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

In the Matter of the First Amended Accusation  
Against:  

HOWARD P. LEVY, D.O.  
57370 29 Palms Highway, Suite 203  
Yucca Valley, CA 92284  
Osteopathic Physician’s and Surgeon’s Certificate  
No. 20A 4148  

Respondent.  

Complainant alleges:  

PARTIES  

1. Angelina M. Burton (Complainant) brings this First Amended Accusation solely in  
her official capacity as the Executive Director of the Osteopathic Medical Board of California  
(Board), Department of Consumer Affairs.  

2. On or about August 3, 1997, the Osteopathic Medical Board of California issued  
Osteopathic Physician’s and Surgeon’s Certificate Number 20A 4148 to Howard P. Levy, D.O.  
(Respondent). The Osteopathic Physician’s and Surgeon’s Certificate was in full force and effect  
at all times relevant to the charges brought herein and will expire on February 28, 2018, unless  
renewed.
JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following sections of the Osteopathic Act (Act)\(^1\) and of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3600 of the Code states that the law governing licentiatees of the Osteopathic Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine.

5. Section 3600-2 of the Code states:

("The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California, however, persons who elect to practice using the term or suffix ‘M.D.’ as provided in Section 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be subject to this section, and the Medical Board of California shall enforce the provisions of the article as to persons who make the election. After making the election, each person so electing shall apply for renewal of his or her certificate to the Medical Board of California, and the Medical Board of California shall issue renewal certificates in the same manner as other renewal certificates are issued by it.")

6. Section 2450.1 of the Code states:

("Protection of the public shall be the highest priority for the Osteopathic Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.")

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\(^1\) The Osteopathic Act is an initiative measure that was approved by the electorate on November 7, 1922. It appears in West's annotated Business and Professions Code commencing at Section 3600, and in the appendix to the Deering's Business and Professions Code, following Section 25762.
7. Section 2227 of the Codes states:

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

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

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

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

“(4) Be publicly reprimanded by the board.

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

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

8. Section 2234 of the Code states:

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

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

“(b) Gross negligence.

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

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

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

“(d) Incompetence.

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

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

“(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

9. Section 2238 of the Code states:

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

10. Section 4022 of the Code states:

“Dangerous drug” or ‘dangerous device’ means any drug or device unsafe for self-use in humans or animals, and includes the following:

“(a) Any drug that bears the legend: “Caution: federal law prohibits dispensing without prescription,” “Rx only,” or words of similar import.
“(b) Any device that bears the statement: ‘Caution: federal law restricts this device to sale by or on the order of a _____’ ‘Rx only,’ or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

“(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.”

11. Section 2242 of the Code states:

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

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

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

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

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

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

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

“(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.”
12. Section 725 of the Code states:

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

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

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

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

13. Section 2239 of the Code states, in pertinent part:

“(a) The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.”
13. Business and Professions Code section 2266 states:

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

14. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

COSTS

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

(Bus. & Prof. Code, § 2234, subd. (b))

16. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed acts or omissions involving gross negligence in the care and treatment of patients SG, TT, IN, AS, and LW.\(^2\) The circumstances are as follows:

17. Respondent is an Osteopathic physician who practices general medicine in Yucca Valley, California. Respondent received his Osteopathic Doctor’s degree in 1974 from Chicago College of Osteopathic Medicine; completed a one-year internship at Detroit Osteopathic Hospital in 1975, and a one-year pediatric residency at Martin Place Hospital, Children’s Hospital

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\(^2\) The names of the patients are abbreviated to protect their privacy rights. The names will be provided to Respondent upon written request for discovery.
of Michigan in 1976. He received his Board Certification from the American College of Osteopathic Family Physicians in 1986. Respondent does not have any training in pain management, spinal injections, or ultrasound procedures, nor is he board certified in those practice areas.

**Patient SG**

18. The Board received a complaint from patient SG’s widow regarding Respondent’s treatment of SG for lower back pain which radiated down SG’s left leg. Respondent treated SG by administering injections into SG’s sacroiliac joint area for pain on November 14 and 21, 2011, as well as administering multiple injections into SG’s left thigh on November 28, 2011.

19. Respondent maintained two sets of medical records for patient SG. The information entered by Respondent in SG’s medical records was largely illegible.

20. SG’s medical records were incomplete and lacked basic elements of history, review of systems, and relevant physical examination findings either positive and negative.

21. Respondent recorded almost no documentation which indicate that he conducted examinations of SG’s lower extremities or neurologic system prior to administering injections to SG.

22. Respondent’s documentation of his procedures was scanty, conflicting with separate notes describing the actual procedure or medications used with no corrections made to the notes. The medical records contained pre-printed procedure notes with blanks to be filled in. The blanks were either not filled, were incompletely filled in, or were illegible in various places.

23. The medical records contained the list of medications Respondent administered which were recorded on a separate paper. The separate paper listed different medications than those listed in the preprinted procedure note. Respondent did not make corrections to these records.

24. One of the preprinted procedure notes in the medical records described an epidural injection, while the chart documentation described a sacroiliac joint injection.

25. There were rarely any informed consent or aftercare instructions present in the medical records.

26. Respondent’s entry of information in SG’s medical records was largely illegible and
was so poor the specifics of the injections cannot be discerned.

27. One set of SG’s medical records were obtained prior to the patient’s death. In those records, which were signed by Respondent, Respondent entered minimal data regarding SG’s history and review of systems, and little to no physical exam data.

28. Respondent’s second set of records for SG are much different. The second set includes additional history, review of systems, and exam findings. The history, review of systems, and exam sections information entered into the medical records by Respondent appears to have been entered weeks after the SG’s visit, after SG’s hospitalization and eventual death. The additional information is not delineated as “late entries.”

29. When questioned about the discrepancies between the two sets of records at the Subject interview Respondent stated his initial set of records were incomplete, and that he “completed” the records sometime later.

30. The standard of care in the community when recording progress notes in medical records is to document relevant history, review of systems, and physical exam findings, with positive and pertinent negatives, in a patient presenting with a symptom. Relevant history and a review of symptom would include noting the duration and severity of symptoms, precipitating and ameliorating factors, temporally associated symptoms and the presence or absence of other potentially related symptoms.

31. Respondent demonstrated an extreme departure from the standard of care by consistently failing to document an adequate and timely history of present illness, review of systems, and pertinent physical examination findings in his progress notes.

32. It is the standard of care to complete the patient’s medical record as soon as possible, either during the visit or immediately after, as well as to sign the record contemporaneously which indicates the progress notes are complete. If the medical records are physical, as opposed to electronic, additional details necessary for completion of the records can be entered as a supplemental page entitled “late entry” containing both the date and time of the late entry as well as the reason for the late entry.

33. Respondent demonstrated an extreme departure from the standard of care by altering
SG’s medical records at the time the patient became extremely ill and died, which time was weeks after Respondent treated the patient at his office.

**Patient TT**

34. On August 8, 2014, as part of a Board requested ongoing investigation by the Division of Investigation Health Quality Investigative Unit, a Unit investigator working in an undercover capacity called Respondent’s office and identified herself as a new patient without medical insurance who wanted to make an appointment to see Respondent. Respondent’s receptionist told the undercover investigator that she would need to make a $106.00 deposit in person and fill out an information packet before she could schedule an appointment. The investigator decided to attempt to see Respondent as a walk-in patient in the future.

35. On September 29, 2014, the undercover investigator, posing as a new patient without medical insurance, went to Respondent’s office as part of the ongoing investigation. The undercover investigator, who identified herself as Ms. “TT” to Respondent’s receptionist, asked if she could see Respondent as a walk-in patient with no health insurance who would pay for the visit in cash. Respondent was unable to see TT until October 6, 2014. TT received a new patient paperwork packet which she was instructed to complete and bring to her October 6, 2014 appointment.

36. On October 6, 2014, TT returned to Respondent’s office and was seen by Respondent. TT told Respondent she experienced severe menstrual cramps. TT told Respondent she used her friends’ pain pills for the pain. The pain pills TT said she obtained from her friend were a controlled substance, and TT requested those specific controlled substances to relieve her cramps.

37. Respondent completed a patient history which was not well documented. Respondent did not run a CURES\(^3\) report during this visit. The medical records for the initial visit did

\(^3\) CURES is the acronym for Controlled Substance Utilization Review and Evaluation System, a database of Schedule II, III and IV controlled substance prescriptions dispensed in California which serves the public health, regulatory oversight agencies, and law enforcement. Access to CURES is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care; and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.
include a pain contract. During this visit Respondent provided TT with a prescription for Norco\textsuperscript{4} 10/325 mg.

38. On January 20, 2015, TT returned to Respondent’s office and was seen by Respondent. At that visit Respondent provided TT with prescription for Percocet\textsuperscript{5} 5/325 mg and Maxzide\textsuperscript{6} 50/25. TT scheduled another appointment for February 3, 2015.

39. On February 3, 2015, TT returned to Respondent’s office and was seen by Respondent. At that visit Respondent provided TT with prescription for Percocet 5/325 mg.

40. Respondent never requested TT’s prior medical records, never performed a physical examination and never ordered diagnostic testing during any of TT’s three visits. Almost all of the notes in TT’s chart were incomplete, lacking basic elements of history, review of systems, and relevant physical exam findings.

41. Respondent’s entry of information in TT’s medical records was largely illegible.

42. Respondent never performed a pain inventory, or a substance abuse risk assessment or a psychiatric comorbidity history, nor did Respondent express concern regarding TT’s use of a friend’s controlled substances during any of TT’s three visits.

43. The standard of care in the community for providing controlled substances to a new patient who is requesting those drugs for non-emergency, non-acute pain, i.e., chronic musculoskeletal or visceral pain which is not a result of cancer or trauma, requires the provider to do the following: obtain past medical records, run a CURES report, obtain an adequate history and review of systems, perform at least a limited physical exam relevant to the presenting complaint, establish a differential diagnosis and a working diagnosis, order or perform diagnostic testing to confirm the diagnosis, not prescribe a controlled substance on the first visit pending receipt of old records and diagnostic testing results, instead offering non-controlled medication and non-medicinal alternative pain management strategies.

\textsuperscript{4} Norco is a name for a compound of acetaminophen (aka APAP) and hydrocodone, a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug as designated by Business and Professions Code section 4022. It is a narcotic drug.

\textsuperscript{5} Percocet is a name for a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug as designated by Business and Professions Code section 4022.

\textsuperscript{6} Maxzide is the brand name for a diuretic, and is a combination of triamterene and hydrochlorothiazide. The drug is usually used to treat hypertension and is not a controlled substance.

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(HOWARD P. LEVY, D.O.) FIRST AMENDED ACCUSATION
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44. The standard of care in the community if controlled substances are prescribed requires that an abuse and addiction risk assessment be performed with functional goals for the patient to be set and agreed upon between the physician and the patient.

45. The standard of care in the community if controlled substances are prescribed requires that the physician maintain close follow up care with reassessment of the utility of the opioids or other controlled substances in achieving the patient’s functional goals.

46. The standard of care in the community when prescribing controlled substances requires the physician to reconsider the use of controlled substances if functional goals are not being achieved.

47. Respondent demonstrated an extreme departure from the standard of care when he prescribed narcotic controlled substances for new patient TT for a complaint of menstrual cramps.

**Patient IN**

48. Patient IN began working for Respondent in 2009, and Respondent treated her several times during the period she worked for him. Respondent never performed a physical examination on IN when he prescribed medications for her.

49. Respondent ordered many diagnostic tests on IN for vague or unclear indications. Despite having a normal stress cardiac echocardiogram and cardiac catheterization in 2010, Respondent performed and interpreted cardiac echocardiograms in 2011 and 2012.

50. Respondent performed and interpreted carotid doppler, abdominal ultrasound, renal ultrasounds, and pelvic ultrasounds in 2011 and 2012, without sufficient documentation of medical indication or necessity

51. Respondent has no training in the performance or interpretation of nebulized, intravenous or intramuscular vitamin, steroid, or antiemetic treatments.

52. Respondent performed nebulized, intravenous or intramuscular vitamin, steroid, or antiemetic treatments on IN with insufficient documentation of medical indication or necessity.

53. Most of the notes in IN’s chart were incomplete, lacking basic elements of history, review of systems, and relevant physical exam findings with positive and pertinent negatives, in IN’s chart. Respondent documented a minimal chart entry stating the patient experienced
“shoulder pain” and prescribed Valium\textsuperscript{7} and Demerol\textsuperscript{8} for treatment.

54. Respondent’s entry of information in IN’s medical records was largely illegible.

55. Respondent administered various nonstandard intravenous medications to IN which included steroids and controlled substances without a clear medical indication or laboratory tests supporting the needs for the intravenous medications.

56. Respondent demonstrated an extreme departure from the standard of care when he administered intravenous medications including steroids and controlled substances without clear documentation of medical indications.

Patient AS

57. Respondent’s long time patient AS suffered chronic, severe pain from a back syndrome which persisted despite multiple attempts at surgical correction. Respondent saw patient AS from on or about June 8, 2010, through in and around 2015. Respondent seldom recorded AS’s history or a functional assessment in AS’s medical records. Respondent rarely performed an appropriate physical examination on AS.

58. Respondent prescribed high doses of methadone\textsuperscript{9} for AS over a long time period and failed to run a CURES report. Respondent did not perform a pain inventory or a substance abuse risk assessment for AS. Respondent did not perform adequate re-assessments of AS’s condition. Respondent never attempted to taper the amount, type, or strength of the medications he prescribed for AS’s pain.

59. Respondent prescribed methadone for AS while the patient was taking several other psychoactive medications despite the fact that methadone has variable effects, effectiveness, and

\textsuperscript{7} Valium is a trade name for the chemical substance diazepam, a benzodiazepam derivative, is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subsection (d)(9), and a dangerous drug pursuant to Business and Professions Code section 4022.

\textsuperscript{8} Demerol is a trade name for meperidine hydrochloride, a strong synthetic opioid analgesic used in the relief of moderate to severe pain, as a pre-operative supplement to anesthesia, and to provide pain relief during labor. A meperidine hydrochloride preparation is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subsection (c)(17), and a dangerous drug pursuant to Business and Professions Code section 4022.

\textsuperscript{9} Methadone is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(14), and a dangerous drug pursuant to Business and Professions Code section 4022.
potency if other psychoactive medications\textsuperscript{10} are concurrently taken.

60. AS was suffering from frequent falls prior to a hospitalization for syncope\textsuperscript{11} but Respondent failed to note this in the patient's history.

61. Respondent's notes for AS were incomplete, lacking basic history, review of symptoms, and relevant physical examination findings both positive and negative. The information entered by Respondent in the patient's medical records was largely illegible.

62. Respondent demonstrated an extreme departure from the standard of care by consistently failing to document an adequate and timely history of present illness, review of systems, and pertinent physical examination findings in his progress notes for AS.

\textbf{Patient LW}

63. Respondent first treated LW in March 2010. LW had sustained a work related injury in 1990 resulting in chronic back pain. Records from other physicians indicate LW had been diagnosed with a herniated disc, fibromyalgia, chronic pain, and chronic fatigue syndrome.

64. Respondent saw LW monthly and administered voluminous epidural injections to her despite the absence on imaging of apparent pathology. Respondent performed more than 50 epidural injections on LW between July 2010 through March 2015.

65. Respondent utilized various preprinted procedure notes containing blanks to be completed by the practitioner. Often the blanks were not filled in, were incompletely filled in, or illegible.

66. Respondent's documentation of his procedures was scanty, conflicting with separate notes describing the actual procedure or medications used with no corrections made to the notes.

67. Respondent's records rarely included either informed consent or aftercare instructions. The legibility of these notes was so poor the specifics of the injections cannot be discerned.

68. Respondent failed to record lot numbers and expiration dates for the injections

\textsuperscript{10} Psychoactive medications are defined as a medication capable of affecting the mind, emotions, and behavior.

\textsuperscript{11} Syncope is defined as a partial or complete loss of consciousness with interruption of awareness of oneself and ones' surroundings.
even when the preprinted injection forms provided blanks for this information.

69. LW’s medical records were incomplete and lacked basic elements of history, review of systems, and relevant physical examination findings either positive and negative.

70. The information entered by Respondent in LW’s medical records was largely illegible.

71. Because LW’s care was covered under worker’s compensation insurance the carrier required progress notes in a particular format which Respondent ostensibly completed for each visit.

72. LW’s progress note appear to be duplicates, with the same documentation including identical stray marks, location of signature, handwriting, etc. with only a change of treatment date. Many of LW’s signatures on the notes were identical, appearing to be photocopies of her original patient signature.

73. Respondent demonstrated an extreme departure from the standard of care by failing to independently complete progress notes for procedures, and choosing instead to duplicate progress notes rather than completing a new note for each visit.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

(Bus. & Prof. Code, § 2234, subd. (c))

74. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent committed repeated negligent acts in the care of his patients, SG, TT, IN, AS, LW, EM, DP, MW, and DP2. The circumstances are as follows:

75. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth.

76. Respondent’s treatment of patients SG, TT, IN, AS, LW, EM, DP, MW, and DP2 as set forth above and in the following circumstances includes the following acts and/or omissions which constitute departures from the standard of practice:

Patient SG

77. The standard of care in the community regarding documentation of information for
invasive procedures (which procedures includes intraarticular\textsuperscript{12} injections) requires the medical practitioner document a signed informed consent for the procedure, including benefit, risk/potential complications, alternatives discussed, and indicators to return.

78. The standard of care in the community regarding documentation of procedures is to clearly document what procedure was performed, the location of the procedure, the technique used, medications used, and complications or adverse reactions noted.

79. Respondent demonstrated a simple departure from the standard of care in the documentation of the injection procedures in SG’s medical records.

80. Respondent demonstrated a simple departure from the standard of care when he failed to document the lot numbers and expiration dates of the medications he administered to SG.

81. The standard of care in the community is to ensure that chart entries notes are legible to people other than the notes’ author.

82. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient SG’s medical records were legible.

**Patient TT**

83. Respondent demonstrated a simple departure from the standard of care when he consistently failed to document an adequate history of present illness, review of systems, and pertinent physical examination findings in the progress notes.

84. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient TT’s medical records were legible.

**Patient IN**

85. The standard of care in the community requires that a physician order tests only if medically indicated and if the results will have an impact on patient treatment.

86. The standard of care in the community requires a physician to be adequately trained to perform and interpret tests.

87. Respondent demonstrated a simple departure from the standard of care when he

\textsuperscript{12} Intraarticular is defined by Medical Dictionary for the Health Professions and Nursing (2012) as within the cavity of a joint.
performed and interpreted multiple imaging studies for patient IN without clear medical indications.

88. Respondent demonstrated a simple departure from the standard of care by performing diagnostic studies without evidence of adequate training in performing and interpreting these tests.

89. Respondent demonstrated a simple departure from the standard of care when he administered nebulized medications to IN without documentation of a medical indication.

90. Respondent demonstrated a simple departure from the standard of care when he consistently failed to document an adequate history of present illness, review of systems, and pertinent physical examination findings in IN’s progress notes.

91. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient IN’s medical records were legible.

Patient AS

92. Respondent demonstrated a simple departure from the standard of care in continuing to prescribe methadone for AS without adequate re-evaluations of the need for this medication, the effect on the patient’s function and failing to obtain the patient’s history of frequent falls.

93. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient AS’s medical records were legible.

Patient LW

94. Respondent demonstrated a simple departure from the standard of care in his documentation of informed consent, potential complications, alternatives to, and return visit guide for the epidural procedures he administered to LW.

95. Respondent demonstrated a simple departure from the standard of care with regard to his documentation of the epidural injections he performed on patient LW.

96. The standard of care in the community when a physician administers medications is to document the name of the medication, the lot number, the expiration date, and the quantity and strength of the medication administered and the time the medication is administered.

97. Respondent demonstrated a simple departure from the standard of care when he failed
to record the lot numbers and expiration dates of the medications he administered to patient LW.

98. Respondent demonstrated a simple departure from the standard of care by consistently failing to document an adequate and timely history of present illness, review of systems, and pertinent physical examination findings in most of his progress notes for patient LW.

99. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient LW’s medical records were legible.

**Patient EM**

100. Respondent’s long time patient EM suffered from chronic pain. Respondent rarely recorded EM’s history, performed a relevant physical examination or performed a functional assessment of the patient. Respondent failed to perform a pain inventory, a substance abuse risk assessment or psychiatric comorbidity history, nor did he run a CURES report on EM.

101. Respondent prescribed both a potent narcotic and a benzodiazepine over a long period of time without adequate reassessments or any attempts to taper the amount, type or strength of medications used.

102. Respondent ordered many diagnostic tests on EM for vague or unclear indications. Respondent performed and interpreted cardiac echocardiograms September 12, 2011, November 9, 2011, and August 1, 2012, despite having the same test results available from another provider on January 27, 2011 and November 27, 2011. Respondent recorded no medical justification for ordering so many cardiac echocardiograms in such a small time period.

103. Respondent also performed and interpreted carotid doppler, abdominal ultrasound, peripheral arterial dopplers, ankle/brachial indexes, and a prostate ultrasound on EM during the same time period, often on multiple occasions for equally questionable purposes. Respondent performed several nebulizer treatments without sufficient documentation of medical indication or necessity. These procedures are not within the usual scope of a Family Medicine practitioner and Respondent has no training in performing or interpreting any of these procedures.

104. EM’s medical records were incomplete and lacked basic elements of history, review of systems, and relevant physical examination findings either positive and negative. Some notes
were blank. The information entered by Respondent in EM’s medical records was largely illegible.

105. Respondent demonstrated a simple departure from the standard of care by consistently failing to document an adequate history of present illness, review of systems, and pertinent physical examination findings in most of his progress notes for patient EM.

106. Respondent demonstrated a simple departure from the standard of care in continuing to prescribe narcotic and benzodiazepine controlled substances for patient EM without adequate reevaluations of the need for these substances or their effect on the patient’s ability to function.

107. Respondent demonstrated a simple departure from the standard of care for patient EM by performing and interpreting multiple imaging studies without clear medical indications.

108. Respondent demonstrated a simple departure from the standard of care for patient EM by performing diagnostic studies without adequate training in performing and interpreting these tests.

109. Respondent demonstrated a simple departure from the standard of care for patient EM by administering nebulized medications without documentation of a medical indication.

110. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient EM’s medical records were legible.

**Patient DP**

111. Respondent administered intravenous and intramuscular vitamins, steroids, and analgesic treatments to DP for headaches without a clear medical indication or laboratory tests supporting the needs for the intravenous medications.

112. Most of the notes in DP’s chart were incomplete, lacking basic elements of history, review of systems, and relevant physical exam findings.

113. Respondent’s entry of information in DP’s medical records was largely illegible.

114. Respondent demonstrated a simple departure from the standard of care when he administered intravenous medications without clear documentation of medical indications or necessity.

115. Respondent demonstrated a simple departure from the standard of care when he
consistently failed to document an adequate history of present illness, review of systems, and pertinent physical examination findings in DP’s medical records.

116. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient DP’s medical records were legible.

Patient MW

117. Patient MW who had chronic back pain, with multiple musculoskeletal complaints, and fibromyalgia, when Respondent began treating her in 2012. Respondent rarely, if ever, performed a relevant physical examination or recorded any history or functional assessment.

118. MW’s medical records were incomplete and lacked basic elements of history, review of systems, and relevant physical examination findings either positive and negative.

119. The information entered by Respondent in MW’s medical records was largely illegible.

120. Respondent did not perform a pain inventory or a substance abuse risk assessment. Respondent did not run a CURES report. Respondent initially treated MW with hydrocodone\(^{13}\) compounds to which he added, at various times, and often simultaneously, tramadol,\(^{14}\) soma,\(^{15}\) cymbalta,\(^{16}\) and amitriptyline.\(^{17}\)

121. Respondent’s documentation of procedures in MW’s medical records was scanty, often conflicting with the description of the actual procedure performed or the medications used with no corrections made to the notes.

122. Respondent utilized various preprinted procedure notes containing blanks to be completed by the practitioner. Often the blanks were not filled in, were incompletely filled in, or

\(^{13}\)Hydrocodone is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug as designated by Business and Professions Code section 4022.

\(^{14}\)Tramadol is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (a), and a dangerous drug as designated by Business and Professions Code section 4022.

\(^{15}\)Soma is not a controlled substance. It is a centrally-acting skeletal muscle relaxant and is a dangerous drug as designated by Business and Professions Code section 4022.

\(^{16}\)Cymbalta is a prescription antidepressant medication. It is a dangerous drug as designated by Business and Professions Code section 4022.

\(^{17}\)Amitriptyline is a prescription antidepressant medication. It is a dangerous drug as designated by Business and Professions Code section 4022.
123. Respondent’s records rarely included either informed consent or aftercare instructions. The legibility of these notes was so poor the specifics of the injections cannot be discerned.

124. Respondent failed to record lot numbers and expiration dates for injections even when the preprinted injection forms provided blanks for this information.

125. Respondent demonstrated a simple departure from the standard of care in continuing to prescribe controlled substances for MW without adequate re-evaluations of the need for these medications or the medication’s effect on the patient’s function.

126. Respondent demonstrated a simple departure from the standard of care in the documentation of the injection procedures in MW’s medical records.

127. Respondent demonstrated a simple departure from the standard of care when he failed to document the lot numbers and expiration dates of the medications he administered to MW.

128. Respondent demonstrated a simple departure from the standard of care when he consistently failed to document an adequate history of present illness, review of systems, and pertinent physical examination findings in MW’s medical records.

129. Respondent demonstrated a simple departure from the standard of care when he failed to ensure that the notes in patient MW’s medical records were legible.

Patient DP2

130. Patient DP2 sustained a work related injury on February 26, 2014, when he fell on a wood pile and was “poked” in his left arm. The patient was referred to Respondent on September 2, 2014, for treatment of this unhealed injury.

131. On September 2, 2014, Respondent evaluated the patient and diagnosed him with an abscess of the left arm with foreign body granuloma and a puncture wound of his forearm. Respondent’s records reflect he noted the lesion to be a “2cm x 2cm indurated large growth on the left lateral forearm.”

132. Respondent prescribed 30 capsules of amoxicillin 500mg to the patient.

133. On September 16, 2014, Respondent saw the patient for a follow-up visit.
Respondent’s notes do not mention whether the arm had improved after the patient took the
antibiotics that Respondent prescribed.

134. Respondent’s notes for the patient’s September 16, 2014, visit do not state that he
wrote a prescription for medication for DP2. Pharmacy records dated September 16, 2014, reflect
Respondent prescribed hydrocodone/APAP 10-325mg tablets for the patient on September 16,
2014.

135. Respondent performed a biopsy on DP2 on October 1, 2014. Respondent’s chart
states Respondent removed a 3.5 cm area of skin. The Hi-Desert Medical Center pathology
report dated October 1, 2014, described the area of skin Respondent removed as measuring 9 x 9
cm.

136. The Hi-Desert Medical Center pathology report from the biopsy Respondent
performed on October 1, 2014, reflected DP2 had “severely actinically damaged skin with surface
verrucoid hyperkeratosis with mixed features of combined seborrheic and actinic keratosis.”

137. On October 2, 2014, DP2 developed pain over his left arm and on October 5, 2014,
the patient’s left arm became swollen. Respondent evaluated DP2 on October 7, 2014, and
referred DP2 to the Hi-Desert Medical Center emergency room because Respondent believed
DP2’s condition might require intravenous antibiotics treatment.

138. Hi-Desert Medical Center physicians diagnosed DP2 with cellulitis and admitted him
into the hospital due to leukocytosis and provided the patient intravenous antibiotics treatment.
During DP2’s hospitalization vancomycin was administered intravenously. Five (5) stitches were
removed from DP2’s arm and he was given antibiotics to take subsequent to his hospital
discharge.

139. Respondent saw DP2 on October 15, 2014, and determined his wound had exudate
and was still oozing. Respondent removed two (2) stitches from DP2’s forearm.

140. Respondent saw DP2 on October 17, 2014, and Respondent’s records state that the
wound is “improved today. No oozing. Decreased Redness. . . .” During this visit DP2 told
Respondent he was experiencing side effects from the antibiotics. Respondent nonetheless
prescribed oral clindamycin and topical mupirocin in addition to the antibiotics prescribed for the
patient when he was released from the hospital.

141. Respondent saw DP2 on October 23, 2014, and Respondent’s chart states the “wound with exudate [was] still oozing” but the patient was determined to be “recovered” with “no further treatment necessary.”

142. The standard of care in the community is to ensure that chart entry notes are legible to people other than the notes’ author.

143. Respondent demonstrated a simple departure from the standard of care when he failed to ensure the notes in patient DP2’s medical records were legible.

144. The standard of care in the community when a physician administers medications is to completely document information on how all medications are to be used in the list of medications prescribed to the patient.

145. Respondent demonstrated a simple departure from the standard of care when he failed to document how the antibiotics he prescribed to the patient were to be used.

146. The standard of care in the community regarding documentation of procedures is to clearly and accurately document chart entries regarding the performed procedure.

147. Respondent demonstrated a simple departure from the standard of care when he recorded erroneous information regarding the size of the skin excised during the patient’s biopsy.

148. The standard of care in the community when prescribing controlled substances requires the physician to document the reason why the medication was prescribed.

149. Respondent demonstrated a simple departure from the standard of care when he failed to document the reason why he prescribed hydrocodone/APAP 10-325mg tablets for the patient.

150. The standard of care in the community when prescribing antibiotics is to ensure that the benefits of the medication outweigh the risks associated with the medication.

151. The standard of care in the community when prescribing antibiotics is to treat the patient with an antibiotic to which the bacterial organism is sensitive and to continue the antibiotic until complete resolution of the infection.

152. The standard of care in the community when prescribing antibiotics is to add an additional antibiotic only if the patient’s infection is not responding to the original antibiotic or if
the patient is having intolerable side effects from the original antibiotic.

153. Respondent demonstrated a simple departure from the standard of care when he prescribed two antibiotics to the patient despite documentation that the patient’s wound was showing objective signs of improvement from the first antibiotic.

154. Respondent demonstrated a simple departure from the standard of care when he prescribed two antibiotics to the patient despite the patient’s complaints of side effects from the combination of antibiotics he was taking.

THIRD CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, Furnishing Dangerous Drugs Without Prior Examination and Medical Indication)

(Bus. & Prof. Code, § 2239, subd. (a))

155. Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code in that Respondent prescribed, dispensed, or furnished dangerous drugs as defined in section 4022 of the Code without appropriate prior examination and a medical indication. The circumstances are as follows:

156. The facts and circumstances of the First and Second Causes for Discipline are incorporated by reference as if set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation of Controlled Substance Statutes)

(Bus. & Prof. Code, § 2238)

157. Respondent is subject to disciplinary action under section 2238 of the Code in that he violated the statutes regulating dangerous drugs or controlled substances. The circumstances are as follows:

158. The facts and circumstances of the First, Second, and Third Causes for Discipline are incorporated by reference as if set forth in full herein.
FIFTH CAUSE FOR DISCIPLINE

(Inadequate Record Keeping)

(Bus. & Prof. Code, § 2266)

159. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate medical records. The circumstances are as follows:

160. The facts and circumstances of the First and Second Cause for Discipline are incorporated by reference as if set forth in full herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

(Bus. & Prof. Code, §2234)

161. Respondent is subject to disciplinary action under section 2234 of the Code in that he committed general unprofessional conduct. The circumstances are as follows:

162. The facts and circumstances set forth in paragraphs 17 through 160 are incorporated by reference as if set forth in full herein.

DISCIPLINE CONSIDERATIONS

163. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about February 14, 2005, Respondent in a prior disciplinary action entitled “In the Matter of the Accusation Against Howard P. Levy, D.O. before the Osteopathic Medical Board of California,” in Case No. 00-2004-1402, was issued a public letter of reprimand as a result of his medical license being suspended in the state of Michigan due to fraudulent billing. That decision is now final and is incorporated by reference as if fully set forth.

164. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about March 17, 2008, Respondent in a prior disciplinary action entitled “In the Matter of the Accusation Against Howard P. Levy, D.O. before the Osteopathic Medical Board of California,” in Case No. 00-2005-001494, was placed on probation for five years due to substandard medical care provided to one patient. That decision is now final and is incorporated by reference as if fully set forth.

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PRAYER

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

1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number 20A 4148, issued to Howard P. Levy, D.O.;

2. Ordering him to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Ordering him to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case and, if placed on probation, ordering him to pay to the Osteopathic Medical Board of California the costs of probation monitoring; and

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

DATED: November 28, 2017

ANGELINA M. BURTON
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2016502510
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DECLARATION OF SERVICE BY CERTIFIED MAIL AND FIRST CLASS MAIL
(Separate Mailings)

In the Matter of the First Amended Accusation Against:
Howard P. Levy, D.O.
Case No: 900-2014-000044

I, the undersigned, declare that I am over 18 years of age and not a party to the
within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA
95834.

On November 28, 2017, I served the attached First Amended Accusation,
Supplemental Statement to Respondent, Request for Discovery and Government
Codes Sections 11507.5, 11507.6 and 11507.7 by placing a true copy thereof
enclosed in a sealed envelope as certified mail with postage thereon fully prepaid and
return receipt requested, and another true copy of the First Amended Accusation,
Supplemental Statement to Respondent, Request for Discovery and
Government Codes Sections 11507.5, 11507.6 and 11507.7 as enclosed in a second
sealed envelope as first class mail with postage thereon fully prepaid, in the internal
mail collection system at the Office of the Osteopathic Medical Board of California
addressed as follows:

NAME AND ADDRESS

Howard P. Levy, D.O.
57370 29 Palms Hwy, Suite 203.
Yucca Valley, CA 92284-2900

Howard P. Levy, D.O.
P O Box 2559
Yucca Valley, CA 92286-2559

(certified and regular mail)

Certified Mail No.
91 7199 9991 7036 7647 6253

Certified Mail No.
91 7199 9991 7036 7647 6260

I declare under penalty of perjury under the laws of the State of California that the
foregoing is true and correct and that this declaration was executed on November 28,
2017 at Sacramento, California.

_______________
Steve Ly
Declarant

________________________
Signature

cc: Jeffrey G. Keane, Esq.
Wendy Widlus, Deputy Attorney General
DECLARATION OF SERVICE BY MAIL

In the Matter of the Accusation Against:

Howard P. Levy, D.O.
Case No: 900 2014 000044

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

DECISION AND ORDER
STIPULATED AGREEMENT AND DISCIPLINARY ORDER

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

NAME AND ADDRESS

Howard P. Levy, D.O.
57370 29 Palms Highway, Suite 203
Yucca Valley, CA 92284

Jeffrey G. Keene, Esq.
74770 Highway 111, Suite 201
Indian Wells, CA 92210

CERT NO.

91 7199 9991 7036 9786 6668

91 7199 9991 7036 9786 6675

Each said envelope was then, on July 16, 2018 sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid and return receipt requested.

Executed on July 16, 2018 at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Machiko Chong
Typed Name

Signature

cc: Wendy Widlus, Supervising Deputy Attorney General