anesthetic such as lidocaine. In 2010-2011, Respondent understood that ASIPP recommended using caution when proceeding with TFESI’s using particulate steroids. This caution included keeping the needle outside of the artery and injecting dye prior to the TFESI’s. In 2010-2011, Respondent always used those precautions when performing TFESI’s using particulate steroids, and his patients had no bad outcomes.

37. In 2010-2011, Respondent tried to follow ASIPP and SIS guidelines or incorporate them into his decision-making when treating patients and when determining the frequency of administering TFESI’s. When a patient initially received a TFESI (either cervical or lumbar), two to three injections were typically necessary for the nerve inflammation to subside. After that first series of injections, if the pain returned, Respondent would try to disperse the injections, keeping them three to four months apart.

38(a). Facet injections are injections delivered into facet joints (joints between vertebrae in the spine). The procedure is performed with the use of fluoroscopy, and Respondent locates the facet level(s) where the procedure will be performed. Local/skin anesthesia is administered, and Respondent inserts the needle, confirms its positioning using fluoroscopy, and injects Marcaine, a local anesthetic, into the facet joint(s).

38(b). Respondent noted that lumbar facets are larger and easier to identify under fluoroscopy than cervical facets. With multiple-level lumbar facet injections, he puts a bend on the needle, places the needle through the skin, injects into the first facet joint, pulls the needle back without withdrawing it from the skin, and moves the needle to inject into the next facet level. With only one puncture in the skin, he is able to administer multiple-level lumbar facet injections very quickly, with a few seconds spent on each level.
39(a). TFESI’s and facet injections are generally used for different types of pain.

39(b). A bulging disc may cause compression/inflammation of a nerve root or a chemical release, both of which in turn may cause pain radiating into the patient’s extremities. TFESI’s are performed to reduce inflammation of spinal nerve roots which should also address radicular pain in the extremities.

39(c). Facet pain is usually localized in a portion of the neck and back which is not radiating to the patient’s extremities. A facet problem is generally mechanical in nature (i.e. worsens with movement) and is associated with stiffness and muscle spasm in a particular facet area. The facet injection addresses the localized pain.

40. Respondent never places his patients under deep sedation to perform any TFESI’s or facet injections. To achieve deep sedation, an anesthesiologist would give the patient a loading dose of IV anesthetic like Propofol, with the usual dose about 200-300 mg, and the patient would be unconscious for the procedure. Respondent’s patients had the option of using monitored anesthesia care (MAC), wherein they would be given IV or intramuscular (IM) sedation, but would remain conscious, with an anesthesiologist present to monitor their vital signs.

41. In 2010-2011, following his performance of procedures, Respondent always drafted computer-produced operative reports. He used an electronic template which could be amended and individualized to include the patient’s relevant information on the operative date. Generally, the description of how the procedure(s) were performed remained in unaltered template form, since the method for performing the procedures rarely differed. However, when dictating his operative reports, Respondent would instruct the transcriber to change/input individual patient information on the template for each procedure.

42. Radio frequency ablation (RFA) / rhizotomy is an alternative procedure to alleviate back pain which Respondent may discuss with patients. RFA uses an electrical current produced by a radio wave to heat up a small area of nerve tissue and to destroy the nerve fibers carrying pain signals to the brain. RFA provides longer pain relief (approximately six months for regrowth) than injections (two to four months). However, since RFA “burns” the nerve (Respondent’s characterization), patients are often afraid of undergoing the procedure. Nevertheless, if the pain relief from injections does not last long, Respondent may recommend that the patient undergo RFA.

Facts Re: Patient K.B.

43. Respondent began treating Patient K.B. on July 28, 2009, when she transferred to his care from another pain management physician. K.B. was a 400-pound, six-foot tall female suffering from chronic low back pain and bilateral knee pain. CT scans performed
prior to December 2, 2010 were positive for lumbar disease (including bulging discs at L4-L5 and L5-S1) and severe osteoarthritis in both knees.\(^5\)

44. During the course of her treatment with Respondent, K.B. was also treating with a psychiatrist, Kamal Preet Dhawan, M.D., who wrote K.B. prescriptions for controlled substances to address anxiety and depression. Dr. Dhawan prescribed no narcotics in addition to those prescribed by Respondent. Respondent was aware that Dr. Dhawan was treating and prescribing for K.B.\(^6\)

45. During the course of her treatment with Respondent, K.B. also received treatment from Dr. Kumar which included intra-articular steroid injections to her knees. Respondent was not involved in performing injections on K.B.’s knees.\(^7\)

46. On January 14, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he saw K.B. and signed the progress note on the same day. According to the progress note, on that date, K.B. continued to suffer from chronic low back pain and complained of added right knee pain. She reported increased ADL’s, greater than 60 percent, after a prior left knee intra-articular steroid injection (performed by Dr. Kumar on December 14, 2010) and through use of medications. Physical therapy attempts had failed. Examination of her lumbar spine revealed L3-L5 para-sistal muscle tenderness, lumbar facet tenderness, and decreased range of motion. Examination of

\(^5\) Since only a limited portion of K.B.’s records were obtained and submitted at the hearing, the facts regarding her treatment prior to that time (i.e. before December 2, 2010) were established by Respondent’s credible testimony.

\(^6\) Complainant’s expert criticized Respondent by observing that the CURES data showed “another provider,” Dr. Dhawan, was writing prescriptions for K.B. and stating that this was “troubling and not explained in the records provided.” (Exhibit 32, P. 1100.) However, it was not alleged nor established by clear and convincing evidence that the prescribing of non-narcotics by a patient’s psychiatrist should be documented in the pain management physician’s records in 2010-2011. Complainant’s expert’s reports and the First Amended Accusation are rife with such ancillary observations without any indication of their materiality to the determination of gross negligence or other causes for discipline.

\(^7\) Dr. Kumar’s December 14, 2010 performance of intra-articular injection of K.B.’s left knee was documented in a typewritten operative report which was prepared using the office template. The signature line at the bottom of the document was incorrectly left as “Narinder S. Grewal, M.D.” instead of “Devinder S. Kumar, M.D.” However, Dr. Kumar was listed as the surgeon, and his signature appears on the signature line. Dr. Kumar’s signature was credibly verified by Respondent and confirmed by the ALJ’s review of their respective signatures throughout the medical records in evidence.
her right knee revealed decreased range of motion and clicking and popping. Regarding her
lumbar spine, K.B. was diagnosed with lumbar facet syndrome and degenerative disc disease
(DDD). The treatment plan included refilling her medications (which included Roxicodone, Neurontin, and Baclofen) and adding Voltaren. K.B. was counseled regarding the use of her medications and was scheduled for a February 15, 2011 right knee intra-articular knee injection.

47. On February 9, 2011, Respondent saw K.B. in his office. He documented the visit with a progress note, which he signed and dated. According to the progress note, K.B. complained of increased pain in her lower back, with the pain greater on the left than the right. She characterized the pain as 9-10 on a 0-10 scale, which was sharp and stabbing. She reported no complaints of leg pain. Respondent inquired about possible side effects, such as constipation, nausea and vomiting, and documented “no side effects.” He also assessed her for signs of addiction and abuse, including a pill count and examining her demeanor, gait, breathing and speech for slurring. He documented his negative findings as “no evidence of addiction.” Respondent also conducted a physical examination and found that the patient had L3-L5 para-spinal muscle spasm, lumbar facet tenderness, and decreased range of motion and increased pain on extension and side bending (movements intended to load the facet joints). K.B. had minimal to no leg pain. His assessment was bilateral lumbar facet syndrome, and his recommended treatment plan was to perform bilateral lumbar facet injections, home exercise and continuation of her medications.

48(a). On February 24, 2011, Respondent performed bilateral lumbar facet injections on KB at the L3-4, L4-5 and L5-S1 levels. Prior to the procedure, K.B. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day at 8:00 a.m., indicating that she was currently experiencing pain in her lower back and knees at a level of 10 on a scale of 0-10.

48(b). Respondent’s dictated operative report for the February 24, 2011 procedure indicated preoperative diagnoses which included bilateral lumbar facet syndrome and DDD.

48(c). The operative report also indicated under “Name of Procedure” that “IV sedation and [MAC]” were used. (Exhibit A, p. 25.) Additionally, in the narrative section,

8 Roxicodone is a brand name for the generic oxycodone, an opioid pain medication.

9 Neurontin is a brand name for gabapentin, a medication used to treat, among other things, epilepsy and neuropathic pain.

10 Baclofen is a muscle relaxer and an anti-spastic agent.

11 Voltaren is a nonsteroidal anti-inflammatory drug (NSAID) used to treat pain and inflammation.
the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id.) However, the separate anesthesia record indicated that, although no IV anesthesia was given, the patient’s heart rate, respirations, blood pressure and oxygen saturation were monitored while she was prone.

48(d). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Clinical signs and symptoms consistent with lumbar facet syndrome.
2. Pain distribution in low back, buttocks and groin.
3. Pain level “9” on a 0-10 scale.
4. Lumbar facet tenderness.
5. Paraspinal muscle spasms in lumbar spine.
6. Patient had 50-60% pain relief from prior similar injections with good functional improvement.
7. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

48(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 38(a).)

49(a). On March 22, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he signed the progress note on the same day.

49(b). According to the March 22, 2011 progress note, on that date K.B. continued to suffer from chronic low back pain, and complained of severe bilateral knee pain, on the left greater than the right. The note documented K.B.’s medications, which included Voltaren, Neurontin, Roxicodone, and Baclofen. K.B. reported positive relief from the medications (pain level “6/10” with medications, and “10/10” without medications) and no adverse reaction. The progress note documented negative findings for addiction or diversion as “addiction diversion.” (Exhibit A, p. 27.) The assessment was bilateral knee pain secondary to degenerative joint disease (DJD), and the plan was to refer K.B. to an orthopedic surgeon for Synvisc® injections in her knees. The patient was counseled regarding the use of her medications and instructed to return for a follow-up visit in one month.

50. On April 29, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he signed the progress note on the same day. K.B. complained of sharp, stabbing, localized pain on both sides of her lower back. However, she also reported increased ADL’s with the procedures and medications
(more than 60 percent), positive relief from the medications (pain level “6/10” with medications, and “10/10” without medications) and no adverse reaction. The progress note documented negative findings for addiction or diversion as “- addiction diversion.” (Exhibit A, p. 28.) Examination of her back revealed para-spinal muscle spasms and facet tenderness at the L3-L5 levels, decreased range of motion and bilateral knee pain. The assessment was bilateral lumbar facet syndrome, lumbar/sacral spondylosis without myelopathy, and bilateral knee pain secondary to DJD. The treatment plan included advising her to continue treatment with the orthopedic surgeon, referring her for treatment with a TENS unit, and continuing with her pain medications on which she was counseled.

51. On May 27, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he saw K.B. and signed the progress note on the same day. K.B. complained of sharp, localized pain on both sides of her lower back. However, she also reported increased ADL’s with the procedures and medications (more than 60 percent increase), positive relief from the medications (pain level “6/10” with medications, and “10/10” without medications) and no adverse reactions. The progress note documented negative findings for addiction or diversion as “- addiction diversion.” (Exhibit A, p. 29.) Examination revealed lumbar para-spinal muscle spasms, lumbar facet tenderness, and decreased range of motion. The assessment was lumbar/sacral spondylosis without myelopathy, lumbar DDD/facet disease, and failed physical therapy. The plan was for K.B. to continue her pain medications on which she was counseled, and to schedule a lumbar facet injection in two weeks.

52(a). On June 15, 2011, Respondent performed bilateral lumbar facet injections on K.B. at the L3-4, L4-5 and L5-S1 levels. Prior to the procedure, K.B. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day at 7:45 a.m., indicating that she was currently experiencing pain in her upper to lower back and at a level of 10 on a scale of 0-10.

52(b). Respondent’s dictated operative report for the June 15, 2011 procedure indicated preoperative diagnoses which included lumbar spondylosis without myelopathy, bilateral lumbar facet syndrome, and degenerative lumbosacral spine/disc/facet disease.

52(c). The operative report also indicated under “Name of Procedure” that MAC was used. Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Exhibit A, p. 40.) The separate anesthesia record indicated that, although no IV anesthesia was given, Demerol 75 mg was administered at 9:10 a.m., and MAC was provided, consisting of monitoring of the patient’s pulse, heart rate, respirations, blood pressure and oxygen saturation while she was prone. The MAC began at 9:46 a.m. and ended at 9:51 a.m. The operation began at 9:47 a.m. and ended at 9:49 a.m.
52(d). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Clinical signs and symptoms consistent with lumbar facet syndrome.
2. Pain distribution in low back, buttocks and groin.
3. Pain level “9” on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement.
5. Lumbar facet tenderness.
6. Paraspinal muscle spasms in lumbar spine.
7. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

52(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 38(a.).)

53. On July 14, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he saw K.B. and signed the progress note on the same day. K.B. complained of “nagging” pain in her lower back, greater on the left side than the right, radiating into her left leg, along with left leg weakness numbness and tingling. However, she also reported increased ADL’s with the procedures and medications (more than 60 percent increase), positive relief from the medications (pain level “8/10” with medications, and “10/10” without medications) and no adverse reactions. The progress note documented negative findings for addiction or diversion as “- addiction diversion.” (Exhibit A, p. 42.) Examination revealed lumbar muscle tenderness and facet tenderness at the L3 through L5 levels, decreased range of motion, and a positive straight leg raising test with spasm. The assessment was lumbar/sacral spondylosis without myelopathy, lumbar DDD/facet disease, lumbar radiculopathy, and failed physical therapy. The plan was for K.B. to continue her pain medications on which she was counseled, and to schedule a left lumbar TFESI injection in one month.

54(a). On August 17, 2011, Respondent performed left TFESI’s on KB at the L4-5 and L5-S1 levels. Prior to the procedure, K.B. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day at 8:00 a.m., indicating that she was currently experiencing pain in her lower back through her left leg, and at a level of 8 on a scale of 0-10.

54(b). Respondent’s dictated operative report for the August 17, 2011 procedure indicated preoperative diagnoses which included lumbar spinal spondylosis without myelopathy, left lumbar radiculopathy/lumbar sacral neuritis, bilateral lumbar facet syndrome, and severe low back and left leg pain.
54(c). The operative report also indicated under “Name of Procedure” that MAC was used. Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Exhibit A, p. 52.) The separate anesthesia record indicated that, although no IV anesthesia was given, Demerol 75 mg was administered at 9:26 a.m., and MAC consisted of monitoring the patient’s pulse, heart rate, respirations, blood pressure and oxygen saturation while she was prone. The MAC began at 9:35 a.m. and ended at 9:43 a.m. The operation began at 9:36 a.m. and ended at 9:41 a.m.

54(d)(1). Under a section entitled Indications and Medical Necessity, the following was listed:

1. MRI evidence of left lumbar radiculopathy and [DDD].
2. Clinical signs and symptoms consistent with lumbar facet syndrome.
3. Pain level is “9-10” on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.
5. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

54(d)(2). In the narrative section, the report stated, “MRI scan was reviewed.” (Id.) This statement and the statement that there was “MRI evidence” were errors, and “MRI” should have read “CT scan.”

54(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 34.)

55. On August 25, 2011, K.B. was seen by Respondent in a follow up examination. She reported pain relief and improved ADL’s from the TFESI’s and pain medications with no side effects. Respondent noted “no evid[ence] of addiction.” (Exhibit A, p. 53.)

56. On September 20, 2011, K.B. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he signed the progress note on the same day. K.B. complained of localized sharp lower back pain. However, she also reported increased ADL’s with the procedures and medications (more than 45 percent increase), positive relief from the medications (pain level “6/10” with medications, and “10/10” without medications) and no adverse reactions. The progress note documented negative findings for addiction or diversion as “- addiction diversion.” (Id. at p. 54.) Examination revealed para-lumbar muscle tenderness and facet tenderness at the L3 through L5 levels, decreased range of motion, and a positive straight leg raising test with spasm. The assessment was lumbar/sacral spondylosis without myelopathy, lumbar DDD/facet disease, and failed physical
therapy. The plan was for K.B. to continue her pain medications on which she was
counseled, and to schedule a follow up in one month.

57(a). On October 24, 2011, Respondent performed bilateral lumbar facet injections
on K.B. at the L3-4, L4-5, and L5-S1 levels. Prior to the procedure, K.B. signed the informed
consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also
filled out the pain diagram that day at 10:00 a.m., indicating that she was currently
experiencing pain in her lower back and at a level of 9 on a scale of 0-10.

57(b). The separate anesthesia record indicated that, although no IV anesthesia was
given, Demerol 75 mg was administered intramuscularly (IM) at 10:40 a.m., and MAC
consisted of monitoring the patient’s pulse, heart rate, blood pressure and oxygen saturation
while she was prone. The MAC began at 10:50 a.m. and ended at 10:57 a.m. The operation
began at 10:51 a.m. and ended at 10:55 a.m.

57(c). The patient’s history and physical form for the date of the procedure indicated
that her diagnoses included lumbar spondylosis without myelopathy, lumbar DDD, and
lumbar facet disease.

57(d). Although Respondent’s October 24, 2011 progress note referred to his dictated
operative report for that date, the dictated report was not included in K.B.’s records produced
at the hearing.

58(a). The last progress note in K.B.’s records produced for the hearing was dated
November 23, 2011. On that date, Respondent saw K.B. and wrote and signed his progress
note. K.B. reported 75 percent pain relief for four days after the lumbar facet injection.
However, she reported that her back pain returned at a pain level of 6 on a scale of 0-10, that
her left knee pain was at a level of 9 on a scale of 0-10, and that pain medications were not
helping. Respondent’s examination revealed decreased range of motion in K.B.’s lumbar
spine, L-3 through L5 level muscle spasm and facet tenderness. As part of the treatment plan,
the patient was scheduled to undergo lumbar RFA on December 28, 2011.

58(b). Respondent testified credibly that he had previously discussed the potential for
RFA with K.B. At the November 23, 2011 visit, K.B. agreed to have RFA on her lumbar
facets. The RFA was performed in late December 2011.\textsuperscript{12}

\textsuperscript{12}The documentation of that procedure was not included in the records produced in
this case because it is outside the one-year period of the document request and patient
authorization.
59. K.B. eventually stopped treatment with Respondent. Toward the end of their treatment relationship, K.B.'s husband contacted Respondent to ask for an early refill. K.B. had not asked for early refills or replacement of lost prescriptions prior to that date. K.B. was informed by Respondent's staff that Respondent cannot provide early refills and that he may choose to discharge a patient if they continue to ask for early refills. K.B. did not return for further treatment.

60. The FAC, paragraph 11A, footnote 1, alleges, "The actual initial date of treatment [for K.B.] is unknown because Respondent’s recordkeeping is inadequate." This allegation was not established. Instead, the evidence established the initial date of treatment was not contained in the records available to the Board because the Board did not request the patient’s complete records and there was no authorization from the patient to provide those records.

61. The FAC, paragraph 11A, alleges that "there are no corresponding history and physical notes as to [the initial] visit, including any indication that an examination took place." This allegation was not established since the records from K.B.’s initial date of treatment were not contained in the records submitted as evidence at the hearing.

62. The FAC, paragraph 11B, alleges that, "At the time the pain management agreement was signed, the patient promised to use only the Costco pharmacy on "L" and "10th" in an unknown city with an unknown phone number for filling pain management medications." This allegation was not established since K.B.’s pain management agreement was not submitted as evidence at the administrative hearing.

63. The FAC, paragraph 11B, also alleges that, "according to the CURES report, most of the patient’s prescriptions were filled at other locations." This allegation was not established by the evidence. The single page of a CURES report admitted into evidence indicated that K.B.’s six prescriptions for Oxycodone which Respondent wrote over the course of 10 months (December 23, 2010, through October 24, 2011) were all filled at a single pharmacy.

64. The FAC, paragraph 11B, also alleges that "there is evidence of prescriptions of controlled substances by multiple providers in 2012, which indicates potential ongoing diversion." This allegation was not established by the evidence.

65. The FAC, paragraph 11C also alleges, "in visits after what is believed to be the initial consultation, there was no documentation regarding K.B.’s response to treatment with the opioid mediations, nor is there any evidence of compliance measures being undertaken. . . ." These allegations were not established, since progress notes indicated increased ADL’s, positive response to medications with no adverse effects, and negative findings of addiction or diversion.
66. The Accusation contained numerous additional allegations which purported to
be "facts," but apparently were opinions of Complainant’s expert. Any alleged facts
regarding K.B. not addressed in this Decision were not established by clear and convincing
evidence.

Facts Re: Patient C.P.

67. Respondent began treating Patient C.P. in about 2000, when he took over
C.P.’s care from another pain management physician. C.P. is a 220-pound quadriplegic male,
confined to a bed after a traumatic injury. He requires a tracheostomy tube and ventilator, G-
tube, and colostomy care. C.P. receives 24-hour care by a licensed vocational nurse (LVN).
For each appointment, he was brought to Respondent’s facility by medical transport and
accompanied by his LVN caregiver and sometimes by his mother as well. However, C.P. was
alert and oriented and able to engage in conversation with Respondent.

68. C.P. suffers from intractable neck pain and headaches, tracheostomy site pain
and muscle spasm in his upper back and cervical spine. Any diagnostic studies were
completed prior to December 2, 2010 (the first date for which the Board requested C.P.’s
records).

69. As detailed in the records submitted at the hearing, Respondent performed
cervical facet injections on C.P. approximately every two months. The cervical facet
injections reportedly helped to ease C.P.’s pain for about two months, after which his pain
worsened, and he returned.

70. Respondent also wrote C.P. prescriptions for narcotic pain medications. These
medications were continued from his prior regimen with his former pain management
physician. The continued medications included: a Fentanyl patch, 25 mg (which was the
lowest dose available), changed every three days; morphine sulfate solution, 30 mg (which is
about one-fifth of the IV dosage), given by C.P.’s caregiver orally, three times per day; and
demerol IM injection, as needed at night to help with tracheal pain and to help him sleep.

71. Routinely, Respondent prescribed patients only one long-acting medication,
either 12 or 24 hours duration, and one short-acting medication for breakthrough pain.
However, C.P. was prescribed two longer-acting medications, Fentanyl and morphine sulfate,
both in small doses, and had a likely tolerance to the medications. It was not Respondent’s
custom to prescribe IM Demerol, and C.P. was the only exception in Respondent’s practice.
Respondent continued C.P.’s prior medication regimen because he had been taking this
combination of medications for years without side effects or complications, including no
indication of metabolite toxicity due to Demerol use.\footnote{Demerol may have negative side effects such as the accumulation of toxic
normally prescribe such a medication regimen for anybody, C.P.’s condition was an extremely unusual circumstance.

72. Respondent explained that, although C.P.’s neck pain was about fifty percent alleviated with facet injections, his tracheal pain and the discomfort of bed confinement (neck pain and muscle spasms with upper chest movement) was controlled only with medication. He could also sleep better and up to six hours with the combination of medications he was given. Respondent had no doubt C.P. was experiencing the reported pain, and Respondent believed C.P. needed the prescribed medications based on his condition, physical examinations, and his feedback at office visits. Respondent also believed that C.P. was benefitting from the medications and injections.

73. At the administrative hearing, Respondent noted that C.P. was unable to self-administer his medications and therefore was not capable of diverting or abusing his medications. C.P.’s medications were administered by either his LVN or his mother, and if either was diverting the medications, C.P. was capable of reporting that to Respondent. Respondent was never given any indication that there was an issue with anyone diverting C.P.’s medications.

74. According to progress notes from February 1, 2011, April 4, 2011, June 6, 2011, August 1, 2011 and October 3, 2011, C.P. was transported by medical transport to Respondent’s office on those dates and received bilateral cervical facet injections. He was seen by Respondent personally, not a PA.

75. On February 2, 2011, C.P. complained of increased neck pain and stiffness in his neck and upper back at a pain level of 9 on a scale of 10. He also complained of tracheostomy site pain. Respondent noted no side effects to the medications and “no signs of addiction.” (Exhibit C, p. 3.) The medications remained the same on this date and throughout C.P.’s treatment. Respondent’s plan included bilateral cervical facet injections.

76(a). On February 1, 2011, Respondent performed bilateral cervical facet injections on C.P. at the C3-C4, C4-C5 and C5-C6 levels. Prior to the procedure, C.P.’s informed consent document contained in the pre-procedure packet was signed. (See Factual Finding 32.) C.P. also indicated for the pain diagram that he was currently experiencing pain at a level of 10 on a scale of 0-10.

metabolites (normeperidine) which can precipitate seizures.
76(b). Respondent’s dictated operative report for the February 1, 2011 procedure indicated preoperative diagnoses which included cervical spondylosis without myelopathy, cervical stenosis, degenerative cervical spine/disc/facet disease, bilateral cervical facet syndrome, and cervicogenic neck pain and headache.

76(c). The operative report also indicated under “Name of Procedure” that “[IM] sedation and [MAC]” were used. (Exhibit C, p. 14.) Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id.) The separate anesthesia record indicated that Demerol 75 mg IM was administered, and the patient’s pulse, blood pressure and oxygen saturation were monitored during the procedure. The MAC began at 11:20 a.m. and ended at 11:26 a.m. The operation began at 11:21 a.m. and ended at 11:25 a.m.

76(d)(1). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Diagnostic MRI scan with clinical signs and symptoms consistent with cervical facet syndrome.
2. Neck pain and upper back pain with stiffness.
3. Pain level is “9-10” on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement.
5. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

76(d)(2). Since C.P.’s records prior to December 1, 2010 were not in evidence, the existence or lack of a prior MRI scan was not established. Consequently, Complainant did not prove that the reference to an MRI scan was erroneous.

76(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure. (See Factual Finding 38(a).)

77. On April 4, 2011, C.P. complained of severe neck pain, headache, and bilateral upper back and neck pain at a pain level of 8 to 10 on a scale of 0-10. Although the last injection had brought “50-60%” relief for six weeks, his pain medications were “recently not helping.” (Exhibit C, p. 16.) Respondent noted no side effects to the medications and “no signs of addiction.” (Id.) Respondent’s plan included bilateral cervical facet injections.

78(a). On April 4, 2011, Respondent performed bilateral cervical facet injections on C.P. at the C3-C4, C4-C5 and C5-C6 levels. Prior to the procedure, C.P.’s caregiver signed
the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) C.P. also indicated for the pain diagram that he was currently experiencing pain at a level of 10 on a scale of 0-10.

78(b). Respondent’s dictated operative report for the April 4, 2011 procedure indicated preoperative diagnoses identical to those in the February 1, 2011 operative report.

78(c). The operative report also indicated under “Name of Procedure” that “[IM] sedation and [MAC]” were used. (Exhibit C, p. 27.) Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id.) The separate anesthesia record indicated that Demerol 75 mg IM was administered, and the patient’s heart rate, pulse, blood pressure and oxygen saturation were monitored during the procedure. The MAC began at 11:33 a.m. and ended at 11:38 a.m. The operation began at 11:35 a.m. and ended at 11:37 a.m.

78(d)(1). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Diagnostic MRI scan with clinical signs and symptoms consistent with cervical facet syndrome.
2. Neck pain and upper back pain with stiffness.
3. Pain level is “9” on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.
5. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

78(d)(2). Since C.P.’s records prior to December 1, 2010 were not in evidence, the existence or lack of a prior MRI scan was not established. Consequently, Complainant did not prove that the reference to an MRI scan was erroneous.

78(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure. (See Factual Finding 38(a).)

79. On June 6, 2011, C.P. complained of tracheostomy site pain, headaches and muscle spasm and stiffness in his neck and upper back at a pain level of 8 to 10 on a scale of 0-10. Pain medications were helping reduce pain, but the pain was still severe, and C.P. was unable to sleep. He obtained “50%” relief for six weeks from his last injection. (Exhibit C, p. 30.) Respondent noted no side effects to the medications and “no signs of addiction.” (Id.) Respondent’s plan included bilateral cervical facet injections.
80. Respondent considered RFA for C.P., but the patient was afraid to "burn" the nerves that were left intact following his accident.

81(a). On June 6, 2011, Respondent performed bilateral cervical facet injections on C.P. at the C3-C4, C4-C5 and C5-C6 levels. Prior to the procedure, C.P.'s caregiver signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32) C.P. also indicated for the pain diagram that he was currently experiencing pain at a level of 7 and 10 on a scale of 0-10.

81(b). Respondent's dictated operative report for the June 6, 2011 procedure indicated preoperative diagnoses which included cervical spondylosis without myelopathy, degenerative cervical spine/disc/facet disease, bilateral cervical facet syndrome, and cervicogenic neck pain and headache.

81(c). The operative report also indicated under "Name of Procedure" that [MAC] was used. (Exhibit C, p. 41.) Additionally, in the narrative section, the report stated, "Due to this patient's anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary." (Id.) However, the separate anesthesia record had a handwritten "X" across the entire page, and a handwritten note, "no IV sedation or MAC." (Id. at p. 39.)

81(d)(1). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Diagnostic MRI scan with clinical signs and symptoms consistent with cervical facet syndrome.
2. Neck pain and upper back pain with stiffness.
3. Pain level is "9-10" on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.

5. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

81(d)(2). Since C.P.'s records prior to December 1, 2010 were not in evidence, the existence or lack of a prior MRI scan was not established. Consequently, Complainant did not prove that the reference to an MRI scan was erroneous.

81(e). The operative report contained documentation of the patient's informed consent and a detailed description of the procedure. (See Factual Finding 38(a).)
82. On August 14, 2011, C.P. complained of severe neck pain, headache, tracheostomy site pain, and upper back and neck pain at a level of 10 on a scale of 0-10. He reported “6+ weeks relief.” (Exhibit C, p. 44.) Respondent noted no side effects to the medications, and his plan included bilateral cervical facet injections.

83(a). On August 14, 2011, Respondent performed bilateral cervical facet injections on C.P. at the C3-C4, C4-C5 and C5-C6 levels. Prior to the procedure, C.P.’s caregiver signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) C.P. also indicated for the pain diagram that he was currently experiencing pain at a level of 10 on a scale of 0-10.

83(b). Respondent’s dictated operative report for the August 1, 2011 procedure indicated preoperative diagnoses identical to those in the June 2011 operative report.

83(c). The operative report also indicated under “Name of Procedure” that “[IM] sedation and [MAC]” were used. (Exhibit C, p. 55.) Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id.) The separate anesthesia record indicated that Demerol 75 mg IM was administered, and the patient’s pulse, blood pressure and oxygen saturation were monitored during the procedure. The MAC began at 11:05 a.m. and ended at 11:11 a.m. The operation began at 11:07 a.m. and ended at 11:09 a.m.

83(d). Under a section entitled Indications and Medical Necessity, the list was identical to that contained in the June 2011 operative report.

83(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure. (See Factual Finding 38(a).)

84. On October 3, 2011, C.P. complained of severe neck pain, headache, bilateral upper back pain and neck pain, stiffness and spasm. He also reported being unable to sleep. He described his pain at a level of 4 to 9 on a scale of 0-10. Although pain medications were helpful, the pain was still unbearable. His last injection brought “50-60%” relief for six weeks. (Exhibit C, p. 57.) Respondent noted “no signs of addiction.” (Id.) Respondent’s plan included bilateral cervical facet injections.

85(a). On October 3, 2011, Respondent performed bilateral cervical facet injections on C.P. at the C3-C4, C4-C5 and C5-C6 levels. Prior to the procedure, C.P.’s caregiver signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) C.P. also indicated for the pain diagram that he was currently experiencing pain at a level of 4 - 9 on a scale of 0-10.
85(b). Respondent’s dictated operative report for the October 3, 2011 procedure indicated preoperative diagnoses identical to those in the June and August 2011 operative reports.

85(c). The operative report also indicated under “Name of Procedure” that “[IM] sedation and [MAC]” were used. (Exhibit C, p. 68.) Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id.) However, the separate anesthesia record had a handwritten “X” across the entire page, and a handwritten note, “no sedation or MAC.” (Id. at p. 66.)

85(d). Under a section entitled Indications and Medical Necessity, the list was identical to that contained in the April 2011 operative report.

85(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure. (See Factual Finding 38(a).)

86. The FAC, paragraph 12, contains numerous allegations alleging a lack of records, such as “no initial intake history, physical, or initial consultation in the medical records,” “no valid opiate agreement,” and “no pain management agreement for the use of controlled substances.” These allegations were not established since the records from C.P.’s initial date of treatment were not contained in the records submitted as evidence at the hearing.

87. The Accusation contained numerous additional allegations which purported to be “facts,” but apparently were opinions of Complainant’s expert. Any alleged facts regarding C.P. not addressed in this Decision were not established by clear and convincing evidence.

Facts Re: Patient A.K.

88. On June 15, 2010, Respondent began treating Patient A.K., a 44-year-old female, who came to him after prior pain management treatment. According to the patient information document filled out on A.K.’s first visit, she had pain in her left arm and shoulder due to an injury from an automobile accident. The pain was listed as 10 on a scale of 0-10. Her prior treatment consisted of physical therapy, with poor results, and use of oxycodone, Vicodin and Tylenol. On the date of her first visit to Respondent’s office, A.K. signed a Consent for Chronic Opioid Therapy and a Pain Management Agreement (see Factual Findings 23 and 25). As was his custom and practice, PA Salcido reviewed the entire new patient packet with A.K., including the patient history form, Consent for Chronic Opioid Therapy, and Pain Management Agreement, and discussed the risks, benefits and alternatives of opioid therapy.
89(a). At the June 15, 2010 visit, Respondent was supervising PA Salcido, and Respondent saw A.K. and signed the progress note on the same day. A.K. complained of left arm and shoulder pain from a motor vehicle accident eight months prior. The pain was constant and ran from her left shoulder to her left hand with numbness, tingling and weakness. She was unable to rotate her arm. A.K.'s pain level was "10/10" without medications, and "2/10" with medications, which allowed her to function.

89(b). PA Salcido examined A.K. and documented the examination in the progress note. The examination involved checking the patient’s major body systems, including: a general examination/overview of the patient (patient displayed no acute distress); examination of her head, eyes, ears, nose and throat; a chest examination (chest clear to auscultation bilaterally); cardiac examination (demonstrating regular rate and rhythm); abdominal examination; and examination of the extremities. The examination of A.K.'s left upper extremity revealed that her left arm was positive for tenderness and pain over her biceps tendon, with decreased range of motion and pain with supination/rotation (i.e. twisting forearm left and right). The assessment was left arm pain, sprain/strain, secondary to motor vehicle accident. The plan was to refer A.K. to undergo a left arm CT scan without contrast to check for fractures, to issue a prescription of Roxicodone (two times per day for pain) and Flexeril (for muscle spasm), and to recommend that she continue her home exercise program. A.K. was counseled regarding the use of medications. Counseling included: discussions of the risks, benefits and side effects of the medications; discussion of the risks of opiate dependency; discussion of the risk of medication interaction; instruction not to exceed the prescribed dosage, particularly of the opiate; and listing any reactions to medications, including dizziness and upset stomach.

89(c). Respondent signed the referral for the CT scan.

90. On June 17, 2010, A.K. underwent a CT scan of her left arm and forearm. It showed no fractures. In the report of the CT scan, the documented indication for the CT scan was: "[Motor vehicle accident] about eight months ago. Ever since then the patient has been having pain in the left shoulder and neck that radiates to the left arm and elbow. . . . The patient also complains of left elbow pain down to the forearm." (Exhibit B, p. 17.)

91(a). On June 29, 2010, A.K. visited Respondent's office and saw PA Jones. Respondent was supervising PA Jones on this day, and he signed the progress note on the same day. A.K. complained of continued pain in her left arm and new pain in her right arm, with the left arm pain greater than the right. She also had headaches and dizziness, without nausea, vomiting or blurry vision. A.K. also complained of cervical pain radiating to her left arm with numbness and tingling in four digits of her hand. Examination revealed weakness and a decrease in her grasp reflex. However, A.K. also reported an increase in ADL’s when
taking the prescribed medications. The progress note documented negative findings for addiction or diversion as "addiction, diversion." ( Exhibit B, p. 18.) The assessment was intractable cervical pain and cervical DDD. The plan was to review the CT scan of the patient’s left arm, to refer her to undergo a CT scan, without contrast, of her cervical spine, and to continue her pain medications on which she was counseled.

91(b). Respondent signed the referral for the CT scan.

92. On July 13, 2010, a CT scan of A.K.’s cervical spine was conducted. The findings included:

C5-C6: There is a 1-2 mm annular bulge. There is mild bilateral facet hypertrophy. There is no spinal canal stenosis centrally. The neural foramina are patent bilaterally.

C6-C7: There is a 2 mm left disc protrusion. There is mild bilateral facet hypertrophy. There is mild left neural foraminal narrowing. The right neural foramen is patent. There is no spinal canal stenosis centrally. [§] . . . [§]

IMPRESSION:  . . . 2. There are mild multilevel degenerative disc changes and uncovertebral degenerative changes. There is mild neural foraminal narrowing at C3-C4, but no evidence of obvious significant stenosis. Otherwise, the remaining levels demonstrate no obvious stenosis or impingement. Of note, is C6-C7, where there is a 2 mm left protrusion. Although there is no obvious bony or soft tissue evidence of impingement, MRI or CT with contrast may be more specific.

(Exhibit B, p. 20.)

93(a). On July 15, 2010, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of chronic left arm and neck pain which she described as a sharp pain radiating from her neck into her left arm with numbness and tingling. She also complained of some low back pain radiating to both hips, but no leg pain. However, she also reported positive relief from the medications (pain level “7/10” with medications, and “10/10” without medications). As was his custom and practice, PA Salcido confirmed by inquiry that A.K. had no complaints of adverse reaction to medications such as no upset stomach, constipation or rash. In the progress note, he documented that she had no adverse reaction. As was also his custom and practice, PA Salcido checked the patient for signs of addiction or diversion. He looked at the patient’s general appearance and evidence of slurred speech or excessively dilated or pinpoint pupils. At this visit, the patient was not asking for early refills of her medications or specific medications by name, and her pill count indicated that she was
appropriately taking her prescribed medications. If the pill count had been deficient, he would have documented that in detail and changed the treatment plan. However, given that the patient demonstrated no evidence of addiction or diversion, PA Salcido summarized his negative findings in the progress note as “Ø div Ø addict.” (Exhibit B, p. 21.)

93(b). Examination revealed paraspinal muscle spasm and tenderness at the C5-C6 and C3-C4 levels and bilateral cervical facet tenderness and decreased range of motion. The patient’s lumbar spine also demonstrated facet tenderness and pain with extension. PA Salcido noted that the patient’s brachioradialis had been sensitive to light touch. A.K.’s diagnoses included cervical radiculopathy/cervical facet syndrome and intractable back pain. PA Salcido’s recommended plan was to increase A.K.’s Roxicodone prescription (from two times per day to every four hours) and to have her undergo a left cervical TFESI.

93(c). Respondent saw A.K. on this visit because PA Salcido had recommended a procedure and the increase in quantity of Roxicodone. Respondent approved the plan.

94. Respondent’s analysis in approving the left cervical TFESI at the C5-C6 level included: A.K. had no fractures, and the pain was constant, radiating from her left shoulder/neck to her left hand. This indicated some type of nerve irritation at the C5-C6 and C6-C7 levels, with it more likely at the C5-C6 level since the shoulder, biceps and forearm were involved. In identifying the nerve root causing the symptomology, Respondent noted the biceps tendon tenderness and decrease of range of motion and pain on supination/pronation (twisting forearm left and right) of the left arm, all of which involve C5-C6. Therefore, from examination, it appeared that the patient had nerve irritation from the C5-C6 and C6-C7 level, predominately C5-C6. Respondent noted that it is not necessary to have immediate muscle atrophy in order to indicate nerve root irritation, but that such atrophy may arise about 18 months later if the patient is unable to move her arm. He also noted that radiculopathy results from nerve inflammation which can be caused by chemicals from a bulging disc or physical compression of the bulging disc. In A.K.’s case, it appeared that chemical radiculopathy was causing her pain. Based on the results of the CT scan of her cervical spine, combined with her complaints of ongoing pain and symptoms predominately into her left arm with weakness, numbness and tingling. Respondent determined that her pain originated primarily from the C5-C6 level. Respondent also noted that the injection into the C5-C6 level would spread somewhat to the surrounding area and would descend through gravity into the C6-C7 space.

95(a). On July 26, 2010, Respondent performed a left cervical TFESI on A.K. at the C5-C6 level. Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day at 7:00 a.m., indicating that she was currently experiencing pain in her upper back; neck, left greater than right, and at a level of 10 on a scale of 0-10.

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95(b). Respondent’s dictated operative report for the July 26, 2010 procedure indicated preoperative diagnoses which included cervical radiculopathy/neuralgia/neuritis, degenerative cervical spine/disc/facet disease, cervical spondylosis/stenosis, and severe neck and left arm pain.

95(c). The operative report also indicated under “Name of Procedure” that IV sedation and MAC was used, with blood pressure, electrocardiogram, and oxygen saturation monitoring. Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Exhibit B, p. 35.) The remaining records (the anesthesia record is absent) do not indicate whether IV anesthesia was given. However, the records indicated that Demerol 50 mg was administered IM at 9:06 a.m., and MAC consisted of monitoring the patient’s blood pressure, pulse, oxygen saturation, and respirations while she was prone. The patient was discharged at 9:25 a.m.

95(d). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Pain level is “9-10” on a 0-10 scale.
2. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

95(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 34.)

96. On August 18, 2010, Dr. Kumar performed bilateral cervical facet injections/medial branch blocks on A.K.

97. On September 27, 2010, A.K. visited Respondent’s office and saw PA Jones. Respondent was supervising PA Jones on this day, and he signed the progress note on the same day. A.K. complained of cervical pain, on the left side greater than the right, radiating to her left arm with weakness, but no numbness or tingling. However, A.K. also reported an increase in ADL’s when taking the prescribed medications, and more than 60 percent improvement following the cervical facet injections on August 18, 2010. A.K. reported positive relief from the medications (pain level “4/10” with medications, and “10/10” without medications) and no adverse reactions. The progress note documented negative findings for addiction or diversion as “- addiction diversion.” (Exhibit B, p. 53.) Following physical examination, the assessment was cervical radiculopathy, cervical facet syndrome, and cervical DDD. The plan was to schedule a left cervical TFESI and to continue with her prescribed medications (adding morphine sulfate and Soma) on which she was counseled.
On September 29, 2010, Dr. Kumar performed a left cervical TFESI on A.K. at the C5-C6 level using a particulate steroid.

(b). On October 21, 2010, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of chronic neck pain, with positive relief from cervical TFESI’s. She also complained of sharp low back pain, radiating to both hips, with spasm, weakness and stiffness. She denied any leg pain. A.K. also reported positive relief from the medications (pain level “5/10” with medications, and “8/10” without medications). PA Salcido confirmed by inquiry that A.K. had no complaints of adverse reaction to medications, and documented that she had no adverse reaction. PA Salcido checked the patient for signs of addiction or diversion, and documented his negative findings in the progress note as “O div O addict.” (Exhibit B, p. 70.)

(b). Physical examination revealed spasm and tenderness at C5-C6, bilateral cervical facet tenderness, with pain on extension /flexion and decreased range of motion. Examination of A.K.’s lumbar spine revealed spasm and tenderness to palpation, bilateral facet tenderness, with pain on extension /flexion and decreased range of motion. The assessment included lumbar/intractable low back pain and cervical facet syndrome. The plan was to refer A.K. for a lumbar CT scan without contrast and to refill her medications.

(c). Respondent approved of the plan. He opted for a CT scan instead of an MRI because it was the fastest of the two methods to obtain diagnostic screening on a patient with severe pain (MediCal prior approval for an MRI can take months), and the two methods did not differ much from a diagnostic standpoint.

A CT of A.K.’s lumbar spine was performed on November 3, 2010. At the L4-L5 level the following was noted: “There is mild disk height loss. There is a 3-mm diffuse disc bulging with a prominent left lateral component resulting in moderate left neural foramen narrowing. . . . There is mild bilateral facet hypertrophy.” (Exhibit B, p. 72.) From the examination and the CT scan, Respondent understood that A.K. had a bulging disc with DDD and bilateral facet hypertrophy (i.e. arthritis of the back joints).

On November 4, 2010, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of sharp low back pain, radiating into both hips, with stiffness and numbness. She denied any leg pain. Findings on examination were the same as on October 21, 2010. PA Salcido reviewed the CT scan with the patient. The assessment was lumbar facet syndrome/lumbar DDD. The plan was to have the patient receive bilateral lumbar facet injections and to increase her morphine sulfate prescription to three tablets per day. The patient was counseled on her medications, particularly since her morphine prescription was being increased. Respondent approved of the plan.
102(a)(1). On the same day, November 4, 2010, Respondent performed bilateral lumbar facet injections.

102(a)(2). The evidence did not establish on which level(s) Respondent performed the November 4, 2010 injections. The patient’s consent document, Respondent’s November 4, 2010 handwritten progress note, and the Physician Orders form indicated that the procedure to be performed was “Bilateral lumbar facet injections,” with no specified level(s). (Exhibit B, pp. 74, 75 and 83.) Respondent’s handwritten description of the procedure in his Surgeon’s Pre-Op Notes, and the handwritten description in the anesthesia record indicated that the injections were at the L4-L5 level. However, Respondent’s dictated operative report for the November 4, 2010 procedure indicated that he had performed bilateral lumbar facet injections at the “L3-L4, L4-L5, L5-L6” levels. (Id. at pp. 88-89.) Given the discrepancy in the November 4, 2010 pre-operative and operative documentation, the records are unclear which levels were injected. Based on (1) the minor errors found in other operative reports (see Factual Findings 54(d)(2), 105(e)(1), and 109(c)), (2) the documentation from prior dates indicating A.K.’s pathology at the L4-L5 level, and (3) the handwritten notes on November 4, 2010 specifying the L4-L5 level, the combined documentation indicates that the bilateral lumbar facet injections may have been performed only at the L4-L5 level. Consequently, the operative report documentation of injection at the “L3-L4, L4-L5, L5-L6” levels calls into question the accuracy of the template-produced operative report. 14

102(b). Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day at 7:00 a.m., indicating that she was currently experiencing pain in her lower back at a level of 9 on a scale of 0-10.

102(c). Respondent’s dictated operative report for the November 4, 2010 procedure indicated preoperative diagnoses which included lumbar spondylosis without myelopathy, lumbar spinal stenosis, bilateral lumbar facet syndrome, and degenerative lumbosacral spine/disc/facet disease.

102(d). The operative report also indicated under “Name of Procedure” that IV sedation and MAC was used, with blood pressure, electrocardiogram, and oxygen saturation monitoring. Additionally, in the narrative section, the report stated, “Due to this patient’s

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14 This possible inaccuracy was not specifically alleged in the accusation nor discussed in testimony, and it does not form a basis for discipline. However, this discrepancy in the pre-operative and operative records is noted in this Decision because it underscores the concern raised over other minor (and otherwise innocuous) inaccuracies in Respondent’s template-produced operative reports which are alleged as bases for discipline due to failure to maintain accurate records.
anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Id. at p. 88.) The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 8:10 a.m., and the procedure began at 8:11 a.m. The procedure was finished at 8:13 a.m., and the anesthesia was discontinued at 8:15 a.m. The records also indicated that Demerol 50 mg was administered IM for pain at 8:20 a.m., after the patient had been transferred to recovery.

102(e). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Clinical signs and symptoms consistent with lumbar facet syndrome.
2. Pain distribution in low back, buttocks, and groin.
3. Pain level is “9” on a 0-10 scale.
4. Lumbar facet tenderness.
5. Paraspinal muscle spasms in lumbar spine.
6. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.
7. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

102(f). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 38(a).)

103. On December 16, 2010, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of sharp low back pain, radiating into both hips. She reported relief with the lumbar facet injection, as well as an increase in ADL’s. However the pain slowly returned, radiating to both lower extremities with spasm, numbness and tingling. Examination revealed lumbar muscle spasm, tenderness and limited range of motion. There was a positive on the straight leg raise test bilaterally. The assessment after examination was lumbar radiculopathy / DDD. The plan was to have the patient receive a left lumbar TFESI at the L4-L5 level and to continue her medications on which she was counseled. Respondent approved of the plan.

104. On February 17, 2011, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of sharp low back pain, radiating into both hips with spasm, weakness, numbness and tingling into both legs, with the left greater than the right. She reported increased ADL’s with medications and procedures (pain level “6/10” with
medications, and “9/10” without medications) and no adverse reactions. The progress note documented no addiction or diversion. The findings on examination were similar to those in December 2010, including the positive on the straight leg raise test bilaterally indicating nerve root impingement going into the lower extremities. The assessment after examination was lumbar radiculopathy / DDD. The plan was to have the patient receive a left lumbar TFESI at the L4-L5 level and to continue her medications on which she was counseled. Respondent saw the patient and approved of the plan.

105(a). On February 24, 2011, Respondent performed left lumbar TFESI’s on A.K. at the L4-L5 and L5-S1 levels.

105(b). Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day, indicating that she was currently experiencing pain in her lower back and left leg at a level of 10 on a scale of 0-10.

105(c). Respondent’s dictated operative report for the November 4, 2010 procedure indicated preoperative diagnoses which included left lumbar radiculopathy/lumbar sacral neuritis, lumbar spinal stenosis/spondylosis, bilateral lumbar facet syndrome, and severe low back and left leg pain.

105(d). The operative report also indicated under “Name of Procedure” that IV sedation and MAC was used, with blood pressure, electrocardiogram, and oxygen saturation monitoring. Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Exhibit B, p. 88.) The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 9:05 a.m., and the procedure began at 9:07 a.m. The procedure was finished at 9:09 a.m., and the anesthesia was discontinued at 9:15 a.m.

105(e)(1). Under a section entitled Indications and Medical Necessity, the following was listed:

1. MRI evidence of left lumbar radiculopathy and [DDD].
2. Clinical signs and symptoms consistent with left lumbar radiculopathy.
3. Pain level is “9” on a 0-10 scale.
4. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.
5. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

105(e)(2). The statement “MRI evidence” was an error, and “MRI” should have read “CT scan.”

105(f). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 34.)

106. On April 7, 2011, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of chronic neck and low back pain secondary to degenerative changes. She described the low back pain as sharp, with spasm, weakness, and tingling, on the left greater than the right. She denied leg pain. A.K. reported pain levels of “6/10” with medications, and “8/10” without medications, with no adverse reactions. The progress note documented no addiction or diversion. The findings on examination were lumbar L3-L5 pain, spasm and tenderness, lumbar facet tenderness with decreased range of motion and pain on flexion and extension. The assessment after examination was lumbar facet syndrome / DDD. The plan was to have the patient receive bilateral lumbar facet injections and to continue with medications and physical therapy. Respondent saw the patient and approved of the plan.

107(a). On April 25, 2011, Respondent performed bilateral lumbar facet injections at the L3-4, L4-L5, and L5-S1 levels.

107(b). Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day, indicating that she was currently experiencing pain in her lower back at a level of 10 on a scale of 0-10.

107(c). Respondent’s dictated operative report for the April 25, 2011 procedure indicated preoperative diagnoses which included lumbar spondylosis without myelopathy, lumbar spinal stenosis, bilateral lumbar facet syndrome, and degenerative lumbosacral spine/disc/facet disease.

107(d). The operative report also indicated under “Name of Procedure” that IV sedation and MAC was used, with blood pressure, electrocardiogram, and oxygen saturation monitoring. Additionally, in the narrative section, the report stated, “Due to this patient’s anxiety, pre-existing, painful condition and the requirement for safety, comfort and optimal procedural conditions, [MAC] was medically necessary.” (Exhibit B, p. 115.) The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of
monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 8:43 a.m., and the procedure began at 8:45 a.m. The procedure was finished at 8:47 a.m., and the anesthesia was discontinued at 8:50 a.m.

107(e). Under a section entitled Indications and Medical Necessity, the following was listed:

1. Clinical signs and symptoms consistent with lumbar facet syndrome.
2. Pain distribution in low back, buttocks, and groin.
3. Pain level is “9-10” on a 0-10 scale.
4. Lumbar facet tenderness.
5. Paraspinal muscle spasms in lumbar spine.
6. Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.
7. Failed physical therapy, conservative therapies and other modalities for pain control.

(Id.)

107(f). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 38(a).)

108. On May 26, 2011, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of chronic low back and neck pain secondary to degenerative changes. She described her low back pain as radiating to her bilateral lower extremities, with associated spasm, numbness and tingling, greater on the left than the right. A.K. stated that she had previously obtained up to 65 percent relief with the lumbar TFESI’s. She reported pain levels of “5/10” with medications, and “7/10” without medications and no adverse reactions. The progress note documented no addiction or diversion. The findings on examination included lumbar L3-L5 paraspinal muscle spasm and tenderness, with decreased range of motion and pain on flexion/extension, and a positive on the straight leg raise test bilaterally. The assessment after examination was lumbar spondylosis, lumbar radiculopathy and lumbar DDD. The plan was to have the patient receive a left lumbar TFESI at the L4-L5 level and to continue her medications on which she was counseled. Respondent saw the patient and approved of the plan.

109(a). On June 28, 2011, Respondent performed left lumbar TFESI’s on A.K. at the L4-L5 and L5-S1 levels.

109(b). Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram
that day, indicating that she was currently experiencing pain in her left leg at a level of 9 on a scale of 0-10.

109(c). Respondent’s dictated operative report for the June 28, 2011 procedure was virtually identical to the operative report for the November 4, 2010 operative report (see Factual Finding 102). This included the language under the section entitled “Indications and Medical Necessity,” which noted “1. MRI evidence of left lumbar radiculopathy and [DDD].” (Exhibit B, p. 128.) This statement regarding “MRI evidence” was an error, and “MRI” should have read “CT scan.”

109(d). The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 8:10 a.m., and the procedure began at 8:11 a.m. The procedure was finished at 8:16 a.m., and the anesthesia was discontinued at 8:17 a.m.

109(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 34.)

110. On July 7, 2011, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day, and he signed the progress note on the same day. A.K. complained of chronic low back pain secondary to degenerative changes. The pain radiated to both hips with spasm, weakness and stiffness, left greater than right. A.K. She reported pain relief of 75 to 85 percent with the lumber TFESI on June 28, 2011. She also reported pain levels of “3/10” with medications, and “5/10” without medications and no adverse reactions. The progress note documented no addiction or diversion. The findings on examination included lumbar L3-L5 pain, spasm and tenderness, and bilateral lumbar facet tenderness with decreased range of motion and pain on flexion/extension. The assessment after examination was lumbar spondylosis without myelopathy, lumbar facet syndrome and lumbar DDD. The plan was to have the patient receive bilateral lumbar facet injections and to continue her medications on which she was counseled. Respondent saw the patient and approved of the plan.

111(a). On August 31, 2011, Respondent performed bilateral lumbar facet injections at the L3-4, L4-L5, and L5-S1 levels.

111(b). Prior to the procedure, A.K. signed the informed consent document contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day, indicating that she was currently experiencing pain in her lower back at a level of 8-10 on a scale of 0-10.
111(c). Respondent’s dictated operative report for the August 31, 2011 procedure was virtually identical to the operative report for the April 25, 2011 operative report (see Factual Finding 107), except that the August 31, 2011 operative report omitted the preoperative diagnosis of lumbar spinal stenosis and it indicated that the patient’s pain level was “‘9’ on a 0-10 scale,” instead of a “‘9-10’ on a 0-10 scale.” (Exhibit B, p. 141.)

111(d). The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 8:45 a.m., and the procedure began at 8:46 a.m. The procedure was finished at 8:50 a.m., and the anesthesia was discontinued at 8:55 a.m.

111(e). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 38(a).)

112. On September 22, 2011, A.K. visited Respondent’s office and saw Respondent personally, with no PA. She reported that her low back pain was 75 percent better with the last injections. However, she complained of neck pain, headache, bilateral upper back pain, and bilateral arm pain, with numbness and tingling in her right arm. Respondent noted that she had no side effects from her medications. Examination revealed C3-C6 paraspinal muscle spasms and facet tenderness with decreased range of motion in the cervical spine. Respondent also noted right arm weakness. He also noted that the deep tendon reflex of the brachioradialis was diminished. Respondent understood that reflexes may take a year to 18 months to diminish in reaction to a bulging disc, and he believed that the examination findings were consistent with a problem at the C5-C6 level. His plan was to perform a right cervical TFESI. Respondent signed his progress note.

113. Respondent noted that A.K. had suffered no significant cervical symptoms for almost one year after obtaining relief from the prior injections (i.e. cervical TFESI by Respondent in July; cervical facet injection by Dr. Kumar in August; and cervical TFESI by Dr. Kumar in September of 2010). This was consistent with his understanding that a patient initially receiving cervical TFESIs may need two to three interventions to remove the inflammation from the inflamed nerves. After the first series of injections, consistent with ASIPP guidelines, it was Respondent’s practice not to repeat the procedure for at least two months, and he strove for a break of at least four months until the next injection. He believed that the lengthy period of relief for A.K. was a good result since the TFESI’s do not permanently eradicate pain, but provide relief from pain and spasm to allow the patient to function normally (i.e. increase ADL’s and be able to sleep).

114(a). On October 31, 2011, Respondent performed a right cervical TFESI on A.K. at the C5-C6 level. Prior to the procedure, A.K. signed the informed consent document
contained in the pre-procedure packet. (See Factual Finding 32.) She also filled out the pain diagram that day, indicating that she was currently experiencing pain in her upper back, neck, and right arm at a level of 10 on a scale of 0-10.

114(b). Respondent’s dictated operative report for the October 31, 2011 procedure was virtually identical to the operative report for the July 26, 2010 operative report (see Factual Finding 95), except that the October 31, 2011 report added a diagnosis of bilateral cervical facet syndrome and indicated right arm pain instead of left. The October 31, 2011 operative report also added a statement that “Patient had 50-60% pain relief from prior similar injections with good functional improvement for more than 6 weeks.” (Id. at p. 153.)

114(c). The anesthesia record indicates that IV anesthesia (Propofol) was administered, and MAC consisted of monitoring the patient’s heart rate, blood pressure, pulse, oxygen saturation, and respirations while she was prone. The anesthesia began at 9:10 a.m., and the procedure began at 9:11 a.m. The procedure was finished at 9:16 a.m., and the anesthesia was discontinued at 9:16 a.m.

114(d). The operative report contained documentation of the patient’s informed consent and a detailed description of the procedure under fluoroscopy. (See Factual Finding 34.)

115. On November 11, 2011, A.K. visited Respondent’s office and saw PA Salcido. Respondent was supervising PA Salcido on this day. The patient reported 75 percent relief from the cervical TFESI on October 31, 2011. However, she complained of low back pain radiating to both hips with associated spasm, weakness and stiffness, greater on the left side than the right. Her pain level was “8/10” with medications. Examination revealed L3-L5 paraspinal muscle spasm and tenderness and bilateral lumbar facet tenderness with pain on flexion/extension and decreased range of motion. The assessment was lumbar spondylosis without myelopathy, lumbar DDD, and lumbar facet syndrome. The plan was to recommend lumbar facet injections and to continue with medications. Because PA Salcido was recommending a procedure, Respondent was brought into the examination room. Respondent saw the patient and approved the plan. However, he failed to sign the progress note for November 17, 2011.

116. Any alleged facts regarding A.K. not addressed in this Decision were not established by clear and convincing evidence.

The Experts – Standard of Care\textsuperscript{15}

\textsuperscript{15} Pain management is an evolving field. The standard of care at issue in this case pertains only to the standard of care in 2010-2011 for pain management physicians treating patients who were not known addicts.
117. Complainant offered the testimony of Michael Verdolin, M.D., to establish the standard of care for treating the three patients in this case. Dr. Verdolin received his medical degree from University of Miami School of Medicine in 1996. He completed an anesthesiology residency in 2000 at the National Naval Medical Center and Walter Reed Army Medical Center (Walter Reed) in Washington, D.C. Dr. Verdolin is certified by the American Board of Anesthesiology (2001 through present), with a subspecialty certification in Pain Management (2004 through present). He completed a fellowship in Interventional Pain Management at Walter Reed in 2004. He has been a Clinical Instructor of Anesthesiology at the National Naval Medical Center (2001-2003) and an Assistant Professor of Anesthesiology, at the Uniformed University of Health Sciences in Bethesda, Maryland (2006-2012). He was the founder and President of Pain Control Associates of San Diego (2007-2014), San Diego Pain and Cardiac Study Group, LLC (2010-2014), and Verdolin Pain Specialists, Inc. (2011-2014). He is currently the President of Pain Consultants of San Diego and Verdolin Medico-legal Consulting, Inc. Dr. Verdolin is licensed to practice medicine in California and has been a medical expert reviewer for the Board since 2007.

118. Respondent offered the testimony of Standiford Helm, II, M.D., M.B.A., to establish the standard of care for the treatment of all three patients. After graduating, magna cum laude, from Harvard College, Dr. Helm obtained his medical degree from Tufts University in 1977. He completed an anesthesiology residency the University of California, Los Angeles (UCLA) in 1980. Dr. Helm is certified by the American Board of Anesthesiology (1982 through present), with a subspecialty certification in Pain Medicine. He is licensed to practice medicine in California and is the Medical Director of The Helm Center for Pain Management in Laguna Hills, California. Dr. Helm is a former President, Executive Vice President, Treasurer and Board of Directors member of ASIPP, and he is the founding President of the California Society of Interventional Pain Physicians, a position he held for six years. He sits on the editorial boards of several medical journals, including the Pain Physician Journal which is published by ASIPP. He has given numerous lectures and published extensively on the topic of pain management. Complainant's expert witness, Dr. Verdolin, knows and admires Dr. Helm and acknowledged that Dr. Helm is a well-respected figure in the field of pain management. Dr. Verdolin also noted that the Pain Physician Journal is a "tier one" journal and that Dr. Helm's position on the editorial board is a prestigious position to hold.

119. Respondent also offered the testimony of Bhupinder S. Saini, M.D., to establish the standard of care for the treatment of all three patients. Dr. Saini graduated from the Government Medical College in Patiala, India, and completed an internship there. He then moved to the United States and completed a one year rotating residency at Ravenswood Hospital in Chicago, Illinois and an anesthesia residency at Youngstown Hospital Association in Ohio (1982-1984). He then joined the Medical College of Wisconsin as an Assistant Professor of Anesthesiology and practiced general anesthesia until the early 1990's when pain management became a new field. He traveled around the world to learn
cutting edge procedures and returned to Wisconsin to educate other physicians in interventional pain management. Dr. Saini is a member of ASIPP and SIS. Dr. Saini is licensed to practice medicine in Wisconsin, and he is the founder and Chairman of Advanced Pain Management, which operates fifty pain clinics in Wisconsin. He served on the Wisconsin State Medical Examining and Licensing Board for many terms (1999-2010). Dr. Saini has given numerous presentations and taught courses on interventional pain management and treatment with narcotic medications.

120. Dr. Saini met Respondent at an RFA conference in California when Respondent was practicing pain management on a part-time basis. Thereafter, Respondent visited Dr. Saini’s practice to learn how to operate a pain management clinic and to observe him performing interventional pain management procedures.

121. Dr. Saini credibly maintained that the standard of care for pain management is generally national in scope, with no major variations by region. He noted that, in general, the standard of care is considered to be what the average community physician practicing in a particular field would do. Consequently, the standard of care could be national or it could be different from region to region. However, Dr. Saini also noted that while some of the “fine points” between regions may differ, the “basic premise” for interventional pain management is the same in that all regions strive to ensure the same thing: safe practice and appropriate prescribing while avoiding diversion and addiction. Dr. Saini is very familiar with the national standard of care as it applies to interventional procedures and the prescribing of pain medications. Dr. Saini agreed that the standard of care for administration of TFESI’s and facet injections are the same in Wisconsin and Valencia, California. Dr. Saini is also familiar with the standard of care in Los Angeles through communication with friends and colleagues, and he noted that it is similar to what is occurring in other regions.

122. Drs. Verdone, Helm, and Saini were equally qualified to testify as experts on the standard of care for the patients receiving interventional pain management care from Respondent. Any additional weight given to one expert’s testimony over the other’s was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

Standard of Care – Use of Medical Board Guidelines

123(a). At the administrative hearing, the parties disagreed about the use of the Board’s published “Guidelines for Prescribing Controlled Substances for Pain” (Guidelines) in determining the standard of care. The Guidelines, adopted in 1994 and revised in 2007, remained effective in 2010-2011. The Guidelines specify that they are a policy statement

16 The Guidelines have been updated, effective 2014. The 2014 update is not applicable to the 2010-2011 treatment in this case.
"intended to improve effective pain management in California, by avoiding under treatment, over treatment, or other inappropriate treatment of a patient’s pain and by clarifying the principles of professional practice that are endorsed by the Medical Board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain.” (Exhibit J, p. 1.) The Guidelines state, “California physicians and surgeons are encouraged to consult this policy statement and the guidelines below.” (Id.)

123(b). Dr. Saini noted that, if a state “makes a certain ruling” such as medical board guidelines, this becomes part of the standard of care for that state. Dr. Helm agreed, noting that physicians should practice consistent with the guidelines, and that if they practice contrary to the Guidelines, they do so at their own risk.

123(c). Dr. Verdolin testified that the Guidelines “are not the standard of care” in California. He maintained that the standard of care is defined as the care of a reasonable physician, trained in the same specialty. According to Dr. Verdolin, the standard of care is based on personal experience and training and is a consensus of evidence-based medicine in a specialty group. However, Dr. Verdolin also testified that the Guidelines are a “generalized consensus to help guide physicians to stay within what is accepted and safe” and can have an effect on the standard of care. Moreover, in rendering his opinions in this case, Dr. Verdolin was asked by the Board to use its Guidelines, and he used them, in conducting his evaluation of whether Respondent complied with the standard of care for prescribing opioids for chronic pain.

123(d). The Board’s Guidelines are not documentation of the standard of care. However, as Dr. Helm pointed out, no reasonable practitioner would contravene the specific recommendations, given that they are issued by a disciplinary body. Moreover, since the Guidelines are a consensus of what is accepted and since reasonable practitioners would follow them, they comprise part of the standard of care as practiced by reasonable pain management physicians in California.

124. The Guidelines, in pertinent part, note:

**History/Physical Examination**

A medical history and physical examination must be accomplished. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance. [¶] . . . [¶]
Annotation Two: The complexity of the history and physical examination may vary based on the practice location. In the emergency department, the operating room, or at night or on the weekends, the physician and surgeon may not always be able to verify the patient’s history and past medical treatment. In continuing care situations for chronic pain management, the physician and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.

Treatment Plan, Objectives

The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychological function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient.

Annotation One: Physicians and surgeons may use control of pain, increase in function, and improved quality of life to evaluate the treatment plan. [¶] . . . [¶]

Informed Consent

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent.

Periodic Review

The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient’s state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician’s evaluation of progress toward treatment objectives. If the patient’s progress is unsatisfactory, the physician and surgeon should
assess the appropriateness of continued use of the current treatment plan and consider the use of other treatment modalities. [§] . . . [§]

*Annotation Two:* Satisfactory response to treatment may be indicated by the patient’s decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient’s response to treatment.

(Id. at pp. 1-3.)

**Standard of Care – Use of Pain Management Agreements in 2010-2011 (K.B., C.P. and A.K.)**

125(a). Complainant criticizes A.K.’s and K.B.’s pain management agreements, particularly the lack of pharmacy selection information by the patients. However, Dr. Verdolin never testified that the use of pain management agreements for all patients was the standard of care for pain management physicians in 2010-2011. Additionally, Dr. Helm noted that pain management agreements, also known as pain contracts, were not required by the standard of care, as specifically indicated by the then-current Guidelines which were a consensus of accepted practice. (See Factual Finding 124, under Informed Consent.) Dr. Saini also testified credibly that pain management agreements were not required by the standard of care in 2010-2011. He opined that Respondent’s pain management agreements exceeded the standard of care in 2010-2011 and that Respondent was not required to have patients identify a specific pharmacy on their initial visit.

125(b). Given the foregoing, Complainant did not establish, by clear and convincing evidence, that Respondent violated the standard of care or that he failed to maintain adequate records with regard to any pain management agreements.

**Standard of Care – Taking of Vital Signs for Initial and Follow-up Visits in 2010-2011 (K.B., C.P., and A.K.)**

126(a)(1). Although he had previously testified that the Guidelines “are not the standard of care,” Dr. Verdolin looked to the Guidelines to support his assertion of required vital signs. Dr. Verdolin testified that the Guidelines require the performance of an “extensive” physical examination at each visit. This reading of the Guidelines is not accurate. The Guidelines require that a “medical history and physical examination must be accomplished,” and indicate that “the complexity of the history and physical examination may vary based on the practice location,” with “a more extensive evaluation” occurring in continuing care situations for chronic pain management as compared to the emergency department, the operating room, or at night or on the weekends, where “the physician and surgeon may not always be able to verify the patient’s history and past medical treatment.” (Exhibit J, pp. 1-3; See Factual Finding 124.)
126(a)(2). Dr. Verdolin opined that the physical examination should include taking the patient’s vital signs because “vital signs are the most basic element of a physical examination.” Vital signs include blood pressure, pulse, heart rate, and if possible, temperature. He opined that this information is important to measure compliance; if the patient is not taking pain medications appropriately, he/she may have a low heart rate from abuse or an elevated heart rate if in withdrawal. In maintaining that physical examinations should include vital signs, Dr. Verdolin also noted that a physician could see if a patient had dilated pupils to determine if the patient was taking medications as prescribed, which could substantiate the need for continued use or a change in the course of treatment. While pupil dilation is not one of the vital signs which would be measured, pupil size is one of the observations Respondent and his PA’s would sometimes use in their assessments to determine signs of possible adverse reaction, abuse or addiction. (See Factual Finding 29.) When asked if he was aware that, in 2010-2011, not all pain management physicians were recording vital signs at each visit, Dr. Verdolin opined only that “they should have been,” and that he has been doing so since medical school. While Dr. Verdolin’s testimony established that the taking of vital signs was a best practices approach which he personally took, his testimony did not establish by clear and convincing evidence that the recording of vital signs at office visits was the standard of care for pain management physicians in 2010-2011.

126(b). Contrary to Dr. Verdolin’s assertions, Drs. Helm and Saini credibly observed that it was not the standard of care in 2010-2011 for pain management physicians to record vital signs at office visits/examinations, although Dr. Saini noted that they are starting to do so now. Dr. Helm noted that for pain management physicians, vital signs do not have any value. He pointed to the then-applicable Guidelines, which did not specify that vital signs must be recorded. Dr. Helm also noted that it was not his routine practice in 2010-2011 to take vital signs at office visits and that he only commenced doing so after reading Dr. Verdolin’s criticisms of Respondent; even if it was not required by the standard of care, Dr. Helm’s practice is to be “conservative” and he sought to remove himself from “the line of fire” by beginning to take vital signs at office visits.

126(c). Complainant did not establish, by clear and convincing evidence that the 2010-2011 standard of care required pain management physicians to record vital signs at office visits, and the opinions of Drs. Helm and Saini were more persuasive than those of Dr. Verdolin. Therefore, the opinions of Drs. Helm and Saini, set forth in Factual Finding 126(b), are adopted as facts herein.

*Standard of Care – Documentation regarding Evaluation for Addiction/Diversion and Response to Opioid Treatment in 2010-2011; Use of Urinalysis or CURES (Patients K.B., C.P., and A.K.)*

127(a)(1). Dr. Verdolin criticized Respondent’s documentation of his evaluation for addiction, diversion or the patient’s response to opioid medications. He opined that
throughout the patients’ records there was “no documented response to treatment with opioid medications, nor . . . any evidence of compliance measures being undertaken.” (Exhibit 32.) Dr. Verdolin stated that in 2010-2011, these compliance measures included: pill counts, wherein the patient brings their medications to every visit and the remaining pills are counted to ensure that the correct number are left based on the prescribed dosage; use of CURES to determine if the patient is seeing multiple prescribers; and urinalysis to check for metabolites and ensure the patient is taking only prescribed medications and not abusing other drugs. Although he criticized Respondent’s failure to use urinalysis in determining drug abuse, Dr. Verdolin also admitted that, in 2010-2011, urinalysis was not required by the standard of care.

127(a)(2). Dr. Verdolin discounted Respondent’s documentation of “[no]addiction/diversion” following his or his PA’s examinations and observations of the patients and pill counts. Dr. Verdolin believed that Respondent’s notations were insufficient because Dr. Verdolin saw “no evidence that [the patient] was not diverting.” According to Dr. Verdolin, it was unclear how the conclusion of “[no] addiction/diversion” was drawn, and he maintained that the conclusion was documented without data and supporting facts in the records. Dr. Verdolin noted that, although Respondent and his PA testified that pill counts were done, there were no pill counts documented in the records. Typically, Dr. Verdolin would expect supporting statements such as “urine screen was negative,” “CURES done,” or “pill count done.”

127(b). As set forth above, and as pointed out by Dr. Helm, Respondent and his PA’s questioned the patients regarding their pain level with and without medications and their level of functioning (i.e. any increase in their ADL’s) in order to assess and document their response to opioid medications. Additionally, Drs. Helm and Saini testified credibly that Respondent and his PA’s adequately assessed for, and documented their assessments of, signs of abuse and diversion. According to Drs. Helm and Saini, neither the use of CURES nor urinalysis was required by the standard of care in 2010-2011. Dr. Helm noted that, in 2009, after CURES “went electronic,” it was extremely difficult to register for CURES because the process required sending notarized documents to Sacramento for processing and the ensuing budget crisis diminished the CURES staff to one or two people. However, Dr. Helm noted that, in 2010-2011, pill counts and physical findings on examination were good methods of monitoring compliance, along with feedback from pharmacies and occasionally family members. Dr. Saini noted that Respondent’s records indicate that he was diligent in addressing the potential diversion and addiction issues which have become prevalent in this country. Physicians are able to determine diversion or lack thereof through various means including patients’ statements/behaviors, such as: preoccupation with obtaining their pain medications; asking for early prescription refills or replacements for allegedly lost medications; or disinterest in physical therapy, diagnostic testing, therapeutic injections or referral to a surgeon. Dr. Saini opined that as long as the basic objective is carried out, physicians may document their findings differently, and a simple notation such as “pill count
fine” or “no signs of addiction” are sufficient to meet the standard of care. A physician need not document all of his/her negative findings or how he/she arrived at the negative finding.

127(c). Regarding the 2010-2011 standard of care for documenting response to opioid medications and evaluation of addiction or diversion, and whether CURES or urinalysis were required, the opinions of Drs. Helm and Saini were more persuasive than those of Dr. Verdolin. Therefore, the opinions of Drs. Helm and Saini, set forth in Factual Finding 127(b), are adopted as facts herein.

Standard of Care – Supervision of PA’s - Delegation of Services Agreements, Counter-signing Notes; Protocols/Formulary (K.B. and A.K.)

128(a). Dr. Verdolin voiced several criticisms regarding Respondent’s supervision of his PA’s which caused him to opine that Respondent had committed extreme departures from the standard of care regarding K.B. and A.K. Based on the information he had, Dr. Verdolin concluded that Respondent was not supervising his PA’s closely. He expressed unease about “the way the relationship between [Respondent] and the PA exists,” and noted that he had significant concerns that the PA’s “appeared to be operating independently” and were not supervised while prescribing medications.

128(b). Dr. Verdolin testified that, at the time of his expert review, Respondent had provided no Delineation of Services Agreements. In Dr. Verdolin’s analysis of whether Respondent committed gross negligence in his supervision of PA’s, the missing Delegation of Services Agreements does not, in itself constitute an extreme departure from the standard of care, but “would be a major contributor.” However, as established by the evidence at hearing, both PA Salcido and PA Jones were working pursuant to Delegation of Services Agreements signed by Respondent and each PA (see Factual Finding 15). According to the Delegation of Services Agreements, both PA Salcido and PA Jones had Drug Enforcement Administration (DEA) numbers under which they were able to write and sign prescriptions. Consequently, Complainant did not establish by clear and convincing evidence that Respondent failed to have Delineation of Services Agreements for his PA’s which was a major factor in Dr. Verdolin’s opinion that Respondent committed gross negligence in his supervision of PA’s.

128(c). Dr. Verdolin pointed out that for a PA who has completed the DEA course and can write Schedule II prescriptions, the progress note must be co-signed by the supervising physician within seven days. Dr. Verdolin testified that it was unclear when Respondent was supervising the PA’s and whether he was present during the examinations because there was no date and time next to Respondent’s co-signatures on the PA’s progress notes. However, Dr. Verdolin admitted on cross examination that there was no requirement that the note had to have a time of Respondent’s signature. Nevertheless, Dr. Verdolin maintained that he still did not know when Respondent saw the note or the patient because his signature had no date next to it. Dr. Verdolin did not address why the date at the top of the
notes was insufficient to indicate the date that Respondent signed it, since the date was the
same day as Respondent’s signature. Dr. Verdolin also pointed to the progress note in A.K.’s
chart on November 17, 2011, which Respondent failed to sign (see Factual Finding 115), and
stated that he assumed that Respondent did not see patients on the same date as the PA’s
“based on a pattern emerging in the records.” Dr. Verdolin did not explain how the one non-
signature was evidence of a “pattern.”

128(d). Dr. Verdolin’s additional criticism of Respondent’s PA supervision included
that Respondent had provided no formulary lists at the time Dr. Verdolin wrote his expert
report. According to Dr. Verdolin, “there was no evidence [of] any sort of control of what the
PA was doing” and no advance authorization for prescription of controlled substances.
However, Dr. Verdolin did not address whether Respondent’s one-page formulary and
practice protocols (see Factual Finding19) were sufficient to meet the standard of care.

128(e). Dr. Saini opined that, as reflected in the three patients’ records, Respondent
provided adequate supervision of PA’s and that his supervision was well within the standard
of care. Dr. Helm also opined that Respondent’s overall supervision of his PA’s was
appropriate and that one missed signature (on November 17, 2011), in light Respondent’s
custom and practice to sign all progress notes, did not constitute a violation of the standard of
care or failure to supervise his PA’s. Both Drs. Saini and Helm opined that the use of a
formulary was not a community standard of care in California. Nevertheless, Dr. Saini
pointed out that Respondent’s office “did have a policy and procedure which delegates the
[PA’s] to prescribe narcotics and also has a list of narcotics to be prescribed in the office
policy book. . . [and that Respondent] used [the PDR] and internet access to get information
regarding narcotics if needed.” (Exhibit II, p. 4.)

128(f). Regarding the 2010-2011 standard of care for supervision of PA’s (including
delegation of services agreements, countersigning of progress notes, and formulary and
protocols), the opinions of Drs. Helm and Saini were more persuasive than those of Dr.
Verdolin. Therefore, the opinions of Drs. Helm and Saini, set forth in Factual Finding 128(e),
are adopted as facts herein.

128(g). Regarding Respondent’s supervision of his PA’s, Complainant failed to
establish by clear and convincing evidence that Respondent committed gross negligence in the
care of patients K.B. and A.K.

Standard of Care re: “Prescribing Guidelines” – Multi-issue Analysis (K.B. and C.P.)

129(a). In his expert report, Dr. Verdolin addressed whether Respondent followed
“prescribing guidelines for controlled substances,” including (in an amalgamated analysis):
“good faith physical examination, prevention of diversion, assessment of benefit and adjusting
treatment according to risk and harm, informed consent of the patient, periodic review,
appropriate consultations and adequate record keeping.” (Exhibit 32.) Dr. Verdolin did not separate out his analyses of these issues, leveling a conglomeration of criticisms (mirrored in the FAC), most of which were factually disproven or which were not established by clear and convincing evidence when weighed against Respondent’s experts’ opinions. However, in his testimony, Dr. Verdolin was unavering in his opinions, despite indications that the factual bases were unsound. For example, as part of the combined analysis in his report, Dr. Verdolin criticized Respondent’s records for K.B. and C.P., noting that “There is no recorded or transcribed initial evaluation and consultation provided for this patient. It is unclear whether risks, benefits, or alternatives to any proposed treatment was given to this patient at the initial consultation, since none is available for review.” (Id. at pp. 1099-1100 and 1104.) This criticism prompted the factual allegations in the FAC that “there are no corresponding history and physical notes as to [the initial] visit, including any indication that an examination took place” (FAC, para. 11A) and that “There is no initial intake history, physical, or initial consultation in the medical records provided for this patient.” (FAC, fn. 2.) As noted above, these allegations were not established since the records from K.B.’s and C.P.’s initial date of treatment were not contained in the records sought by the investigation, reviewed by Dr. Verdolin, or submitted as evidence at the hearing. Nevertheless, when asked on cross examination whether he should have stated that he did not have the ability to offer an opinion regarding the lack of documentation because he did not know if he had been provided the patient’s complete records, Dr. Verdolin insisted that, although he knew he did not have all of the patients’ records, it was fair for him to form his opinion based on only the materials provided to him. This willingness to form an opinion using insufficient or disproven evidence calls into question the reliability of Dr. Verdolin’s findings and conclusions.\(^\text{17}\)

129(b). Regarding the following of prescribing guidelines (under which umbrella Dr. Verdolin included the issues of good faith physical examination, prevention of diversion, assessment of benefit and adjusting treatment according to risk and harm, informed consent of the patient, period review, appropriate consultations and adequate record keeping), Complainant failed to establish by clear and convincing evidence that Respondent committed gross negligence in the care of patients K.B. and C.P.

*Standard of Care – Medical Necessity and Appropriate Performance of Lumbar Facet Injections and Lumbar TFESI’s on Patient K.B.*

130(a). In his expert report, in addressing the medical necessity for lumbar facet injections and lumbar TFESI’s on K.B., Dr. Verdolin opined that Respondent’s treatment of

\(^\text{17}\) “The expert’s opinion is no better than the facts on which it is based” and, “where the facts underlying the expert’s opinion are proved to be false or nonexistent, not only is the expert’s opinion destroyed but the falsity permeates his entire testimony; it tends to prove his untruthfulness as a witness.” (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.)
K.B. using these injections constituted a simple departure from the standard of care. He explained his opinion by way of another amalgamated analysis as follows:

Pain from the lumbar facet joints is a possible case of back pain. . . . Initial treatment for this problem is with nonsteroidal anti-inflammatory agents [(NSAID’s)] such as Motrin or Naprosyn combined with physical therapy and other noninvasive options. Typically, this problem is not treated with sustained-release opioids. Interventional options include direct facet joint injections. The standard response to interpret this as a successful procedure is several weeks to months of pain relief. When sustained pain relief is not achieved, but suspicion still rests on the facet joints, accepted practice is to perform medial branch blocks. A comprehensive pain diary, hour by hour, is provided to the patient. If there is greater than 50% pain relief on this side that is anesthetized, then [RFA] of the target is offered. This procedure can provide 6 to 12 months of "permanent" pain relief. . . . It is clear from the record that the patient had many, many repeated facet joint injections, which did not seem to produce long lasting relief, despite the contradictory language in the dictated operative report. . . . None of the documentation provided suggests analysis of response to the injections and any consideration of change in plan to include the diagnostic medial branch injection. She was not offered [RFA] based on any of the notes, and continually failed the facet joint injections. This is ascertained by the fact that her pain is always listed as 10 out of 10, and that her use of controlled substances was not diminished. It is unclear whether the patient benefitted at all from these interventions, or that they were medically necessary based on the documentation provided. The guidelines published in Pain Physician conclude that lumbar "intra-articular" facet injections, the repeated procedure performed by the respondent, has only moderate evidence of efficacy, and should not be repeated ad infinitum without good evidence of efficacy, in a particular patient. . . .

(Exhibit 32, p. 1101.)

130(b). Several of Dr. Verdolin’s assertions are overstated or unsubstantiated. Although he contended that K.B. “had many, many repeated facet joint injections,” the records indicated that she had three lumbar facet injections and one lumbar TFESI over the course of the year at issue. Additionally, while Dr. Verdolin asserted that the injections “did not seem to produce long lasting relief,” the records indicate that K.B. obtained relief with spans of two months to four months between injections. This would apparently fit Dr. Verdolin’s own definition of a “successful” procedure which was one that provided “several weeks to months of pain relief.” Dr. Verdolin also contended that there was no documented
“analysis of response to the injections,” that “it is unclear whether the patient benefitted at all from these interventions,” and that the facet injections “continually failed” as “ascertained by the fact that her pain is always listed as 10 out of 10.” However, these assertions were not substantiated by the evidence. The records document K.B.’s reports of relief from the injections (“more than 60 percent” at times) and increased ADL’s, with a pain level as low as 6/10 at times, not “always listed as 10 out of 10.” Additionally, Dr. Verdolin testified that facet injections should be administered only three to four times per year due to the “concern of repeated exposure to steroids.” However, Dr. Verdolin did not analyze this concern in light of Respondent’s use of Marcaine, a local anesthetic, rather than a steroid for facet injections. Furthermore, K.B. had only three facet injections in the year at issue, thereby meeting Dr. Verdolin’s asserted criteria for proper administration.

130(c). In making his assertion that lumbar facet injections “should not be repeated ad infinitum” (which was an exaggeration given that K.B. received three lumbar facet injections and one lumbar TFESI in a one year period), Dr. Verdolin cited “the guidelines published in Pain Physician.” Although he testified that he used ASIPP “guidelines” in developing his opinions (including his opinions regarding the use of particulate steroids, below), Dr. Verdolin admitted that ASIPP guidelines are not the standard of care. Complainant also presented journal articles (published prior to and after 2010-2011) from the Pain Physician, the publication of ASIPP, and asserted that these articles were considered guidelines from ASIPP and part of the standard of care. The evidence did not establish that the positions advocated by the authors of those articles were either guidelines of ASIPP or the standard of care for pain physicians in 2010 to 2011.

130(d). Dr. Helm testified credibly that Respondent’s care and treatment of K.B. was entirely within the standard of care. Additionally, Dr. Saini noted that Respondent’s care and treatment benefitted K.B., whose pain was controlled.

130(e). Dr. Helm noted that there is “high quality evidence in the form of prospective randomized trials showing sustained relief – meaning months” from the use of local anesthetics such as Marcaine for both facet and epidural injections. In treating facet disease, therapeutic facet injections may be used as opposed to diagnostic treatment/injections. It is in the mainstream to use local anesthetic, without steroids, for maintenance of patients with facet disease. When discussing the length of time Marcaine (.5 percent) could provide pain relief, Dr. Saini noted that this was a “complex phenomenon,” and “the nervous system is a very smart system.” Although the duration of local anesthetic is about three to four hours, at times it provides very extended relief and the duration lasts much longer. While these are typically diagnostic blocks, they become therapeutic because the pain is relieved for weeks to months.

130(f). Given the foregoing, Complainant failed to establish by clear and convincing evidence that Respondent committed any departure from the standard of care in performing the lumbar facet injections and lumbar TFESI’s in his treatment of K.B.
Standard of Care re: Injectable Demerol, Two Long-Acting Opioids and Cervical Facet Injections for Patient CP

131(a). Dr. Verdolin opined that Respondent’s prescribing injectable Demerol to C.P. was concerning and an extreme departure from the standard of care. However, he did not specifically testify that in 2010-2011, the standard or care for pain management physicians precluded them from prescribing injectable Demerol in such dosages and circumstances as C.P.’s.

131(b). Dr. Verdolin also criticized the use of two long-acting opiates, MS Contin (a sustained release morphine lasting 12 hours), and Fentanyl patches (which can last for three days and have a 17 hour half-life). He opined that there was no rational explanation for using multiple long-acting opioids at the same time, that there was a potential for death, overdose or complication, and that it was unclear which medication was working.

131(c). Dr. Verdolin also opined that it was unclear if there was evidence that C.P. had cervical facet syndrome, and that he did not see diagnostic studies for this patient. He did not address the absence of such studies in light of the fact that C.P.’s records were limited in time. Dr. Verdolin also opined that other procedures such as Botox for spastic muscles could have been considered. He did not specifically state that the standard of care in 2010-2011 required this or other considerations. Dr. Verdolin also opined that medial branch blocks should have been considered one side at a time to determine which joint was a problem. He also stated that it was not possible to perform bilateral intra-articular injections at multiple levels in four minutes with any degree of accuracy. However, Respondent’s credible testimony regarding his ability to do so contradicted this assertion. Dr. Verdolin’s overall conclusion was that Respondent’s overall management of patient C.P., based on the records provided, constituted an extreme departure from the standard of care.

132(a). Dr. Helm opined that Respondent’s care of C.P. and his documentation for the patient were within the standard of care. Dr. Helm noted that the use of Demerol had been initiated by a prior physician. Dr. Helm acknowledged that physicians do not routinely prescribe Demerol because it can break down to normeperidine, which can induce seizures. However, C.P. was prescribed 75 mg IM, so that his daily dose of Demerol was under the threshold at which one would be worried about normeperidine toxicity. Additionally, C.P. had been using this dosage for a while with no ill effects, so toxicity was not a risk factor. Furthermore, the Guidelines call for the physician to “tailor pharmacological therapy to the individual medical needs of each patient,” and C.P. was a unique patient in that he had suffered from a catastrophic neurologic condition and was a ventilator-dependent quadriplegic, and the prescribed medications, including the Demerol, helped provide relief.
132(b). Dr. Saini opined that C.P.’s medical records supported the patient’s treatment and procedures provided by Respondent. Dr. Saini noted that C.P. was a quadriplegic with a tracheostomy in place who suffered from severe neck pain and pain around the tracheostomy, and his care was “almost palliative,” along with interventional procedures. He commended Respondent for caring for C.P and making his life comfortable. Dr. Saini opined that all of the cervical injections to alleviate C.P.’s pain were “absolutely appropriate.” Dr. Saini pointed out that C.P.’s medication regimen, started by the patient’s primary care physician, helped the patient to remain comfortable and that the Demerol allowed him to get some sleep at night. Additionally, Dr. Saini opined that the dose of Demerol was low enough that normeperidine toxicity was not an issue. C.P. was stable on his medications and his pain was relatively controlled, with no evidence of abhorrent drug behavior or addiction. Dr. Saini opined that Respondent’s continued prescribing of C.P.’s medications, including the Demerol IM at night, was within the standard of care. Dr. Saini also opined that Respondent’s medical records for C.P. complied with the standard of care for pain management physicians in 2010-2011.

132(c). Both Drs. Helm and Saini credibly maintained that there was sufficient evidence to support a showing of weeks to months of relief from injections using local anesthetics such as Marcaine. (See detailed analysis in Factual Finding 130(e).) Dr. Saini acknowledged that C.P.’s reports of pain relief could have been due to the use of the two modalities, the medications and the injections, and opined that this was “acceptable” since it was what worked for this patient.

133. Regarding Respondent’s care of patient C.P. (specifically the prescriptions for Demerol IM, two long-acting opioids and the use of cervical facet injections), the opinions of Drs. Helm and Saini were more persuasive than those of Dr. Verdolin. Therefore, the opinions of Drs. Helm and Saini, set forth in Factual Findings 132(a), 132(b) and 132(c), are adopted as facts herein.

134. Complainant failed to establish by clear and convincing evidence that Respondent committed gross negligence in the care of patient C.P.

Standard of Care re: Medical Necessity for and Proper Administration of Cervical TFESI’s (Choice of Level and Use of Particulate Steroids) for Patient A.K.

135(a). In his 2012 expert report and 2014 supplemental expert report, Dr. Verdolin opined that Respondent departed from the standard of care with regard to the medical necessity for and proper administration of cervical TFESI’s on patient A.K. Dr. Verdolin explained his opinions by way of an amalgamated analysis. Generally, his criticisms focused on whether the cervical TFESI in July 2010 was performed at the correct level of the cervical spine, whether the use of a particulate steroid in the cervical TFESI’s was within the standard
of care, and whether the sedation used during the cervical TFESI’s was within the standard of care.

135(b)(1). Dr. Verdolin pointed out that procedures are “usually performed at the level of the suspected nerve root irritation and narrowing.” Dr. Verdolin opined that Respondent’s decision to perform the July 26, 2010 cervical TFESI at the C5-C6 level was “based on a paucity of evidence” and that A.K. “did not present with radicular symptoms” or changes in muscle tone or in reflexes. He noted that the CT scan indicated a potential disc protrusion at the C6-C7 level, but the injection was performed at the C5-C6 level “where no pathology existed per the CT scan.” (Exhibits 32 and 38; Testimony of Dr. Verdolin.)

135(b)(2). Dr. Verdolin’s assertions were not borne out by the evidence. At the June 15 and July 15, 2010 visits, A.K. complained of pain radiating into her left arm and hand, with numbness, tingling and weakness. At the June 15, 2010 visit, there was noted tenderness and pain over A.K.’s biceps tendon, and at the July 15, 2010 visit, the patient’s brachioradialis was sensitive to light touch. There was also decreased range of motion and pain with supination/rotation (i.e. twisting forearm left and right). Additionally, the CT scan indicated a 1-2 mm annular bulge and mild bilateral facet hypertrophy at the C5-C6 level. Furthermore, Respondent’s analysis in approving the left cervical TFESI at the C5-C6 level (see Factual Finding 94) was cogent and supported by the diagnostic testing combined with findings on physical examination. Respondent’s determination of C5-C6 as the appropriate level for injection was supported by the credible testimonies of Drs. Helm and Saini, who opined that Respondent did not deviate from the standard of care. They noted that the CT scan found a 1-2 mm disc bulge at C5-C6 with facet hypertrophy, and they opined that Respondent’s decision to inject at that level was appropriately based on the patient’s history, the imaging, and findings on physical examination. Dr. Helm also credibly noted that a physician’s differing opinion regarding another physician’s determination does not render that determination below the standard of care.  

135(c). Dr. Verdolin criticized Respondent’s “use of deep sedation,” in performing the TFESI’s on A.K. noting that “greater than 60 percent” of physicians would not perform deep sedation, “but some might.” Dr. Verdolin did not establish that the use of “deep sedation” was contrary to the standard of care. Additionally, Dr. Verdolin never established

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18 In selecting a method of treatment, skillful members of the medical profession may differ; however, the practitioner must keep within the “recognized and approved methods.” (Callahan v. Hahnemann Hospital (1934) 1 Cal.2d 447.) If so, negligence is not shown by evidence that other medicines or treatment might have been employed. (Jensen v. Findlay (1936) 17 Cal.App.2d 536.) The mere fact that there is a difference of medical opinion concerning the desirability of one particular medical procedure over another does not establish that the determination to use one of the procedures was negligent. (Clemens v. Regents of Univ. of Cal. (1970) 8 Cal.App.3d 1, 13.)
that Respondent actually used “deep sedation” with A.K. Respondent credibly established that he does not place his patients under deep sedation (see Factual Finding 40), and Dr. Saini agreed on review of the anesthesia records that A.K. was not provided deep IV sedation with Propofol. Dr. Saini noted that the doses of Propofol given to A.K. were small and insufficient to render the patient unconscious.

135(d)(1). Dr. Verdolin also criticized Respondent’s use of particulate steroids in cervical TFESI’s performed on A.K. Dr. Verdolin noted that transfominal injection of particulate steroids into the cervical spine has been associated with higher instances of paralysis and death. He further noted that merely placing the needle into the cervical spine for transfominal injection can cause vasospasm of blood vessels, and adding particulate steroids increases the risk that “something bad can happen.” Dr. Verdolin opined that it was the standard of care “to avoid” performing cervical TFESI’s with particulate steroids and that Respondent violated the 2010-2011 standard of care by performing cervical TFESI’s with a particulate steroid. Dr. Verdolin based his determination of the 2010-2011 standard of care largely on several publications, including a 2009 article in ASIPP’s Pain Physician journal. However, the evidence did not establish that the positions advocated in any of his cited articles were the standard of care for pain physicians in 2010-2011. Nevertheless, Dr. Verdolin maintained that, based on the “cautionary information that was developing,” by 2009 the vast majority of pain management physicians had stopped performing cervical TFESI’s using particulate steroids. He asserted that it was “widely known” in the pain management community in 2010-2011 that particulate steroids should not be used in cervical TFESI’s, and that “by 2011, pain physicians should not have been [performing cervical TFESI’s using particulate steroids] because of the potential risk of catastrophic events.” However, he acknowledged on cross examination that there were still instances in 2011 (included for diagnostic purposes and for studies being performed) where cervical TFESI’s using particulate steroids were being administered. Dr. Verdolin stated that he did not expect “everyone to make changes” in their practice based on the literature. He admitted that in the literature and among professionals, the “debate [is] continuing” regarding what is causing the catastrophic events, and that evidence has not established that they are caused solely by the use of particulate steroids, but that they have also been associated with transfominal injections using just local anesthesia. Dr. Verdolin conceded that this is an issue that is evolving.

135(d)(2). Drs. Helm and Saini opined that Respondent did not deviate from the 2010-2011 standard of care in his care and treatment of A.K. by performing cervical TFESI’s with a particulate steroid. Drs. Helm and Saini maintain that the 2010-2011 standard of care did not mandate avoiding particulate steroids. Instead, the issue was and remains vigorously debated in literature and by professionals, trending to the idea that vasospasm, not particulate steroids, are the cause of complications.

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135(e). Dr. Verdolin also opined that Respondent committed an extreme departure from the standard of care by performing bilateral cervical facet blocks and that he committed a simple departure from the standard of care by using deep sedation to perform for those bilateral cervical facet blocks. However, this opinion is based on inaccurate assumptions because the records indicated that Dr. Kumar performed the cervical facet injections on A.K. Respondent did not perform any cervical facet injections on A.K.; he performed two cervical TFESI’s, three bilateral lumbar facet injections, and two lumbar TFESI’s.

135(f). Given the foregoing, Complainant failed to establish by clear and convincing evidence that Respondent committed any departure from the standard of care in his care and treatment of A.K.

_Inaccurate Records – Failure to Change “Boilerplate” Language in Template-created Operative Reports (K.B. and A.K.)_

136. Dr. Verdolin criticized the use of “boilerplate” language in Respondent’s operative reports, noting that many of the operative reports contained the same terminology. He cited examples, such as: “Patient had 50-60% pain relief from prior similar injections with good functional improvement”; and “Failed physical therapy, conservative therapies and other modalities for pain control.” The similar language led him to believe that the operative reports were not accurate. However, while the same language was used in operative reports, this does not necessarily establish that the cited language was inaccurate. The medical records for patients K.B. and A.K. generally support the information in their operative reports regarding the pain relief they received from prior similar injections and the fact that they had previously unsuccessfully tried physical therapy.

137. However, K.B.’s and A.K.’s operative reports did contain errors in citing the diagnostic testing relied upon as “MRI” instead of “CT.” (K.B. – August 17, 2011 operative report; A.K. – February 24, 2011 and June 28, 2011 operative reports.) Drs. Helm and Saini testified credibly that this mistake is not below the standard of care and does not constitute negligence. Indeed, such errors are not unusual, as evidenced by Dr. Verdolin’s 2012 expert report. Dr. Verdinlin, who criticizes Respondent for inaccurately citing to MRI’s in his operative reports when the diagnostic testing was in fact a CT scan, makes the same mistake in his expert report, citing “MRI evidence” when in fact the diagnostic testing done on A.K. was a CT scan of her cervical spine. (Exhibit 32, p. 1109.)

138. Nevertheless, while such errors are not below the standard of care, the operative reports are still technically “inaccurate” records within the meaning of Business and Professions Code section 2266.
Disciplinary Considerations - Respondent’s Rehabilitation and Character Evidence

139(a). After being served with the Accusation in 2013, Respondent changed many of his policies and customs to address all of Complainant’s criticisms.

139(b). Respondent no longer uses particulate steroids for cervical injections.

139(c). Respondent began taking and recording vital signs for all patients’ consultations, not just before surgical procedures.

139(d). Respondent registered with CURES and began obtaining CURES reports on every patient for every visit.

139(e). Respondent obtains urinalysis on every patient’s first visit and then every two to four months, as indicated, based on a patient’s history, examination and possible diversion.

139(f). Respondent began documenting more carefully and thoroughly, detailing the patient’s history of abuse, addiction, and diversion.

139(g). Respondent has transitioned from handwritten notes to electronic medical records.

139(h). Respondent expanded his medication formulary from one page to 1,000 pages. The new, extensive formulary contains the names of any potential medications which could be prescribed in his practice, along with the indications, contraindications and side effects. Respondent equated his new formulary to the PDR.

140. In April 2013, Respondent completed a multi-day medical recordkeeping course at the University of California, San Diego School of Medicine (UCSD).

141. In July 2013, Respondent completed a multi-day prescribing practices course at UCSD.

142(a). Respondent has the support of numerous friends and colleagues who testified and submitted letters on his behalf.

142(b). Frank Mohamed Yusuf, M.D., Chief of Staff at HMNMH twice (including in 2010-2011), has known Respondent for about 25 years. He characterized Respondent as a caring, diligent physician who has an excellent knowledge of pain medications and who has made patients’ lives better. Respondent has a reputation among his colleagues as an excellent physician.
142(c). Eugene Ralph Dorio, M.D., current Chairman of the Department of Medicine at HMNMMH has known Respondent for many years. Dr. Dorio practices internal medicine with a palliative and hospice care practice. He trusts Respondent and refers patients to him for pain management. Dr. Dorio is grateful to Respondent for improving his patients’ quality of life. Dr. Dorio has never heard anything negative about Respondent from either his patients or colleagues in the medical community.

142(d). Gregory D. Jenkins, M.D. has practiced medicine in Newhall, California for 22 years and has hospital privileges at HMNMMH where he has been Chief of Staff twice in the past 20 years. Dr. Jenkins refers patients who have difficult pain issues to Respondent. He has confidence in Respondent’s ability to provide care to his patients and make them feel better without any complications. According to Dr. Jenkins, Respondent’s patients have been happy with his care, and Respondent has a reputation as an excellent physician.

LEGAL CONCLUSIONS

Causes for Discipline

1. Cause does not exist to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed gross negligence in his care of patients K.B., C.P., or A.K., as set forth in Factual Findings 1 through 138.

2. Cause does not exist to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed repeated negligent acts in his care of patients K.B., C.P., or A.K., set forth in Factual Findings 1 through 138.

3(a). Cause does not exist to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to Business and Professions Code section 3502.1, subdivision (a)(2), in

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19 The standard of proof which must be met to establish the charging allegations is “clear and convincing evidence.” (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal—so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (Katie V. v. Superior Court (2005) 130 Cal.App.4th 586, 594.)
that Complainant failed to establish, by clear and convincing evidence, that Respondent failed to properly supervise physician assistants in the care and treatment of patients K.B., C.P., and A.K., by failure "to prepare and adopt ... a written, practice-specific formulary and protocols," as set forth in Factual Findings 1 through 138, and Legal Conclusions 3(b) and 3(c).

3(b). Business and Professions Code section 3502.1, subdivision (a)(2), provides:

Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. . .

3(c). Respondent and PA Salcido testified credibly that Respondent had written protocols in place, a one-page formulary/list of medications, and an office policy to use the PDR in prescribing medications. Dr. Verdone’s criticism spoke only to the absence of a formulary and did not address whether the written protocols, one page formulary/list and policy to use the PDR was sufficient to meet the standard of care or the mandates of section 3501.2. Complainant did not establish, by clear and convincing evidence that Respondent had violated Business and Professions Code section 3502.1, subdivision (a)(2).

4. Cause does not exist to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to Business and Professions Code section 3502.1, subdivision (e), in that Complainant failed to establish, by clear and convincing evidence, that Respondent failed to properly supervise physician assistants in the care and treatment of patients K.B., C.P., and A.K., by failing to review and countersign the patients’ medical records, as set forth in Factual Findings 1 through 138.

5. Cause does not exist to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to California Code of Regulations, title 16, section 1399.540, in that Complainant failed establish, by clear and convincing evidence, that Respondent failed to have delegation of services agreements for physician assistants participating in the care and treatment of patients K.B., C.P., and A.K., as set forth in Factual Finding 15.

6. Cause exists to discipline Respondent’s physician’s and surgeon’s certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to
maintain accurate records in his care of patients K.B. and A.K. by failure to change the boilerplate language in template-created operative reports, as set forth in Factual Findings 41, 54, 105, 109, 137 and 138.

**Analysis re: Level of Discipline**

7(a). Complainant established that Respondent engaged in three instances of failure to maintain accurate records by neglecting to change the boilerplate language in template-created operative reports (leaving the incorrect word, “MRI,” instead of changing it to the correct, “CT scan”). While such errors are not below the standard of care, the operative reports were technically “inaccurate records,” within the meaning of Business and Professions Code section 2266. The remaining question is the nature of the discipline to be imposed against Respondent’s certificate for his violations.

7(b). Business and Professions Code section 2229, provides, in pertinent part:

(a) Protection of the public shall be the highest priority for the Division of Medical Quality, . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.

(b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, [or] the division, . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . . .

7(c). Business and Professions Code section 2227, subdivision (a), provides:

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

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

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

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

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

7(d). Complainant’s expert apparently holds himself to a very high standard as a physician, and he commendably advocates holding all other physicians to that high standard. However, Complainant did not establish by clear and convincing evidence that the standards advocated by Dr. Verdolin in his numerous criticisms of Respondent were the standard of care for pain management physicians in 2010 and 2011. Consequently, Complainant failed to establish that Respondent engaged in gross negligence or repeated negligent acts in his treatment of patients K.B., C.P., and A.K. Nevertheless, despite Respondent’s belief that he had met standard of care, he endeavored to meet the high standard advocated by Complainant. Since 2013, Respondent has worked diligently to change numerous aspects of his practice, including: discontinuing the use of particulate steroids for cervical injections; recording vital signs for all patients’ consultations; obtaining CURES reports on every patient for every visit; obtaining urinalysis on every patient’s first visit and periodically thereafter, as indicated; documenting in detail patients’ histories of abuse, addiction, and diversion; transitioning from handwritten notes to electronic medical records; and expanding his medication formulary from one page to 1,000 pages. He also completed a medical recordkeeping course and a prescribing practices course at UCSD. Given that protection of the public is the primary purpose of the Board, Respondent demonstrated his desire to work in conjunction with the Board on this paramount goal of patient safety.

7(e). The one remaining area of concern involves Respondent’s three inaccurate operative reports resulting from his office’s use of a template for completion of those documents. While the three proven inaccuracies were relatively harmless and did not rise to the level of professional negligence, any inaccuracy in patient records raises a concern for continued inaccuracy in a manner which may cause confusion by subsequent reviewers and treatment providers (as demonstrated by other the ambiguity noted in A.K.’s November 4, 2010 operative report). Respondent has converted all of his recordkeeping to electronic medical records, so his use of templates for completion of documents could remain a potential problem area, although the 2013 medical recordkeeping course likely covered this concern. Consequently, cause for discipline exists, and the Board must acknowledge, to both the public and the medical community, that the acts and omissions of Respondent were not in compliance with the Business and Profession Code.

7(f). Given the foregoing, and in light of Respondent’s lengthy history of licensure without prior discipline, his lauded skills and compassion, the minor nature of his violations, and the mitigating evidence proffered at the hearing (in the form of demonstrated willingness to improve his practice to promote the Board’s goals), a public reprimand will best protect the public without imposing overly harsh and punitive discipline on Respondent.
ORDER

Respondent is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4), and is publicly reproved under the provisions of Business and Professions Code section 495, for the conduct specified in Legal Conclusions 6 and 7(e).

DATED: December 17, 2015

[Signature]

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings