



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



Timothy Bruce Martin, D.O.
111 West C Street, Suite C
Benicia, CA 94510-3163

NOV 30 2015

Dear Timothy Bruce Martin:

Re: OI File Number H-15-4-2106-9

This is to notify you that you are being excluded from participation in any capacity in the Medicare, Medicaid, and all Federal health care programs as defined in section 1128B(f) of the Social Security Act (Act). The Act defines a Federal health care program as any plan or program that provides health care benefits, whether directly or indirectly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (except the Federal Employees Health Benefits Program). State health care programs are defined in section 1128(h) and include plans and programs under titles XIX, V, XX, and XXI. The scope of this exclusion is broad and will have a significant effect on your ability to work in the health care field.

This action is being taken under section 1128(b)(4) of the Act (42 U.S.C. 1320a-7(b)) because your license to practice medicine or provide health care as an osteopathic physician and surgeon in the State of California was revoked, suspended, or otherwise lost or was surrendered while a formal disciplinary proceeding was pending before the Osteopathic Medical Board of California, Department of Consumer Affairs, State of California for reasons bearing on your professional competence, professional performance, or financial integrity. See 42 U.S.C. 1320a-7(b), 42 C.F.R. 1001.501.

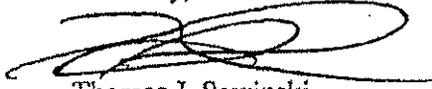
This program exclusion is effective 20 days from the date of this letter and will remain in effect until you are reinstated by the Office of Inspector General (OIG). To be eligible for reinstatement, you must regain your license as an osteopathic physician and surgeon in the State of California.

This exclusion will affect your ability to claim payment from these programs for items or services that you render; it will NOT affect your right to collect benefits under any Federal health care program such as Medicare, Medicaid, and Social Security. You may find more information regarding exclusions on the OIG's website, including Frequently Asked Questions and the Special Advisory Bulletin about the Effect of Exclusion. To access this site, go to <http://oig.hhs.gov>, click on EXCLUSIONS DATABASE, and then choose the item you would like to access.

A detailed explanation of the authority for this exclusion, its effect, and your appeal rights is enclosed and is incorporated as part of this notice by specific reference. You should read this document carefully, act upon it as necessary, and retain it for future reference.

REINSTATEMENT IS NOT AUTOMATIC. You must apply to the OIG and be granted reinstatement. Obtaining a license, moving to another State, or obtaining a provider number from a Medicare contractor, a State agency, or a Federal health care program does not reinstate your eligibility to participate in those programs.

Sincerely,



Thomas J. Sowinski
Reviewing Official
Health Care Program Exclusions

Enclosures

cc: San Francisco Regional Office
/jep

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FEB 12 2014

**OSTEOPATHIC MEDICAL BOARD
OF CALIFORNIA**

8
9 **BEFORE THE**
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 00-2011-003230

13 **TIMOTHY B. MARTIN, D.O.**

ACCUSATION

14 111 West C Street, Suite C
15 Benicia, CA 94510

16 Osteopathic Physician's and Surgeon's
Certificate No. 20A4909

17 Respondent.

18
19 Complainant alleges:

20 **PARTIES**

21 1. Angelina M. Burton (Complainant) brings this Accusation solely in her official
22 capacity as the Executive Director of the Osteopathic Medical Board of California, Department of
23 Consumer Affairs (hereinafter the "Board" or the "Osteopathic Medical Board").

24 2. On or about June 18, 1983, the Osteopathic Medical Board of California issued
25 Osteopathic Physician's and Surgeon's Certificate No. 20A4909 to Timothy B. Martin, D.O.
26 (Respondent). The Certificate was in full force and effect at all times relevant to the charges
27 brought herein and will expire on May 31, 2015, unless renewed.

28

PRIOR DISCIPLINE

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2 3. On October 4, 2000, in a prior disciplinary action before the Osteopathic Medical
3 Board of California entitled "In the Matter of the Accusation Against Timothy B. Martin, D.O.,"
4 Case Number 00-04, the Board issued a Decision and Order, effective October 4, 2000, in which
5 discipline was imposed on Respondent's license. The discipline was pursuant to a Stipulated
6 Settlement and Disciplinary Order. In the Decision, Respondent's Osteopathic Physician's and
7 Surgeon's Certificate was revoked, but the revocation was stayed and Respondent was placed on
8 probation for a period of three years and subject to certain terms and conditions which included
9 ~~successful completion of the PACE Physician Prescribing Course and an additional 25 hours~~
10 annually of CME courses.

11 4. On February 4, 2003, the Board issued a Decision in "The Matter of the Petition for
12 Termination of Probation" which was filed by Respondent. In its Decision, the Board granted the
13 petition, deemed the probation to be successfully completed, and terminated Respondent's
14 probation and fully restored his license status.

JURISDICTION

15
16 5. This Accusation is brought before the Osteopathic Medical Board of California
17 (Board), Department of Consumer Affairs, under the authority of the following laws. All section
18 references are to the Business and Professions Code unless otherwise indicated.

19 6. Section 3600 of the Code states that the law governing licentiates of the Osteopathic
20 Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2,
21 relating to medicine, known as the Medical Practice Act.

22 7. Section 3600-2 of the Code states:

23 "The Osteopathic Medical Board of California shall enforce those portions of the Medical
24 Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2
25 of the Business and Professions Code, as now existing or hereafter amended, as to persons who
26 hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California,
27 however, persons who elect to practice using the term or suffix "M.D." as provided in Section
28 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be

1 subject to this section, and the Medical Board of California shall enforce the provisions of the
2 article as to persons who make the election. After making the election, each person so electing
3 shall apply for renewal of his or her certificate to the Medical Board of California, and the
4 Medical Board of California shall issue renewal certificates in the same manner as other renewal
5 certificates are issued by it."

6 8. Section 725 of the Code states:

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

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

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

21 "(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section
22 for treating intractable pain in compliance with Section 2241.5."

23 9. Section 2228 of the Code authorizes the Osteopathic Medical Board of California to
24 discipline a licensee by placing him or her on probation.

25 ///

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1 10. Section 2234 of the Code states, in pertinent part:

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

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

7 "(b) Gross negligence.

8 "(c) Repeated negligent acts.

9 "(d) Incompetence.

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

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

13 11. Section 2242 of the Code states, in pertinent part:

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

17 12. Section 2266 of the Code states:

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

20 13. Section 2450 of the Code provides that the Osteopathic Medical Board of California
21 will enforce the provisions of the Medical Practice Act relating to persons holding or applying for
22 physician's and surgeon's certificates issued by the Osteopathic Medical Board of California
23 under the Osteopathic Act.

24 14. Section 2451 of the Code states:

25 "The words "Medical Board of California," the term "board," or any reference to a division
26 of the Medical Board of California, as used in this chapter shall be deemed to mean the
27 "Osteopathic Medical Board of California, where that board exercises the functions granted to it
28 by the Osteopathic Act."

1 21. **OxyContin** is a trade name for **oxycodone hydrochloride** (“**Oxycodone**”)
2 controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from an
3 opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other
4 therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation.
5 OxyContin is a Schedule II controlled substance and narcotic as defined by section 11055,
6 subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as
7 defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a
8 dangerous drug as defined in Business and Professions Code section 4022. Respiratory
9 depression is the chief hazard from all opioid agonist preparations. OxyContin should be used
10 with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are
11 concurrently receiving other central nervous system depressants including sedatives or hypnotics,
12 general anesthetics, phenothiazines, other tranquilizers, and alcohol.

13 22. **Suboxone** is a trade name for a combination of **buprenorphine hydrochloride and**
14 **naloxone hydrochloride**. It is indicated for the treatment of opioid addiction. Buprenorphine is
15 an opioid similar to morphine, codeine, and heroin; however, it produces less euphoria and
16 therefore may be easier to stop taking. It is a Schedule V controlled substance under Health and
17 Safety Code section 11058(d) and is a dangerous drug as defined in section 4022 of the Business
18 and Professions Code. Buprenorphine is used for maintenance during or after opiate withdrawal.
19 Buprenorphine can cause drug dependence of the morphine type. Under the Drug Addiction
20 Treatment Act, codified at 21 U.S.C. section 823(g), prescription use of Suboxone in the
21 treatment of opioid dependence is limited to physicians who meet certain qualifying requirements
22 and have notified the Secretary of Health and Human Services (HHS) of their intent to prescribe
23 the product for the treatment of opioid dependence and have been assigned a unique treatment
24 number that must be included on every prescription. This “DATA Waiver” allows qualifying
25 physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V
26 narcotic medications specifically approved by the U.S. Food and Drug Administration (FDA).
27 Suboxone received FDA approval for use in opioid addiction therapy in October of 2002.

1 d. Dr. Hill examines the patient and either writes or types the chart note. Dr. Hill
2 maintains possession of the patients' records.

3 e. Respondent's role is to write the Schedule II prescriptions, which Dr. Hill is
4 prohibited from issuing during his probation.

5 f. Respondent occasionally performs an osteopathic manipulation on a patient.

6 27. On August 31, 2010, the Board issued its Decision that became effective on
7 September 30, 2010, in which Dr. Hill was placed on probation. One of the probation terms
8 prohibited Dr. Hill from prescribing Schedule II controlled substances.

9 28. In an interview with the Board, Dr. Hill stated that he did not have a DEA license and
10 so was unable to prescribe any controlled substances between October 1, 2010 and about October
11 16, 2010.

12 29. Patient SB was a patient of Dr. Hill since November 2008 and was seen for what Dr.
13 Hill described as upper back and right shoulder pain that started after a motor vehicle accident in
14 2006. Dr. Hill never performed and documented a complete initial history and physical
15 examination of patient SB.

16 30. On or about September 1, 2010, patient SB saw Dr. Hill for "chronic soft tissue back
17 pain" and "intermittent anxiety." Dr. Hill prescribed #40 Xanax, #100 Norco, and added a
18 prescription for #50 Oxycodone 15 mg., without documenting an appropriate examination and a
19 medical indication.

20 31. On or about October 7, 2010, which was a Thursday, Dr. Hill saw patient SB and
21 typed the chart note, including that the new prescription for #20 Suboxone was "per Dr. Martin."
22 This is the first mention of Respondent in the patient's chart. There is no record that Respondent
23 saw and evaluated the patient on that date. No appropriate history and physical examination is
24 documented. There is no documented medical indication for the prescribing. Respondent's
25 undated initials appear on the chart.

26 32. On or about October 25, 2010, which was a Friday, Respondent authorized patient
27 SB's early refill request for #60 Alprazolam (Xanax), which had originally been prescribed by
28 Dr. Hill. Respondent, however, had never seen the patient and there is no documentation of an

1 appropriate examination and a medical indication. According to the records, patient SB received
2 #120 Alprazolam between September 23, 2010 and October 7, 2010.

3 33. On or about December 23, 2010, which was a Thursday, patient SB saw Dr. Hill, who
4 handwrote his chart note, which included documenting prescriptions for #100 Norco plus one
5 refill, #60 Xanax plus one refill, and a new prescription for #50 Oxycodone 15 mg. "per Dr.
6 Martin." Respondent's initials appear on the chart without a date. There is no indication that
7 Respondent saw and examined the patient. There is no documentation of a medical indication for
8 the Oxycodone.

9 34. Starting on January 18, 2011 through May 6, 2011, patient SB saw Dr. Hill for five
10 monthly visits, all of which were on days other than Wednesday. There is no documentation that
11 Respondent saw and examined the patient. Yet, Respondent continued to prescribe monthly to
12 patient SB #50 Oxycodone 15 mg. with Dr. Hill prescribing monthly about #200 Norco and #120
13 Xanax. Respondent did not document a medical indication for his prescribing.

14 35. On or about May 19, 2011, which was a Thursday, Respondent wrote his only chart
15 note in patient SB's chart, which is not completely legible. Respondent's note included, for the
16 first time, "+/-" which Respondent told the Board was his notation that he discussed the risks and
17 benefits of chronic oxycodone treatment with the patient. Respondent continued to prescribe #50
18 Oxycodone 15 mg. to the patient. Respondent did not document an appropriate medical
19 examination and a medical indication for the prescription.

20 36. From about June 8, 2011 through at least March 28, 2012, patient SB continued to see
21 Dr. Hill on about a monthly basis on Wednesdays. Dr. Hill wrote or typed the chart notes for
22 those visits. Respondent continued to prescribe approximately monthly #50 Oxycodone 15 mg.
23 with Dr. Hill prescribing #200 Norco and #120 Xanax.

24 37. During the course of his treatment of patient SB, Respondent did not document an
25 etiology of the patient's chronic low back pain, did not order further studies or a referral to a
26 specialist, did not document the previous treatments and their results, and did not review and
27 assess the patient's psychiatric condition, substance abuse history, and/or opioid risk. Respondent
28

1 never documented an examination in the patient's chart and never documented a medical
2 indication for his treatment. Respondent's initials and brief notes are all undated.

3 38. Respondent's overall care and treatment of patient SB constitutes unprofessional
4 conduct through gross negligence and/or incompetence and/or negligent acts and/or excessive
5 prescribing and prescribing without an appropriate medical examination and medical indication,
6 including but not limited to the following:

7 a. Respondent did not perform and document a complete history and physical
8 examination of patient SB that would support his prescriptions for controlled substances.

9 There was no adequate documentation of an assessment of the patient's pain, physical and
10 psychological function, a substance abuse history, history of prior pain treatment, and an
11 assessment of underlying or co-existing diseases or conditions.

12 b. Respondent entered only one clinical note in the patient's chart during the entire
13 course of treatment. There is no documentation that Respondent participated in any clinical
14 decision-making. Respondent failed to independently examine and evaluate the patient.
15 Respondent wrote prescriptions for approximately seven months without seeing the patient.

16 c. Respondent did not document the presence of a recognized medical indication for
17 the use and the dosage of the prescribed drugs.

18 d. Respondent did not document a treatment plan and objectives of the treatment in
19 patient SB's chart. There is no documentation that Respondent participated in any clinical
20 decision-making regarding the patient's treatment.

21 e. Respondent did not document a discussion with the patient about the risks and
22 benefits of chronic opioid medications until about seven months after he had begun
23 prescribing opioids on a monthly basis.

24 f. Respondent failed to document performing a periodic review of the treatment
25 including, but not limited to, assessment of the etiology to the patient's back pain, ordering
26 imaging studies, the patient's progress toward treatment objectives and the patient's
27 response to treatment, the appropriateness of continuing the current treatment plan, and
28 consideration of using other therapeutic modalities and/or other alternative treatments.

1 g. Respondent failed to delineate a diagnosis for this patient and failed to consult
2 with or refer the patient to appropriate specialists.

3 h. Respondent failed to independently assess the patient's need for treatment and to
4 document his findings in the patient's chart.

5 i. Respondent excessively prescribed controlled substances without documenting an
6 appropriate medical indication.

7 j. Respondent's medical records were inadequate.

8
9 **SECOND CAUSE FOR DISCIPLINE**

10 (Unprofessional Conduct re Patient CC: Gross Negligence/Incompetence/Negligent
Acts/Excessive Prescribing/Prescribing Without an Appropriate Medical Examination/Indication)

11 39. Respondent is subject to disciplinary action for unprofessional conduct under sections
12 2234 (b) and/or (d) and/or section 2242 and/or section 725 of the Code, regarding his treatment of
13 patient CC, as described herein below.

14 40. Paragraphs 26, 27 and 28 are incorporated herein by reference, as if fully set forth.

15 41. Patient CC was a patient of Dr. Hill since about January 2004 and had a history of
16 chronic back pain and mild anxiety. Dr. Hill, however, never performed and documented a
17 complete initial history and physical examination.

18 42. Prior to Respondent's involvement with patient CC's treatment, Dr. Hill was treating
19 patient CC for low back pain and for foot pain that was purportedly the result of a bunionectomy
20 in June 2009. During the entire course of treatment, Dr. Hill never performed an appropriate
21 evaluation and never documented an appropriate medical indication for his treatment.

22 43. At the time Respondent first became involved with the care of patient CC, on or about
23 October 5, 2010, patient CC was being prescribed monthly by Dr. Hill: #100 Oxycodone 15 mg.
24 and #100 Norco 10/325, both on a "prn" basis, and #72 Klonopin, without Dr. Hill documenting
25 appropriate medical indications for his treatment.

26 44. According to Dr. Hill's typed chart note for October 5, 2010, which was a Tuesday,
27 he saw patient CC for osteopathic manipulation for her chronic back pain. Dr. Hill documented
28

1 prescribing Norco "per Dr. Martin." A handwritten note dated October 7, 2010 (a Thursday)
2 indicates that a prescription for #60 Norco with one refill was discussed with Respondent Dr.
3 Martin. The only indication that Respondent was involved in this visit is his undated signature in
4 the chart next to the chart note. There is no indication that Respondent saw the patient before
5 prescribing. Respondent did not provide his own independent assessment of the patient's clinical
6 status and did not document obtaining informed consent.

7 45. On or about December 9, 2010, which was a Thursday, Dr. Hill saw patient CC for
8 chronic back and foot pain and he handwrote the chart note, some of which is illegible. It appears
9 that the treatment included prescriptions for #100 Norco, #24 Klonopin, and #100 Oxycodone 15
10 mg. Respondent's initials are undated next to Dr. Hill's chart note. There is no indication that
11 Respondent saw the patient and conducted an appropriate examination on that date and obtained
12 informed consent. Yet, Respondent issued the prescription for the Oxycodone.

13 46. On or about January 7, 2011, which was a Friday, Dr. Hill saw patient CC who was
14 still complaining of low back pain and foot pain. Dr. Hill typed the chart note, which included a
15 prescription for #100 Oxycodone 15 mg. Respondent's initials appear on the chart without a date.
16 There is no indication that Respondent saw and examined the patient on that date. Respondent
17 was the prescriber of the Oxycodone.

18 47. According to his chart notes, Dr. Hill saw patient CC monthly for the next four
19 months: on February 15, 2011 (a Tuesday), on March 15, 2011 (a Tuesday), on April 11, 2011 (a
20 Monday), and on May 6, 2011 (a Friday). Dr. Hill noted the prescriptions to be issued, including
21 #100 Oxycodone 15 mg. along with prescriptions for #100 Norco and Klonopin. Respondent's
22 initials appear on the chart without a date. There is no indication that Respondent saw and
23 examined the patient. Respondent did not document a medical indication for the prescriptions
24 issued. Respondent was the prescriber of the Oxycodone.

25 48. On or about May 11, 2011, which was a Wednesday, Dr. Hill made a brief
26 handwritten chart note that the patient had come in for Oxycodone. Respondent then, for the first
27 time, made a very brief note of "+/-", which he told the Board was his notation that he discussed
28 the effects of chronic oxycodone treatment with the patient. Respondent issued a prescription for

1 the #100 Oxycodone that Dr. Hill had noted in the chart. Respondent did not document an
2 appropriate medical examination and a medical indication for the prescription.

3 49. For about three months after May 11, 2011, patient CC saw Dr. Hill who wrote the
4 chart notes that included a note of a prescription for #100 Oxycodone 15 mg. Respondent's
5 undated initials, along with a few brief instructions, also appear in the chart. Respondent,
6 however, did not document an appropriate medical examination and a medical indication for his
7 treatment.

8 50. On or about August 24, 2011, patient CC saw Dr. Hill who handwrote the chart note,
9 noting the patient was having increased foot pain from her June 2011 foot surgery. Although the
10 chart note is illegible with regard to the treatments, Respondent's initials and a brief note appear
11 undated. Dr. Hill apparently issued a prescription for #100 Norco with one refill. Respondent
12 increased the prescription for #100 Oxycodone from 15 mg to 30 mg., without documenting an
13 appropriate medical indication.

14 51. Between September 30, 2011 through about March 14, 2012, patient CC received
15 prescriptions from Respondent for #300 Oxycodone 30 mg. At the same time, patient CC
16 received from Dr. Hill prescriptions for #750 Norco and #96 Klonopin.

17 52. The last documented visit of patient CC in Dr. Hill's chart was for March 14, 2012.
18 Although there is no record of what was prescribed to patient CC, a CURES report indicates that,
19 on March 14, 2012, patient CC filled a prescription for #100 Oxycodone 30 mg. written by
20 Respondent.

21 53. There is a urine drug toxicology screen of patient CC dated March 14, 2012 in the
22 chart that showed inconsistent results – there was an absence of oxycodone, which was
23 prescribed, and there was the presence of methadone, which was not prescribed.

24 54. According to the CURES report, between the approximately five-month period of
25 March 30, 2012 to September 4, 2012, patient CC received the following prescriptions: #300
26 OxyContin 30 mg. (oxycodone hydrochloride) prescribed by Respondent; and, #640 Norco
27 325/10 mg.; and, #144 Klonopin 0.5 mg. (clonazepam) prescribed by Dr. Hill.

28

1 55. Respondent's overall care and treatment of patient CC constitutes unprofessional
2 conduct through gross negligence and/or incompetence and/or negligent acts and/or excessive
3 prescribing and prescribing without an appropriate medical examination and medical indication,
4 including but not limited to the following:

5 a. Respondent did not perform and document a complete history and physical
6 examination of patient CC that would support his prescriptions for chronic opioids
7 (Oxycodone.) There was no adequate documentation of an assessment of the patient's pain,
8 physical and psychological function, a substance abuse history, history of prior pain
9 treatment, and an assessment of underlying or co-existing diseases or conditions.

10 b. Respondent never entered a clinical note in the patient's chart during the entire
11 course of treatment. There is no documentation that Respondent participated in any clinical
12 decision-making. Respondent failed to independently examine and evaluate the patient.
13 Respondent wrote prescriptions for seven months without seeing the patient.

14 c. Respondent did not document the presence of a recognized medical indication for
15 the use of Oxycodone and/or for the increases in dosages.

16 d. Respondent did not document a treatment plan and objectives of the treatment in
17 the patient's chart. There is no documentation that Respondent participated in any clinical
18 decision-making regarding the patient's treatment.

19 e. Respondent did not document a discussion with the patient about the risks and
20 benefits of chronic opioid medications until about eight months after he had begun
21 prescribing opioids on a monthly basis.

22 f. Respondent failed to document performing a periodic review of the treatment
23 including, but not limited to, the patient's progress toward treatment objectives and the
24 patient's response to treatment, the appropriateness of continuing the current treatment
25 plan, and consideration of using other therapeutic modalities and/or other alternative
26 treatments. During the course of treatment, patient CC had ongoing foot and back pain
27 which Respondent failed to properly assess.
28

1 g. Respondent failed to delineate a diagnosis for this patient and failed to consult
2 with or refer the patient to appropriate specialists. Respondent failed to consult with and/or
3 to coordinate care with the patient's podiatric surgeon.

4 h. Respondent failed to independently assess the patient's need for treatment and to
5 document his findings in the patient's chart.

6 i. Respondent excessively prescribed controlled substances without documenting an
7 appropriate medical indication.

8 j. Respondent's medical records were inadequate.

9
10 **THIRD CAUSE FOR DISCIPLINE**

11 (Unprofessional Conduct re Patient NS: Gross Negligence/Incompetence/Negligent
12 Acts/Excessive Prescribing/Prescribing Without an Appropriate Medical Examination/Indication)

13 56. Respondent is subject to disciplinary action for unprofessional conduct under sections
14 2234 (b) and/or (d) and/or section 2242 and/or section 725 of the Code, regarding his treatment of
15 patient NS, as described herein below.

16 57. Paragraphs 26, 27 and 28 are incorporated herein by reference, as if fully set forth.

17 58. Patient NS was a patient of Dr. Hill since September 2008 and had a history of
18 endometriosis with multiple laparoscopic interventions. Prior to Respondent's involvement with
19 patient NS's treatment, Dr. Hill diagnosed low back pain or chronic soft tissue pain in patient NS
20 without documenting adequate findings to support the diagnosis and without performing a
21 complete history and physical examination.

22 59. At the time Respondent first became involved with the care of patient NS, on or about
23 October 30, 2010, patient NS was being prescribed monthly by Dr. Hill: #200 Norco, #200
24 Oxycodone 30 mg., and #90 Ativan. According to Dr. Hill's typed chart note for October 30,
25 2010, which was a Saturday, he saw patient NS for "chronic back and diffuse soft tissue pain."
26 Dr. Hill documented prescriptions for #200 Oxycodone 30 mg., #200 Norco, and #90 Ativan,
27 without documenting a medical indication for the prescribing. The only indication that
28 Respondent was involved in this visit is his undated signature in the chart next to the typed note

1 of the oxycodone prescription. There is no indication that Respondent saw the patient during this
2 visit. Respondent did not provide his own independent assessment of the patient's clinical status
3 and did not document obtaining informed consent for the use of oxycodone.

4 60. On or about November 23, 2010, which was a Tuesday, Dr. Hill saw patient NS and
5 typed the chart note which included a prescription for #200 Oxycodone 30 mg. "discussed with
6 Dr. Martin." The patient also filled a prescription for #200 Norco. Respondent's initials appear
7 on the chart without a date but there is no documentation that Respondent saw the patient and/or
8 conducted an examination of the patient. Again, Respondent did not provide his own
9 independent assessment of the patient's clinical status and did not document obtaining informed
10 consent for the use of oxycodone.

11 61. On or about December 16, 2010, which was a Thursday, Dr. Hill saw patient NS and
12 typed the chart note which included a new "trial" prescription for #30 Subutex 8 mg. and a
13 prescription for #200 Oxycodone 30 mg. There are no documented medical indications for the
14 prescribing. Respondent's initials are undated on the chart and there is no indication that
15 Respondent saw the patient.

16 62. Between December 23, 2010 and on or about January 20, 2011, patient NS received
17 from Dr. Hill #250 Norco, #30 Subutex, and #30 Lorazepam.

18 63. On or about February 18, 2011, which was a Friday, Dr. Hill saw patient NS and
19 handwrote the chart note which included a prescription for #60 Oxycodone, along with #150
20 Norco with a refill and #45 Subutex. Respondent prescribed the oxycodone although he did not
21 see the patient on this date.

22 64. On or about March 14, 2011, which was a Monday, Dr. Hill saw patient NS and typed
23 the chart note, which included a prescription for #45 Subutex, #150 Norco with a refill, and a
24 prescription for #60 Oxycodone 30 mg. "per Dr. Martin." Respondent's initials appear on the
25 chart without a date. Respondent, however, did not see the patient and/or conduct an examination
26 on that date. Respondent was the prescriber of the oxycodone.

27 65. It was not until April 13, 2011, which was a Wednesday, that Respondent
28 documented for the first time, albeit with a very brief note of "+/-", that he discussed the effects

1 of chronic oxycodone treatment with the patient. Respondent issued a prescription for #60
2 Oxycodone 30 mg. without documenting a medical indication.

3 66. From April 2011 through at least February 2012, Respondent continued to prescribe,
4 about every three to four weeks, #60 Oxycodone 30 mg. for patient NS, without documenting an
5 appropriate medical examination and without establishing a medical indication for the treatment.

6 67. On or about August 31, 2011, which was a Wednesday, Dr. Hill saw patient NS and
7 typed the chart note that included a note that the patient was not achieving adequate pain control.
8 Respondent doubled the prescription to #120 Oxycodone, which level he then continued to
9 prescribe for the next six months. Respondent's initials appear on the chart without a date. There
10 is no indication that Respondent saw the patient and conducted an appropriate examination.

11 68. On or about March 15, 2012, which was a Thursday, Dr. Hill saw patient NS and
12 typed the chart note, which included a prescription for #60 Oxycodone 30 mg. There is no
13 indication that Respondent saw the patient and conducted an appropriate examination on that
14 date. Respondent, however, was the prescriber of the oxycodone.

15 69. April 11, 2012 is the last documented visit of NS that the Medical Board obtained.
16 Dr. Hill saw the patient on that date and typed a chart note that included a prescription for #60
17 Oxycodone with a handwritten note changing the amount to #120. There is no indication that
18 Respondent saw the patient and conducted an appropriate examination on that date. Respondent
19 was the prescriber of #120 Oxycodone, 30 mg.

20 70. Respondent's overall care and treatment of patient NS constitutes unprofessional
21 conduct through gross negligence and/or incompetence and/or negligent acts and/or excessive
22 prescribing and prescribing without an appropriate medical examination and medical indication,
23 including but not limited to the following:

24 a. Respondent did not perform and document a complete history and physical
25 examination of patient NS that would support his prescriptions for chronic opioids
26 (Oxycodone.) There was no adequate documentation of an assessment of the patient's pain,
27 physical and psychological function, a substance abuse history, history of prior pain
28 treatment, and an assessment of underlying or co-existing diseases or conditions.

1 b. Respondent never entered a clinical note in the patient's chart during the entire
2 course of treatment. There is no documentation that Respondent participated in any clinical
3 decision-making. Respondent failed to independently examine and evaluate the patient.

4 c. Respondent did not document the presence of a recognized medical indication for
5 the use of Oxycodone and/or for the increases in dosages.

6 d. Respondent did not document a treatment plan and objectives of the treatment in
7 the patient's chart. There is no documentation that Respondent participated in any clinical
8 decision-making regarding the patient's treatment.

9 e. Respondent did not document a discussion with the patient about the risks and
10 benefits of chronic opioid medications until more than five months after he had begun to
11 prescribe Oxycodone on a monthly basis.

12 f. Respondent failed to document performing a periodic review of the treatment
13 including, but not limited to, the patient's progress toward treatment objectives and the
14 patient's response to treatment, the appropriateness of continuing the current treatment
15 plan, and consideration of using other therapeutic modalities and/or other alternative
16 treatments. During the course of treatment, patient NS had ongoing symptoms and
17 developed increased pelvic and low back pain which Respondent failed to properly assess.

18 g. Respondent failed to consult with or refer the patient to appropriate specialists
19 regarding his diagnoses and medical care. Respondent did not note whether the patient was
20 under the care of a gynecologist.

21 h. Respondent failed to independently assess the patient's need for treatment and to
22 document his findings in the patient's chart.

23 i. Respondent excessively prescribed controlled substances without documenting an
24 appropriate medical indication.

25 j. Respondent's medical records were inadequate.
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27
28

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient MM; Gross Negligence/Incompetence/Negligent Acts/Excessive Prescribing/Prescribing Without an Appropriate Medical Examination and Medical Indication)

71. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 (b) and/or (d) and/or section 2242 and/or section 725 of the Code, regarding his treatment of patient MM, as described herein below.

72. Paragraphs 26, 27 and 28 are incorporated herein by reference, as if fully set forth.

73. Patient MM was a patient of Dr. Hill since February 2006 and was seen for what Dr. Hill described as chronic back and neck pain. Dr. Hill never performed and documented a complete initial history and physical examination. Prior to Respondent's involvement with patient MM's treatment, Dr. Hill prescribed short-acting opioids, primarily Norco, on a generally monthly basis for about a four and a half year period. During the entire course of treatment, Dr. Hill never performed a more extensive evaluation than what was documented in the initial chart note.

74. At the time Respondent first became involved with the care of patient MM, on or about August 27, 2010, patient MM was being prescribed approximately #100 Norco monthly by Dr. Hill.

75. According to Dr. Hill's handwritten chart note, he saw patient MM on August 27, 2010, which was a Friday. Dr. Hill prescribed #100 Norco plus two refills for the month (for a total of #300 Norco) and documented an additional prescription for #100 Oxycodone 15 mg., without documenting a medical indication for the prescribing. Respondent's undated signature appears in the chart next to the note about the Oxycodone prescription. Respondent did not provide his own independent assessment of the patient's clinical status and did not document obtaining informed consent for the use of oxycodone.

76. On or about November 1, 2010, a Monday, patient MM saw Dr. Hill who documented in the patient's chart prescriptions for #30 Subutex 8 mg. and #100 Norco with one refill, without documenting a medical indication.

1 77. Two days later, on or about Wednesday, November 3, 2010, Dr. Hill typed a chart
2 note for another visit with patient MM that included documenting the issuance of an additional
3 prescription for #150 Oxycodone 30 mg., which is a Schedule II drug, "per Dr. Martin."
4 Respondent's initials appear on the chart but are undated. Respondent did not document an
5 appropriate examination of the patient. Respondent did not perform and document his own
6 independent assessment of the patient's clinical status and did not document obtaining informed
7 consent for the use of oxycodone. There is no documented medical indication for the Oxycodone
8 prescription, especially the increase in daily dosage.

9 78. ~~Patient MM continued to receive prescriptions for between #100 and #150~~
10 Oxycodone 30 mg tablets every 3-4 weeks from Respondent, in addition to as many as #300
11 tablets of Norco 10 mg. monthly along with Subutex and Xanax from Dr. Hill.

12 79. Patient MM visited Dr. Hill on March 5, 2011 and on March 22, 2011, which visits
13 were on Saturday and Tuesday, respectively. Dr. Hill's chart notes for these two visits include
14 the prescriptions that were issued, which included #150 Oxycodone. Although Respondent's
15 initials appear on the chart, they are undated and there is no documentation that Respondent saw
16 the patient on those dates. In March 2011, patient MM received #300 Oxycodone, #350 Norco,
17 #30 Buprenorphine, and #90 Lorazepam.

18 80. On or about February 8, 2012, a Tuesday, patient MM saw Dr. Hill who documented
19 that the patient reported that his function had increased. Dr. Hill typed the chart notes, including
20 documenting the prescriptions for #150 Oxycodone 30 mg, #100 Norco, #12 Xanax, and
21 testosterone IM. Although Respondent's initials appear next to the typed chart note for the
22 Oxycodone prescription, the initials are undated and there is no documentation that Respondent
23 saw the patient on this date. There is no documented medical indication established for
24 Respondent's prescribing.

25 81. Although Dr. Hill diagnosed patient MM with chronic back and neck pain, during the
26 approximately six years of treatment, there is no documentation of a thorough evaluation of the
27 etiology of the patient's chronic low back pain by either Dr. Hill or by Respondent.

28

1 82. Other than his undated signature and an occasional note of instructions for
2 Oxycodone use, Respondent made no notations in the patient's chart and it is not established that
3 Respondent saw the patient during each of the visits for which he documented issuing a
4 prescription for a Schedule II controlled substance.

5 83. It was not until April 13, 2011 that Respondent documented for the first time, albeit
6 with a very brief note of "+/-", that he discussed the effects of chronic oxycodone treatment with
7 the patient.

8 84. Respondent's overall care and treatment of patient MM constitutes unprofessional
9 conduct through gross negligence and/or incompetence and/or negligent acts and/or excessive
10 prescribing and prescribing without an appropriate medical examination and medical indication,
11 including but not limited to the following:

12 a. Respondent did not perform and document a complete history and physical
13 examination of patient MM that would support his prescriptions for chronic opioids
14 (Oxycodone.) There was no adequate documentation of an assessment of the patient's pain,
15 physical and psychological function, a substance abuse history, history of prior pain
16 treatment, and an assessment of underlying or co-existing diseases or conditions.

17 b. Respondent never entered a clinical note in the patient's chart during the entire
18 course of treatment. There is no documentation that Respondent participated in any clinical
19 decision-making. Respondent failed to independently examine and evaluate the patient.

20 c. Respondent did not document the presence of a recognized medical indication for
21 the use of Oxycodone and/or for the increases in dosages.

22 d. Respondent did not document a treatment plan and objectives of the treatment in
23 the patient's chart. There is no documentation that Respondent participated in any clinical
24 decision-making regarding the patient's treatment.

25 e. Respondent did not document a discussion with the patient about the risks and
26 benefits of chronic opioid medications until approximately eight months after he had begun
27 to prescribe Oxycodone on a monthly basis.

28

1 f. Respondent failed to document performing a periodic review of the treatment
2 including, but not limited to, the patient's progress toward treatment objectives and the
3 patient's response to treatment, the appropriateness of continuing the current treatment
4 plan, and consideration of using other therapeutic modalities and/or other alternative
5 treatments.

6 g. Respondent failed to consult with or refer the patient to appropriate specialists
7 regarding his diagnoses and medical care.

8 h. Respondent failed to independently assess the patient's need for treatment and to
9 document his findings in the patient's chart.

10 i. Respondent excessively prescribed controlled substances without documenting an
11 appropriate medical indication.

12 j. Respondent's medical records were inadequate.

13
14 **FIFTH CAUSE FOR DISCIPLINE**

15 (Unprofessional Conduct: Repeated Negligent Acts re Patients SB, CC, NS, and/or MM)

16 85. In the alternative, Respondent is subject to disciplinary action for unprofessional
17 conduct under section 2234 (c) for repeated negligent acts regarding his acts and omissions
18 regarding patient MM and/or patient NS and/or patient CC and/or patient SB. Paragraphs 26
19 through 84 are incorporated herein by reference, as if fully set forth.

20
21 **SIXTH CAUSE FOR DISCIPLINE**

22 (Unprofessional Conduct: Inadequate Record Keeping re Patients SB, CC, NS, and/or MM)

23 86. Respondent is subject to disciplinary action for unprofessional conduct under section
24 2234 through section 2266 for his failure to maintain adequate and accurate records relating to the
25 provision of services to his patients MM, NS, CC, and/or SB, jointly and severally.

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28 ///

1 PRAYER

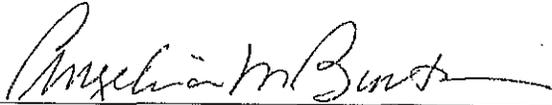
2 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
3 and that following the hearing the Osteopathic Medical Board of California issue a decision:

4 1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number
5 20A4909, issued to Timothy B. Martin, D.O.;

6 2. Ordering Timothy B. Martin, D.O. to pay the Osteopathic Medical Board of
7 California the reasonable costs of the investigation and enforcement of this case, pursuant to
8 Business and Professions Code section 125.3;

9 3. Taking such other and further action as deemed necessary and proper.

10
11 DATED: February 12, 2014


12 ANGELINA M. BURTON
13 Executive Director
14 Osteopathic Medical Board of California
15 Department of Consumer Affairs
16 State of California
17 Complainant

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

In the Matter of the Accusation Against:

TIMOTHY B. MARTIN, D.O.

Osteopathic Physician's and Surgeon's
Certificate No. 20A4909

Respondent.

Case No. 00-2011-003230

OAH No. 2014110125

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on February 23, 24 and 25, 2015, in Oakland, California.

Lynne K. Dombrowski, Deputy Attorney General, represented Complainant Angelina M. Burton, Executive Director of the Osteopathic Medical Board of California.

Steven B. Bassoff, Attorney at Law, represented Respondent Timothy B. Martin, D.O., who was present.

The record was left open at the parties' request to allow them to file written closing argument. The briefs were timely received and marked for identification as follows: Complainant's Closing Argument is Exhibit 24, Respondent's Closing Argument is Exhibit A, and Complainant's Reply Closing Argument is Exhibit 25.

The record closed on April 3, 2015.

FACTUAL FINDINGS

1. Complainant Angelina M. Burton issued the Second Amended Accusation in her official capacity as Executive Director of the Osteopathic Medical Board of California (Board).

2. On June 18, 1983, the Board issued Osteopathic Physician's and Surgeon's Certificate No. 20A4909 to Timothy B. Martin, D.O. (Respondent). Respondent's license will expire on May 31, 2015, unless renewed.

3. The standard of proof applied in making the Factual Findings in this matter is clear and convincing evidence to a reasonable certainty.

Prior license discipline

4. Effective October 4, 2000, the Board adopted a Stipulated Settlement and Disciplinary Order concerning Respondent's certificate. The Board revoked the certificate, but stayed the revocation and placed it on probation for three years pursuant to terms and conditions. Among other conditions, Respondent was required to complete the PACE Physician Prescribing course and 25 hours of continuing medical education (CME) courses in addition to the hours required for re-licensure.

5. The 2000 discipline was based on allegations that in his care of two patients, Respondent committed gross negligence, incompetence, and unprofessional conduct. Respondent was treating both patients for various pain conditions. For patient RJ, it was alleged that Respondent prescribed hundreds of narcotics and controlled substances each year for a 12-year period; that his examinations of RJ were identical each year; and that he failed to document RJ's vital signs and other important information in the medical record. For patient LJ, it was alleged that during a six-year treatment period, Respondent provided LJ with prescriptions for hundreds of narcotics and controlled substances each year; that the amounts were excessive for the pathologies noted in LJ's medical records; and that important information was not documented by Respondent in LJ's medical records.

6. Effective February 4, 2003, the Board issued a Decision granting Respondent's petition to terminate probation. The Board found the probation successfully completed and fully restored Respondent's license status.

7. Asked what he learned in the PACE course, Respondent noted that he took the course 15 years ago. Nonetheless, he recalls classes and lectures on evaluations, management, and documenting any evaluations or management of patients. In addition, he is "generally aware" of the proper procedures for prescribing and documentation from medical school and the CME courses he took each year. Overall, Respondent feels that his probationary term "made [him] a better physician."

Current accusation

8. In an Accusation signed February 12, 2014, Complainant alleges unprofessional conduct by Respondent in the medical care and treatment of four patients he treated for chronic pain, while working part-time in the office of Dickie Hill, D.O. The allegations include that he was grossly negligent and/or incompetent, and/or committed repeated negligent acts, by virtue of prescribing controlled substances and dangerous drugs

without appropriate prior examinations and medical indication. Complainant also charged Respondent with inadequate record keeping.

Relevant medications

9. The medications prescribed by Respondent during the time period addressed herein include the following controlled substances and/or dangerous drugs:

a. Ativan, a trade name for lorazepam, is a Schedule IV controlled substance as defined by Health and Safety Code section 11057 and section 1308.14 of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

b. Klonopin is a trade name for clonazepam and is an anticonvulsant of the benzodiazepine class of drugs. It is a Schedule IV controlled substance as defined by Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined by Business and Professions Code section 4022. Like other benzodiazepines, it can produce psychological and physical dependence.

c. Norco is a trade name for hydrocodone bitartrate with acetaminophen. Hydrocodone bitartrate is a semi-synthetic narcotic analgesic. It was a Schedule III controlled substance as defined by Health and Safety Code section 11056, subdivision (e), and section 1308.13(e) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022 at the time of the events herein. It is now a Schedule II controlled substance.

d. OxyContin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is derived from an opium alkaloid. OxyContin is a Schedule II controlled substance as defined by Health and Safety Code section 11055, subdivision (b)(1), and section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

e. Suboxone is a trade name for a combination of buprenorphine hydrochloride and naloxone hydrochloride. It is indicated for the treatment of opioid addiction. Buprenorphine is an opioid similar to morphine, codeine, and heroin. It is a Schedule V controlled substance under Health and Safety Code section 11058, subdivision (d), and a dangerous drug as defined in Business and Professions Code section 4022. Buprenorphine is used for maintenance during or after opiate withdrawal. It can cause drug dependence of the morphine type. Under the Drug Addiction Treatment Act, codified at 21 U.S. C. section 823(g), prescription use of Suboxone in the treatment of opioid dependence is limited to physicians who meet certain qualifying requirements and have notified the Secretary of Health and Human Services of their intent to prescribe the product for the treatment of opioid dependence and have been assigned a unique treatment number that must be included on every prescription. This "DATA Waiver" allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule

III, IV, or V narcotic medications specifically approved by the U.S. Food and Drug Administration.

f. Subutex is also a trade name for buprenorphine hydrochloride. Subutex is approved for use in medication-assisted opioid addiction therapy, but unlike Suboxone, it is not combined with naloxone to block the effects of opioids. It is primarily used for its long-term opioid effects in aiding opioid withdrawal.

g. Xanax is a trade name for alprazolam tablets. Alprazolam is a psychotropic triazolo analogue of the benzodiazepine class of central nervous system-active compounds. It is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d), and section 1308.14(c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022.

*Respondent's education and background*¹

10. Respondent graduated from the Oklahoma College of Osteopathic Medicine and Surgery in 1982. He completed his internship at Humana Hospital of South Broward in Florida. Respondent is board certified in family practice, and was re-certified in 2008.

In 1984, Respondent moved to California and established a private solo practice in San Rafael. He began working on an intermittent basis for the California Department of Corrections (CDC) at San Quentin State Prison in approximately 2004, and subsequently took a full-time position with the CDC. In 2009, Respondent retired from that position, and in the same year began working part-time for IMD, an industrial medicine clinic in Burlingame. He also worked part-time for "Quick Health," which he described as a "doc-in-the-box" operation, from approximately 2007 to 2009.

11. In addition to his work with Dr. Hill as described below, Respondent continues to work for IMD, and also works occasionally for Hilltop Imaging. Both of these positions are generally one day each week. His address of record with the Board is Dr. Hill's business address.

Respondent's practice with Dr. Hill

12. In a decision effective September 30, 2010, the Board took action against the certificate of Dickie Lynn Hill, D.O. It found cause for discipline for gross negligence in the care and treatment of three patients; inadequate record keeping (including that Dr. Hill's records were "illegible, incomplete, inaccurate, incomprehensible and inadequate"); prescribing without prior examination and medical indication; repeated acts of excessive prescribing; and incompetence. In addition, Dr. Hill was disciplined for dishonest acts and false statements in conjunction with his completion of Department of Motor Vehicle forms for patients.

¹ Respondent did not submit a resume or CV in evidence. The information about his education and background are taken solely from his Board interview and testimony.

13. Respondent testified that he did not read the Board's decision that resulted in Dr. Hill's current probationary status. He testified at Dr. Hill's hearing, but cannot recall if it was as an expert. He does not recall reviewing any medical records. Respondent only knew that Dr. Hill was on probation and that he was not permitted to write prescriptions for Schedule II controlled substances. The only other factual finding he was aware of was that there was not adequate documentation to support the prescribing. He was not aware of the factual finding of excessive prescribing of controlled substances.

14. Respondent has known Dr. Hill since high school; Dr. Hill was a senior when Respondent was a sophomore. They met again when they attended osteopathic medical school at the same time, and both relocated to the same area of northern California to practice medicine. They would cover each other's practices when the need arose; Respondent described the relationship as "like a friendly partnership."

15. Respondent decided to help Dr. Hill care for his continuing chronic pain patients who had been receiving prescriptions for Schedule II controlled substances. He decided to do so "because there were patients to be seen and treated and there was no other option." He was concerned that the patients receive "continuity of care." Respondent was not paid for his service; he worked out of friendship and in light of Dr. Hill's financial struggles.

Respondent estimated that this arrangement began in October 2010. At first, the schedule was more random, but they eventually decided to jointly see the patients who needed controlled substances on Wednesday mornings. In his interview with the Board (August 1, 2012), Respondent stated that he only saw patients in Dr. Hill's office on Wednesdays. At hearing, he testified that he saw patients on other days as well, but his testimony on this point was vague.

16. Respondent testified that "the great majority of the time" the two physicians would see the patients together for the entirety of the patient visit. He also stated that they saw the patients "in tandem" and that this occurred 98 to 99 percent of the time. Respondent reports that Dr. Hill was the scribe for the visit, typing the notes in the patient's medical record. Occasionally, Respondent would write an entire chart note, but would generally only initial the note. His initials meant that he was present or that he had prescribed a controlled substance for the patient.

Board investigation

17. The Board initiated an investigation with a referral to the Department of Consumer Affairs Health Quality Investigative Unit. Investigator Craig Leader was assigned to the case, and obtained information, including CURES² Doctor's Prescribing History reports

² CURES is an acronym for Controlled Substance Utilization Review and Evaluation System. It is a database administered by the California Department of Justice that compiles information concerning the prescribing and dispensing of Schedule II through IV controlled substances.

concerning Respondent. Leader subsequently collected information that included certain medical records for the four patients discussed in the Accusation, and CURES Patient Prescription Profile reports and prescriptions from various pharmacies.

Expert opinion evidence

- KENNETH HAN, D.O.

18. Kenneth Han, D.O., has been licensed as an osteopathic physician since 1999. He is currently the Chief Physician at University of California at Riverside, Campus Health, and is an Assistant Professor at the UC Riverside School of Medicine. He also "carries a full patient load." Since 2012, he has served as the Medical Director of the Veterans Administration Hospital, Long Beach Whittier Branch. Dr. Han is board certified in internal medicine. He received his osteopathic medical degree from the Philadelphia College of Osteopathic Medicine.

19. Dr. Han authored a report to the Board dated October 8, 2012, concerning his review of Respondent's care of the four patients. He also testified at hearing. In addition to his knowledge and experience, Dr. Han's opinions are based upon his review of medical records and related CURES reports and prescriptions, and the transcript of Respondent's Board interview.

20. Dr. Han's overall opinion, based on his expertise and the material he reviewed, is contained in his report:

[Respondent] did not thoroughly evaluate the etiology for chronic low back pain. Opioids, including Norco and oxycontin regimen [were] not supported by documentation (often illegible) provided. Dr. Hill ordered and managed Schedule II medications that were written by [Respondent]. Risks of medications regarding interactions with benzodiazepine and opioids were not documented Treatment goals and objectives were not clearly reassessed after titration of opioid medications. Consultations to pain management and psychiatry were not completed. Periodic review was not performed. And patient records were illegible, difficult to follow, and not in chronological order. . . .

21. Dr. Han's report and testimony revealed that he thoroughly reviewed the materials provided and analyzed the facts in conjunction with the standard of care of osteopathic physicians in the care of patients who complain of pain. His opinions were clear, factually based, and ultimately persuasive. His opinions identified acts or omissions as constituting negligence or gross negligence; that is, as simple or extreme departures from the standard of care, or incompetence, or violative of statutes. For all of these reasons, Dr. Han's opinions inform the factual findings concerning the care of the four patients.

- CHARLES S. SZABO, M.D., Ph.D.

22. Charles S. Szabo, M.D., Ph.D., is board certified in anesthesiology (1986) and pain medicine (1994). Since 1993, he has practiced pain management in San Francisco, and currently sees patients two days a week. Since 2008, he has conducted utilization reviews in workers' compensation matters. In that position, he has reviewed over 1,000 cases per year, and sees many different types of treatment and approaches to pain medicine and care. Dr. Szabo has also reviewed cases for the Board, and the Medical Board, since 1989. He received his medical degree from the University of California, San Francisco, in 1980, and completed a residency in anesthesiology at the same institution in 1984.

23. Dr. Szabo reviewed Respondent's care of all four patients. He reviewed their medical records and their CURES reports for two years, beginning in September 2010; the complaint from the Board; Respondent's CV; and the transcript of Respondent's Board interview. Dr. Szabo authored a written report dated November 27, 2012, and testified at hearing.

24. In his review, Dr. Szabo evaluated the care provided the four patients in the context of the guidelines issued in 2003 by the Medical Board for prescribing controlled substances for chronic pain conditions. The guidelines are consistent with the standard of care, which is the same for osteopathic physicians. Dr. Szabo's written report evaluates each patient consistently with each category of the guidelines: medical history and physical examination; treatment plan objectives; informed consent; periodic review; consultation; maintenance of medical records; compliance with controlled substances laws and regulations; excessive prescribing (Bus. & Prof. Code, § 725); and prescribing without medical indication (Bus. & Prof. Code, § 2242).

Dr. Szabo is an expert in the treatment of chronic pain and his opinions were very persuasive. His explanations of his opinions, in his report and in his testimony, were exceptionally clear and convincing. For all of these reasons, Dr. Szabo's opinions significantly inform the factual findings of the standard of care for treating and prescribing for chronic pain patients, and as regards the care of the four patients.

Standard of care

25. When treating a patient who complains of pain, a medical history and physical examination must be completed. These tasks include assessing the patient's pain and physical and psychosocial functioning; obtaining a substance abuse history and history of prior treatment; and assessing underlying and coexistent diseases or conditions. The presence of a recognized medical indication for the use of a controlled substance must be documented.

The treatment plan should state objectives for evaluating the outcome of the plan, such as pain relief, improved physical and psychosocial functioning, and whether further diagnostic evaluations or treatments are planned. The physician should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a

rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

In the area of informed consent, the physician should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver, or guardian.

The physician 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 and modification of controlled substances for pain management therapy depends on the physician's evaluation of progress towards treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

The physician should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain management specialist. In addition, physicians should give special attention to those pain patients who are at risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation, and consultation with addiction medicine specialists and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

The standard of care requires the physician to keep accurate and complete records of his treatment, including of a patient's medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

26. Prescribing found to be excessive often involves prescribing controlled substances. An evaluation of excessive prescribing generally involves a consideration of the nature of the medical complaint, the amount, and the frequency. Excessive prescribing can be of a single type of drug, or several of a certain class (such as opioids), or prescribing a large amount of drugs without justification.

27. Prescribing without medical indication covers a situation where a physician simply prescribes a medication, usually a controlled substance, without an underlying pathology that indicates a need for the medication.

Findings on allegations concerning four patients

PATIENT SB

28. Patient SB had been a patient of Dr. Hill's since 2008, and was seen for upper back and right shoulder pain resulting from a motor vehicle accident in 2006. There is no

documentation in her chart of a history, physical examination, or diagnosis. On September 1, 2010, SB saw Dr. Hill and he prescribed #40 Xanax, #10 Norco, and #50 oxycodone 15 mg.

29. On Thursday, October 7, 2010, Dr. Hill saw SB and typed a chart note, which includes the statement that a new prescription for #20 Suboxone was "per [Respondent]." No medical indication for the medications is charted. Respondent's initials appear on the note.

30. On Monday, October 25, 2010, Respondent authorized SB's early refill request for Xanax, which was originally prescribed by Dr. Hill. Respondent admitted he did not see SB on that date, and there is no record of him seeing her previously. No examination or medical indication for the medication is documented.

31. On Thursday, December 23, 2010, Dr. Hill saw SB and wrote a chart note documenting prescriptions for #100 Norco plus one refill, #60 Xanax plus one refill, and a new prescription for oxycodone 15 mg. "per [Respondent]." Respondent's initials appear on the note. There is no documentation of a medical indication for the oxycodone, or that Respondent examined or even saw SB that day.

Dr. Hill wrote everything but the signature on Respondent's prescription form, including the date. It bears Respondent's signature.

32. From January 18, 2011 through May 6, 2011, Dr. Hill saw SB for five monthly visits, all on days other than Wednesday. He prescribed approximately #200 Norco and #120 Xanax per month. There is no documentation that Respondent saw and examined SB, and yet he continued to prescribe #50 oxycodone 15 mg. per month. He did not document a medical indication for the medications.

There is no chart note documenting a prescription dated Thursday, February 24, 2011, issued to SB for #50 oxycodone 15 mg. It is written on Respondent's pad. Other than Respondent's signature, all of the handwriting is Dr. Hill's.

33. The chart note on May 19, 2011, is the only note written by Respondent in SB's chart, and it is not completely legible. He included the notation "+/-" (the plus-minus note), which he asserts documents that he discussed the risks and benefits of the medication with the patient. His note does not document an examination or a medical indication for a prescription of #50 oxycodone 15 mg. The twelve lines of mostly illegible handwriting and, on other days, the occasional note concerning medication instructions, are the only notations in the chart by Respondent, save his initials.

34. From June 8, 2011 through March 28, 2012, Dr. Hill continued to see SB approximately every Wednesday. Dr. Hill prescribed #200 Norco and #120 Xanax, and Respondent prescribed #50 oxycodone 15 mg. While Dr. Hill made chart notes for the visits, there was no medical indication for the prescribing of the medications, separately or in combination.

35. Respondent testified that SB was suffering from a “multiplicity of problems,” including chronic back and shoulder pain from a motor vehicle accident and a fall. He asserts that he performed a physical examination, discussed that he was there to provide continuity of care, discussed treatment plans and objectives, and reviewed the plan at each visit. The positive and negative effects of narcotics were discussed, including constipation and diarrhea. He prescribed Suboxone to see if it would be adequate to control SB’s pain and to prevent withdrawal symptoms from a previous narcotic. It was not completely successful, so he began prescribing oxycodone, which SB reported was helpful.

36. Respondent testified that his initials on a chart note mean that he was the prescribing physician. Asked whether his initials meant that he was physically present, Respondent testified that he could not recall; then subsequently testified that sometimes his initials were on a note when he was not present. He therefore could not state whether he was present for SB’s visit on Thursday, October 7, 2010.

37. When asked why Dr. Hill filled out Respondent’s prescriptions, Respondent testified that it was because they were seeing the patients together, and he did not think it was “a violation to do it that way.” He denied ever signing a prescription in advance for Dr. Hill to complete.

38. Respondent’s testimony in this respect was not credible. It is not reasonable to believe that he would see a patient, examine him or her, and engage in extensive discussions but make no chart note. If Dr. Hill was indeed acting as scribe, it is not reasonable to believe that Dr. Hill would not enter such notes. Respondent’s explanation of why Dr. Hill would fill out all of the information on one of Respondent’s prescription forms is likewise not reasonable or persuasive.

39. Respondent’s care and treatment of Patient SB constituted unprofessional conduct in the following respects.

a. Respondent did not perform and document a complete history and physical examination that supported his prescriptions for controlled substances. There was not an adequate documentation of an assessment of SB’s pain, physical and psychological function, a substance abuse history, history of prior pain treatment, and an assessment of underlying or co-existing diseases or conditions. No diagnosis was made as regards SB’s pain symptoms. This was an extreme departure from the standard of care and gross negligence.

b. Respondent did not document any clinical decision-making regarding SB’s treatment; he did not reveal a treatment plan or identify objectives for evaluating a treatment plan. He failed to independently examine and evaluate SB. Oxycodone was prescribed without indication or rationale for the prescription. No rationale was provided for the switch from Suboxone to oxycodone, or for providing two short-acting medications (#200 Norco from Dr. Hill and #50 oxycodone from Respondent). Respondent wrote prescriptions for SB for approximately seven months without any evidence in the chart that he saw SB. This was an extreme departure from the standard of care and gross negligence.

c. Respondent did not document a discussion with SB about the risks and benefits of chronic opioid medications (even by his plus-minus note) until about seven months after he had begun prescribing opioids on a monthly basis. Prior to this, there was no note that he had discussed the use of Norco and oxycodone with SB. This was a simple departure from the standard of care and negligence.

d. Respondent failed to document performing a periodic review of the treatment including an assessment of the etiology of SB's back pain, ordering imaging studies, SB's progress toward treatment objectives and SB's response to treatment, the appropriateness of continuing the current treatment plan, and consideration of the use of other treatment modalities. This was an extreme departure from the standard of care and gross negligence.

e. Respondent failed to discuss or to refer SB for outside consultation, or to review any outside medical records, despite the claim of persistent back pain and prescribing large doses of opioids. Respondent failed to delineate a diagnosis for SB and failed to consult with or refer SB to appropriate specialists. This was a simple departure from the standard of care and negligence.

f. SB's medical records were inadequate. There is no indication that Respondent independently assessed SB's need for treatment, made a diagnosis, or documented his findings in SB's chart. As more fully described above, Respondent failed to maintain the required medical records for the treatment of SB. This was an extreme departure from the standard of care and gross negligence.

g. Respondent provided Suboxone to SB, and then #50 oxycodone 50 mg. monthly. A diagnosis was never provided other than back pain secondary to a motor vehicle accident, and there was no physical examination consistent with SB's complaints. No workup was ever undertaken to validate SB's complaints or determine the cause of her pain. For these reasons, it is determined that Respondent prescribed for SB without medical indication.

PATIENT CC

40. Patient CC began seeing Dr. Hill in 2004 for low back pain, foot pain, and mild anxiety. In 2010, Dr. Hill was prescribing #100 oxycodone 15 mg., #100 Norco 10/325, and #72 Klonopin to CC on a monthly basis.

41. On October 5, 2010, Dr. Hill saw CC for an osteopathic manipulation for chronic back pain. He documented prescribing Norco "per [Respondent]." Dr. Hill noted that on Thursday, October 7, 2010, he discussed a prescription for #60 Norco with one refill with Respondent. Respondent initialed the chart, but there is no indication that Respondent saw CC or did an independent assessment.

42. On Thursday, December 9, 2010, Dr. Hill saw CC and handwrote a chart note that included prescriptions for #100 Norco, #24 Klonopin, and #100 oxycodone 15 mg.

Respondent's initials are next to the note, but there is no indication that Respondent saw CC. Dr. Hill wrote prescriptions for Norco and Klonopin on his own prescription pad, and wrote the prescription for oxycodone on Respondent's pad. Respondent's signature is on the oxycodone prescription.

43. On Friday, January 7, 2011, Dr. Hill saw CC and typed a chart note, including a prescription for #100 oxycodone 15 mg. Respondent's initials are on the chart, but there is no indication that Respondent saw CC. Dr. Hill wrote and dated a prescription for oxycodone on Respondent's pad and Respondent signed it.

44. CC's chart indicates that Dr. Hill saw her on a monthly basis for the next four months: Tuesday, February 15, 2011; Tuesday, March 15, 2011; Monday, April 11, 2011; and Friday, May 6, 2011. Dr. Hill noted the prescriptions to be issued, including the oxycodone, and Respondent's initials appear on each entry. There is no indication that Respondent saw or examined CC on any of these dates. In this regard, it is noted that he has stated that he was working in another office on Fridays during this time period.

45. On Wednesday, May 11, 2011, Dr. Hill made typewritten notes in CC's chart, and Respondent entered some mostly illegible handwritten notes. These included that CC had come in for oxycodone and said that it was useful for her pain. Respondent also entered the plus-minus note for the first time in CC's chart. He testified that this meant he discussed the effects of chronic oxycodone treatment with CC. Respondent issued a prescription for #100 oxycodone. He did not document an appropriate medical examination or a medical indication for the prescription. Respondent continued to prescribe oxycodone for CC for the next few months.

46. There are handwritten chart notes of a visit by CC on Wednesday, August 24, 2011. They appear to be a mixture of Dr. Hill's and Respondent's handwriting, including Respondent's initials at the bottom. On that date, CC's oxycodone prescription for #100 remained, but the dosage was doubled to 30 mg. tablets, as opposed to 15 mg. No medical indication for this increase was documented.

47. Between September 30, 2011, and approximately March 14, 2012, CC received prescriptions from Respondent for a total of #300 oxycodone 30 mg. At the same time, Dr. Hill issued prescriptions for #750 Norco and #96 Klonopin. Combining an opioid (oxycodone) and a benzodiazepine (Klonopin) is dangerous. Depending on the dosage and what else the patient is taking, the result can be respiratory depression or other serious medical conditions that can lead to death.

48. A CURES report shows that CC filled a prescription from Respondent for #100 oxycodone 30 mg. on March 14, 2012. A urine drug toxicology screen of CC dated the same date revealed no oxycodone, which had been prescribed for months, but was positive for methadone, which had not been prescribed. CC's chart does not reveal what action, if any, Respondent took following the receipt of the lab results.

The CURES report also shows that for an approximate five-month period in 2012, CC received the following prescriptions: #300 oxycodone 30 mg, prescribed by Respondent and #640 Norco 324/10 mg, and #144 Klonopin 0.5 mg, prescribed by Dr. Hill.

49. Respondent's care and treatment of Patient CC constituted unprofessional conduct in the following respects.

a. Respondent did not perform and document a complete history and physical examination that supported his prescriptions for controlled substances. There was not an adequate documentation of an assessment of CC's pain, physical and psychological function, a substance abuse history, history of prior pain treatment, and an assessment of underlying or co-existing diseases or conditions. No diagnosis was made as regards CC's pain symptoms. This was an extreme departure from the standard of care and gross negligence.

b. Respondent did not document any clinical decision-making regarding CC's treatment; he did not identify a treatment plan or identify objectives for evaluating a treatment plan. He failed to independently examine and evaluate CC. Oxycodone was prescribed without indication or rationale for the prescription. No rationale was provided for the increase in oxycodone dosage. This was an extreme departure from the standard of care and gross negligence.

c. Respondent did not document a discussion with CC about the risks and benefits of chronic opioid medications (even by his plus-minus note) until about eight months after he had begun prescribing opioids. This was a simple departure from the standard of care and negligence.

d. Respondent failed to document performing a periodic review of the treatment including an assessment of the etiology of CC's ongoing low back pain and foot pain, ordering imaging studies, CC's progress toward treatment objectives and CC's response to treatment, the appropriateness of continuing the current treatment plan, and consideration of the use of other treatment modalities. This was an extreme departure from the standard of care and gross negligence.

e. Respondent failed to discuss or to refer CC for outside consultation, or to review any outside medical records, despite prescribing large doses of opioids. Respondent failed to delineate a diagnosis for CC and failed to obtain imaging studies. This was a simple departure from the standard of care and negligence.

f. CC's medical records were inadequate. There is no indication that Respondent independently assessed CC's need for treatment, made a diagnosis, or documented his findings in CC's chart. As more fully described above, Respondent failed to maintain the required medical records for the treatment of CC. This was an extreme departure from the standard of care and gross negligence.

g. Respondent provided oxycodone to CC on almost a monthly basis. A valid diagnosis was never provided and there was no physical examination consistent with CC's complaints. No workup was ever undertaken to validate CC's complaints or determine the cause of her pain. For these reasons, it is determined that Respondent prescribed for CC without medical indication.

PATIENT NS

50. Patient NS had been a patient of Dr. Hill's since 2008. She had a history of endometriosis and had undergone multiple surgeries for this condition. Dr. Hill had previously noted low back pain and chronic soft tissue pain, although NS's medical record does not include documentation of a physical examination, history, or adequate findings to support a diagnosis. NS testified that she saw Dr. Hill for pain management due to stage four endometriosis, and that she had tried surgery, injections, and hormone treatments, but was still "trying to get some kind of relief."

51. NS testified that Respondent performed a physical examination, but the chart contains no note of such. Respondent's first appearance in the chart is his initials on notes of an office visit on Saturday, October 30, 2010. The initials appear next to the note that oxycodone was prescribed. Dr. Hill authored the note on that date, and filled out one of Respondent's prescription forms for #200 oxycodone 30 mg. The prescription bears Respondent's signature.

52. On Tuesday, November 23, 2010, Dr. Hill saw NS and typed a chart note, including a prescription for #200 oxycodone 30 mg. "discussed with [Respondent]." Dr. Hill filled out one of Respondent's prescription forms, and it bears Respondent's signature.

53. Between October 30 and November 23, 2010, according to CURES reports, NS received #400 oxycodone from Respondent, and #400 Norco and #90 lorazepam from Dr. Hill.

54. On Thursday, December 16, 2010, Dr. Hill saw NS and typed a chart note which included a new "trial" prescription for #30 Subutex 8 mg. and a prescription for #200 oxycodone 30 mg. Respondent's initials are on the note, but there is no indication that Respondent saw NS. Dr. Hill filled out one of Respondent's prescription forms, and it bears Respondent's signature. Subutex is used to ease withdrawal from opioids. There is no note as to why Subutex was prescribed.

55. On Friday, February 18, 2011, Dr. Hill saw NS and wrote a chart note which included a prescription for #60 oxycodone, #150 Norco with a refill, and #45 Subutex. The note bears Respondent's initials, but there is no indication that he signed it that day, and he has stated that he worked elsewhere on Fridays.

56. A prescription dated Thursday, February 24, 2011, written on one of Respondent's prescription forms, was issued to NS for #60 oxycodone. Respondent testified that the prescription bears his signature, with the balance of the information filled out by Dr. Hill. Respondent did not explain why there is not a corresponding chart note for this

prescription, nor did he otherwise explain its issuance. He stated that he did not “have anything to show I was present that date.”

57. On Monday, March 14, 2011, Dr. Hill saw NS and typed a chart note, including a prescription for #45 Subutex, #150 Norco with a refill, and a prescription for #60 oxycodone “per [Respondent].” Respondent’s initials appear on the chart without a date. There is no other indication that Respondent saw NS on that date. Dr. Hill wrote and dated the prescription for oxycodone on one of Respondent’s forms and it bears Respondent’s signature.

58. On Wednesday, April 13, 2011, Respondent for the first time placed in the chart note his plus-minus notation, indicating he discussed the pros and cons of the medication with NS. He issued a prescription for #60 oxycodone 30 mg. without documenting a medical indication for the prescription. Respondent continued to issue the same prescription to NS every three to four weeks, until at least February 2012. No medical indication for these prescriptions was noted in NS’s chart.

59. On Wednesday, August 31, 2011, Dr. Hill saw NS and typed a chart note, including that NS was “not doing well-less than adequate pain control with only” oxycodone, and that she feels she needs four oxycodone per day coupled with four to six Norco per day. He also noted that she had no new complaints, but that her husband was in the hospital for a heart condition and that life had been more stressful. Respondent issued a prescription for #120 oxycodone, double the previous amount, and continued this prescribing for six months. His undated initials appear on the chart, with no indication that he saw NS or conducted an examination. There is no indication that anything else was suggested or tried for NS’s complaints of stress.

60. On Wednesday, March 14, 2012, Respondent wrote a prescription for #60 oxycodone 30 mg. for NS, but she was not seen that day. Dr. Hill saw NS the following day, March 15. He typed a chart note, including the prescription Respondent wrote the previous day.

Respondent testified that it was possible that he wrote the prescription without seeing NS. His initials appear on the March 15 chart note.

61. On Wednesday, April 11, 2012, Dr. Hill saw NS and typed a chart note that included a prescription for #60 oxycodone with a handwritten note changing the amount to #120. A CURES report states that NS filled a prescription by Respondent for #120 oxycodone 30 mg. on April 11, 2012.

62. NS testified that she stopped seeing Respondent about two years ago, but still sees Dr. Hill. She no longer takes oxycodone. She has been seeing some “alternative practitioners,” and she is trying to take as little medication as possible. NS also said that she does not know if she was ever told why Dr. Hill did not prescribe controlled substances. He was treating her for the disorders that she had, including endometriosis.

63. Respondent's care and treatment of Patient NS constituted unprofessional conduct in the following respects.

a. Respondent did not perform and document a complete history and physical examination that supported his prescriptions for controlled substances. There was not an adequate documentation of an assessment of NS's pain, physical and psychological function, a substance abuse history, history of prior pain treatment, and an assessment of underlying or co-existing diseases or conditions. No diagnosis was made as regards NS's pain symptoms. This was an extreme departure from the standard of care and gross negligence.

b. Respondent did not document any clinical decision-making regarding NS's treatment; he did not reveal a treatment plan or identify objectives for evaluating a treatment plan. He failed to independently examine and evaluate NS. His note in the chart on May 11, 2011, where he stated the physical exam was consistent with previous exams, and the oxycodone was useful, did not meet the standard of care. Oxycodone was prescribed without indication or rationale for the prescription. No rationale was provided for increasing oxycodone dosage. Dr. Hill provided Subutex and Norco, and there was no rationale provided for the use of three opioid analgesics. This was an extreme departure from the standard of care and gross negligence.

c. Respondent did not document a discussion with NS about the risks and benefits of chronic opioid medications (even by his plus-minus note) until about six months after he had begun prescribing opioids. In addition, NS was receiving a potentially dangerous mix of medications. This was a simple departure from the standard of care and negligence.

d. Respondent wrote one chart note during the 18 months of treatment, and added to some of Dr. Hill's notes. But he failed to document performing a periodic review of the treatment. Over the last year of treatment, dosages were changed and Subutex was added without any rationale provided. No review of the treatment was documented. This was an extreme departure from the standard of care and gross negligence.

e. Respondent failed to discuss or to refer NS for outside consultation, or to review any outside medical records, despite prescribing large doses of opioids. Although endometriosis is stated to be NS's diagnosis, reason for pain, and for seeking treatment, the medical record contains no indication that she is under the care of a gynecologist. No imaging studies are mentioned. In addition, no alternative treatments were discussed, such as physical therapy, use of other medications, massage, therapeutic exercise or acupuncture. Despite the prescription for Subutex, no pain management specialist or addiction medicine specialist was consulted. This was a simple departure from the standard of care and negligence.

f. NS's medical records were inadequate. There is no indication that Respondent independently assessed NS's need for treatment, made a diagnosis, or documented his findings in NS's chart, except for the cursory notes described previously. As more fully described above, Respondent failed to maintain the required medical records for the treatment of NS. This was an extreme departure from the standard of care and gross negligence.

g. Respondent provided oxycodone to NS continuously for 18 months, including increasing the dosage. On one occasion, it appears he did so following her request to Dr. Hill for a double amount, in part due to stress. He provided no history and physical examination consistent with NS's complaints of pain. He did not establish a recognized diagnosis warranting continuous treatment with opioids. For these reasons, it is determined that Respondent prescribed for NS without medical indication.

PATIENT MM

64. Patient MM began seeing Dr. Hill in 2006 for what Dr. Hill described as chronic back and neck pain. Dr. Hill never sought an etiology for the pain, or actually diagnosed MM. He prescribed short-acting opioids, primarily #100 Norco, approximately monthly, for about four and one-half years.

65. Dr. Hill's prescribing restrictions became effective on September 30, 2010. He saw MM on August 27, 2010, and issued a prescription for #100 oxycodone 15 mg. Respondent first testified that he first saw MM on that same date, but subsequently testified that he had been in error. Respondent's initials and a note appear on the MM's chart on August 27, but Respondent was not involved with Dr. Hill's practice or with MM at that time. It is reasonable to infer that Respondent added his initials and a note to the chart on a later date, despite not having seen or been involved with MM's treatment in August 2010.

66. Respondent next appears involved in MM's care as of Wednesday, November 3, 2010. A chart note typed by Dr. Hill documents prescriptions for continued Subutex and #50 oxycodone 30 mg. "per [Respondent]." Respondent's initials are on the note. There is no documentation in the chart that Respondent examined MM, performed his own independent assessment of his status, or obtained informed consent for oxycodone.

67. MM testified at hearing that he was examined by Respondent, and that they talked. He understood that this was because Dr. Hill "could no longer prescribe the medications." MM explained that he had chronic pain that made it difficult to work as a plumber. Respondent gave him an adjustment and checked his blood pressure and reflexes. Dr. Hill was also present.

As regards the oxycodone, Respondent explained to MM that it was a short or fast acting medication, and that he should break it in half and take one-half "later." He does not recall if Respondent discussed the positives and negatives of the medication. MM denied seeing Dr. Hill and Respondent for the purpose of obtaining oxycodone. He stated that he has not obtained a prescription for pain "in a little while." MM estimates he received an oxycodone prescription from Respondent about one and one-half months ago, and a prescription for Norco from Dr. Hill about six months ago.

68. On November 17, 2010, Dr. Hill saw MM and typed a chart note documenting the issuance of a prescription for #150 oxycodone 30 mg. "per [Respondent]." Respondent's

initials are on the note. The prescription represents a tripled daily dose of oxycodone, only two weeks after MM's initial visit with Respondent. There is no medical indication noted for the prescription, including for the increase in dosage. Respondent testified that he filled out all of the information on this prescription form.

69. Respondent's prescribing for MM continued every three to four weeks. He prescribed between #100 and #150 oxycodone 30 mg. tablets. During this time, MM was also receiving #300 Norco 10 mg., Subutex, and Xanax from Dr. Hill. No medical indication for any of these medications was documented.

70. Dr. Hill saw MM on Saturday, March 5 and Tuesday, March 22, 2011. Respondent's initials are on the chart notes, but there is no further indication that Respondent saw MM on those dates. Dr. Hill noted prescriptions of #150 oxycodone for each visit. In summary, in March 2011, MM received #300 oxycodone, #350 Norco, #30 Buprenorphine, and #90 Lorazepam. There was no medical indication for these medications documented, whether separately or in combination.

71. On a visit April 13, 2011, Respondent placed his plus-minus note on MM's chart note, indicating that he discussed oxycodone with MM. This notation also appears on subsequent chart notes.

72. On Wednesday, February 8, 2012, MM saw Dr. Hill, who typed a chart note. Dr. Hill documented prescriptions for #150 oxycodone 30 mg., #100 Norco, #12 Xanax, and testosterone IM. Respondent's undated initials appear next to the oxycodone prescription note. There is no medical indication identified for the prescription.

73. Notwithstanding the testimony of MM of a type of physical examination by Respondent, the evidence did not establish that Respondent performed a history and physical sufficient to determine the etiology of MM's pain complaints or to support treatment with opioids for an extended period of time. To the contrary, Respondent's treatment of MM was without medical indication for the prescription of controlled substances.

74. Respondent's care and treatment of Patient MM constituted unprofessional conduct in the following respects.

a. Respondent did not perform and document a complete history and physical examination that supported his prescriptions for controlled substances. There was not an adequate documentation of an assessment of MM's pain, physical and psychological function, a substance abuse history, history of prior pain treatment, and an assessment of underlying or co-existing diseases or conditions. No diagnosis was made as regards MM's pain symptoms. No clinical note of any kind was entered into MM's chart. This was an extreme departure from the standard of care and gross negligence.

b. Respondent did not document any clinical decision-making regarding MM's treatment; he did not reveal a treatment plan or identify objectives for evaluating a treatment

plan. Oxycodone was prescribed without indication or rationale for the prescription. No rationale was provided for increasing oxycodone dosage. This was an extreme departure from the standard of care and gross negligence.

c. Respondent did not document a discussion with MM about the risks and benefits of chronic opioid medications (even by his plus-minus note) until about five months after he began prescribing opioids. This was a simple departure from the standard of care and negligence.

d. No review of the treatment was documented. Respondent provided no notations other than an as-needed instruction for using oxycodone, despite the variance in amounts from 100 to 150 per month and Dr. Hill's prescriptions for Norco and Subutex. This was an extreme departure from the standard of care and gross negligence.

e. Respondent failed to discuss or to refer MM for outside consultation, or to review any outside medical records, despite prescribing large doses of opioids. Despite the complaint of ongoing lower back pain treated with opioids, MM was not referred for studies, spinal injections, physical therapy, massage or any other treatment. There was no actual diagnosis, and no effort was apparently made to make a diagnosis. Despite the prescription of approximately 400 opioid medications per month, no pain management specialist or addiction medicine specialist was consulted. This was a simple departure from the standard of care and negligence.

f. MM's medical records were inadequate. There is no record of Respondent's care of MM except of the oxycodone prescriptions he provided. There was no indication that Respondent independently assessed MM's need for treatment, made a diagnosis, or documented his findings in MM's chart. As more fully described above, Respondent failed to maintain the required medical records for the treatment of MM. This was an extreme departure from the standard of care and gross negligence.

g. Respondent provided #150 oxycodone 30 mg. each month to MM, who he knew to be receiving 300 Norco from Dr. Hill. In March 2011, MM received 300 oxycodone from Respondent and 350 Norco and 30 buprenorphine tabs from Dr. Hill. Respondent did not establish a recognized diagnosis warranting continuous treatment with opioids. For these reasons, it is determined that Respondent prescribed for MM without medical indication.

Cost Recovery

75. The Board has incurred the following costs in connection with the investigation and enforcement of this case:

Board Investigative Services

<u>Year</u>	<u>Hours</u>	<u>Hourly Rate</u>	<u>Charges</u>
July 2011	7.25	\$125	\$ 906.25
July-Nov 2012	8.75	125	1,093.75
Dec 2012-Feb 2013	7.50	117	877.50
Total: \$2,877.50			

An additional 25.5 hours at \$150 per hour, were spent by medical experts for reviewing and evaluating case-related materials, report writing, hearing preparation and examinations, for a total expenditure of \$3,825. There was also a transcription cost of \$52.25.

The Board's investigative costs total \$6,754.75.

76. The Department of Justice has billed the Board \$46,745 for services rendered through February 13, 2015, by Deputy Attorney's General Brenda Reyes and Lynne Dombrowski and Senior Legal Analyst Catherine Santillan.

In addition, Ms. Dombrowski declared that additional hours "were or will be, incurred and billed" to the Board for work performed February 14 through 22, 2015, up until the commencement of the hearing. The estimate resulted in an additional amount of \$7,140. For reasons discussed below, the additional estimated amount is not accepted.

77. The amount of \$53,499.75 is found to represent the reasonable costs of investigation and enforcement.

LEGAL CONCLUSIONS

1. The Medical Practice Act applies to the Osteopathic Medical Board of California so far as it is consistent with the Osteopathic Act, pursuant to Business and Professions Code section 2452.

Causes for Discipline

2. Unprofessional conduct is grounds for discipline of an osteopathic physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes violating provisions of the Medical Practice Act (Bus. & Prof. Code, § 2234, subd.

(a)), gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), incompetence (Bus. & Prof. Code, § 2234, subd. (d)), and prescribing dangerous drugs without an appropriate prior examination and a medical indication (Bus. & Prof. Code, § 2242, subd. (a)). In addition, unprofessional conduct includes "Repeated acts of clearly excessive prescribing, furnishing, dispensing or administering of drugs . . ." (Bus. & Prof. Code, § 725, subd. (a)), and failing to maintain adequate records (Bus. & Prof. Code, § 2266).

GROSS NEGLIGENCE

3. The evidence established that Respondent committed gross negligence (Findings 39, 49, 63 and 74). Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b).

REPEATED NEGLIGENT ACTS

4. The evidence established that Respondent committed repeated negligent acts (Findings 39, 49, 63 and 74). Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c).

INCOMPETENCE

5. The evidence did not establish that Respondent lacked the knowledge or skill to treat the four patients in this matter according to the applicable standards of care; in other words, incompetence was not proven. Accordingly, no cause for license discipline exists pursuant to Business and Professions Code section 2234, subdivision (d).

UNLAWFUL PRESCRIBING

6. The evidence established that Respondent prescribed dangerous drugs without an appropriate prior examination and/or medical indication (Findings 39, 49, 63 and 74). Cause for license discipline for unprofessional conduct therefore exists pursuant to Business and Professions Code sections 2242, subdivision (a), and 2234, subdivision (a).

INADEQUATE RECORD KEEPING

7. The evidence established that Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients by failing to document a treatment plan for patients (Findings 39, 49, 63 and 74). Cause for license discipline for unprofessional conduct therefore exists pursuant to Business and Professions Code sections 2266, and 2234, subdivision (a).

COST RECOVERY

8. Business and Professions Code section 125.3 provides that a licensee may be ordered to pay the Board "a sum not to exceed the reasonable costs of the investigation and

enforcement of the case.” An agency that seeks to recover its costs must submit declarations “that contain specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs” (Cal. Code Regs., tit. 1, § 1042.) The declaration or billing records must “describe the general tasks performed, the time spent on each task and the hourly rate or other compensation for the service.” (Cal. Code Regs., tit. 1, § 1042, subd. (b).) In the instant case, counsel requests that an additional \$7,140 be awarded for costs based upon her good faith estimate. Such an estimate does not describe the tasks performed or the amount of time spent on each task, and it is not supported by itemized billing statements. It is, therefore, insufficient to establish the actual costs incurred and the reasonableness of the costs. Therefore, as stated in Finding 77, the sum of \$53,499.75 was established as the amount of the reasonable costs recoverable pursuant to Business and Professions Code section 125.3.

The case of *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 sets forth the factors to be considered in determining whether the cost award should be less than the actual, reasonable costs. The factors include whether the licensee has been successful at hearing in getting charges dismissed or reduced, the licensee’s subjective good faith belief in the merits of his or her position, whether the licensee has raised a colorable challenge to the proposed discipline, the financial ability of the licensee to pay, and whether the scope of the investigation was appropriate to the alleged misconduct. None of these factors were shown to significantly militate in Respondent’s favor. Respondent shall be required to reimburse the Board \$53,499.75 for its costs of investigation and enforcement.

Analysis

9. Cause for discipline having been established, it remains to determine the appropriate measure of discipline. In this regard, it is noted that the purpose of these proceedings is protection of the public, not punishment of the licensee. When possible, certificates should be placed on probation with conditions, such as completing educational courses, designed to enable rehabilitation and eventual reinstatement. Such a result is often appropriate the first time a physician is found in violation of the Act; however, in this instance Respondent completed a term of probation for license discipline that was grounded in similar controlled substance prescribing and medical record keeping issues. He completed a course in prescribing practices in conjunction with that probation order, and yet again committed serious violations in the same area.

In his practice at Dr. Hill’s office, Respondent evidenced a disregard for the laws surrounding the prescribing of controlled substances and dangerous drugs that puts patients and the public at risk. The conduct was particularly egregious given Respondent’s prior discipline for very similar conduct. The evidence established that Dr. Hill brought Respondent to his practice to write prescriptions for controlled substances. Respondent did not independently evaluate the patients, even though it was evident that they had not been evaluated or diagnosed by Dr. Hill. He initialed the charts, not always on the day the patient was seen, and in some instances without seeing the patient himself. Respondent provided his prescription pad to Dr. Hill, who would fill in all of the information, except the signature. The only explanation for this

procedure was that this was the way they did things, and Respondent was unaware that there was anything wrong with the procedure. It was not demonstrated that Dr. Hill and Respondent "practiced together," as described by Respondent. But even if they had, Respondent has an independent duty to examine and treat the patients he sees, and certainly those for whom he prescribes controlled substances. Respondent is correct in his argument that no patient harm was proven, but it is axiomatic that the Board is not required to wait until a physician actually harms a patient to take action against a physician's certificate. It is determined that public protection requires revocation of Respondent's certificate.

ORDER

1. Osteopathic Physician's and Surgeon's Certificate No. 20A4909, issued to Respondent Timothy B. Martin, D.O., is revoked.

2. Timothy B. Martin, D.O., is ordered to pay \$53,499.75 to the Osteopathic Medical Board of California for the costs of investigation and enforcement of this case.

DATED: April 9, 2015



MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings

FILED

APR 8 0 2015

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

In the Matter of the Accusation Against:

TIMOTHY B. MARTIN, D.O.

Osteopathic Physician's and Surgeon's
Certificate No. 20A4909

Respondent

Case No. 00-2011-003230

OAH No. 2014110125

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on 6/1/2015.

IT IS SO ORDERED 4/30/2015.

By: Joseph A. Zammuto
JOSEPH A. ZAMMUTO, D.O., PRESIDENT
FOR THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS