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8 **BEFORE THE**
BOARD OF PHARMACY
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. 5852

11 **ROSS MEDICAL PHARMACY**
12 **1818 S. Western Avenue**
13 **Los Angeles, CA 90006**

A C C U S A T I O N

14 **Pharmacy Permit No. PHY 39267**

15 And

16 **SEUNG YOL KIM**
17 **5351 Quail Canyon Road**
La Crescenta, CA 91214

18 **Pharmacist License No. RPH 40147**

19 Respondents.

20
21 Complainant alleges:

22 **PARTIES**

23 1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity
24 as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

25 2. On or about April 6, 1993, the Board of Pharmacy issued Pharmacy Permit Number
26 PHY 39267 to Ross Medical Pharmacy, Seung Yol Kim (Respondents). The Pharmacy Permit
27 was in full force and effect at all times relevant to the charges brought herein and will expire on
28 April 1, 2017, unless renewed.

1 naturopathic doctor pursuant to Section 3640.7, or upon an order to furnish drugs or transmit a
2 prescription from a certified nurse-midwife, nurse practitioner, physician assistant, naturopathic
3 doctor pursuant to Section 3640.5, or pharmacist acting within the scope of his or her practice.

4 "(b) "Dispense" also means and refers to the furnishing of drugs or devices directly to a
5 patient by a physician, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse-
6 midwife, nurse practitioner, naturopathic doctor, or physician assistant acting within the scope of
7 his or her practice."

8 8. Section 4113, subdivisions (c) and (d), state:

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10 "(c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all
11 state and federal laws and regulations pertaining to the practice of pharmacy.

12 9. Section 4301 of the Code states, in pertinent part:

13 "The board shall take action against any holder of a license who is guilty of unprofessional
14 conduct or whose license has been procured by fraud or misrepresentation or issued by mistake.
15 Unprofessional conduct shall include, but is not limited to, any of the following:

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17 "(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a)
18 of Section 11153 of the Health and Safety Code.

19 "(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a)
20 of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining
21 whether the furnishing of controlled substances is clearly excessive shall include, but not be
22 limited to, the amount of controlled substances furnished, the previous ordering pattern of the
23 customer (including size and frequency of orders), the type and size of the customer, and where
24 and to whom the customer distributes its product.

25

26 "(j) The violation of any of the statutes of this state, or any other state, or of the United
27 States regulating controlled substances and dangerous drugs.

28

1 "(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the
2 violation of or conspiring to violate any provision or term of this chapter or of the applicable
3 federal and state laws and regulations governing pharmacy, including regulations established by
4 the board or by any other state or federal regulatory agency.

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6 10. Health and Safety Code section 11153, subdivision (a) states:

7 "(a) A prescription for a controlled substance shall only be issued for a legitimate medical
8 purpose by an individual practitioner acting in the usual course of his or her professional practice.
9 The responsibility for the proper prescribing and dispensing of controlled substances is upon the
10 prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the
11 prescription. Except as authorized by this division, the following are not legal prescriptions:

12 (1) an order purporting to be a prescription which is issued not in the usual course of professional
13 treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of
14 controlled substances, which is issued not in the course of professional treatment or as part of an
15 authorized narcotic treatment program, for the purpose of providing the user with controlled
16 substances, sufficient to keep him or her comfortable by maintaining customary use."

17 **REGULATORY PROVISIONS**

18 11. California Code of Regulations, title 16, section 1761 provides that:

19 "(a) No pharmacist shall compound or dispense any prescription which contains any
20 significant error, omission, irregularity, uncertainty, ambiguity or alteration: Upon receipt of any
21 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to
22 validate the prescription.

23 "(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense
24 a controlled substance prescription where the pharmacist knows or has objective reason to know
25 that said prescription was not issued for a legitimate medical purpose."

26 **COST RECOVERY**

27 12. Section 125.3 of the Code states, in pertinent part, that the Board may request the
28 administrative law judge to direct a licentiate found to have committed a violation or violations of

1 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
2 enforcement of the case.

3 **CONTROLLED SUBSTANCES**

4 13. **“Alprazolam”**, the generic name for Xanax, is a Schedule IV controlled substance
5 pursuant to Health and Safety Code section 11057, subdivision (d)(1) and is a dangerous drug
6 pursuant to Code section 4022.

7 14. **“Phenergan with Codeine”** is the brand name for Promethazine with Codeine. It is
8 a Schedule V controlled substance pursuant to Health and Safety Code section 11058(c)(1) and is
9 a dangerous drug pursuant to Business and Professions Code section 4022.

10 15. **“Carisoprodol”**, also known as Soma, is a Schedule IV controlled substance
11 pursuant to 21 Code of Federal Regulations 1308.17, subdivision (c)(6) and is a dangerous drug
12 pursuant to Code section 4022.

13 16. **“Hydrocodone/acetaminophen”** is a Schedule II controlled substance pursuant to
14 Health and Safety Code section 11056, subdivision (e)(4) and is a dangerous drug pursuant to
15 Code section 4022.

16 **BACKGROUND RE BOARD INVESTIGATION**

17 **AND INSPECTION OF PHARMACY ON FEBRUARY 25, 2014**

18 17. On or about September 25, 2013, the Board received a crime report from WeTip
19 which alleged that 1818 N. Western Avenue, Room 500, Los Angeles paid \$20 to use patient
20 names and billed their insurances for services which were never provided to them. According to
21 WeTip, the manager kept the medicine that Dr. M.G. wrote after a “fake visit” and the pharmacy
22 downstairs was also in on this scam. Investigation revealed that Ross Medical Pharmacy (and/or
23 the pharmacy) is located on the first floor of Southfork Medical Clinic (Southfork Clinic and/or
24 clinic) and dispensed erroneous and uncertain prescriptions that were prescribed by the clinic.

25 18. On or about February 25, 2014, the Board’s Inspector went to 1818 S. Western
26 Avenue, Room 5, Los Angeles, CA 90006 and knocked on the door, but no one answered. A
27 maintenance person indicated that Southfork Clinic had closed down. The Board’s Inspector
28 went to the first floor of the same building and conducted an inspection of Ross Medical

1 Pharmacy. Pharmacy technician L.B. told the Inspector they stopped taking prescriptions from
2 Southfork Clinic and the pharmacy does not dispense prescriptions from out of the area patients.
3 Respondent Kim stated that a few months ago, Dr. M.G. quit or was fired from Southfork Clinic
4 and a new prescriber named Dr. P.M. introduced himself to Kim and said he was a surgeon and
5 pain management prescriber. On February 22, 2014, a SWAT team came and arrested everyone
6 in the clinic.

7 19. The Inspector reviewed the numerous books of Ross Medical Pharmacy's
8 prescriptions, and found an average of about five patients' prescriptions per day were dispensed
9 by the pharmacy and written at the clinic. She collected a sample of those prescription hardcopies
10 and daily reports for various days to determine which percentage of prescriptions they dispensed
11 were for the clinic.

12 20. The Inspector asked Respondent Kim about his corresponding responsibilities as a
13 pharmacist, and he was confused. He then asked Respondent if it was within the scope of
14 practice for a pain management prescriber to write extensive number of promethazine with
15 codeine for cough. Respondent Kim replied "yes", he believed it was within his scope of
16 practice.

17 21. Between January 1, 2013 and October 18, 2013, Respondent Ross Medical Pharmacy
18 and Respondent Kim filled prescriptions written by Dr. P.M. and Dr. M.G. of Southfork Clinic
19 for Promethazine with Codeine #240 and Alprazolam 2 mg #60. The Board's Inspector found the
20 following irregularities with these prescriptions, which Respondent Kim should have questioned:

- 21 • The same combination of medications prescribed by the two prescribers of the clinic for
22 most of their patients.
- 23 • Most patients were prescribed Alprazolam for muscle spasms and Promethazine with
24 Codeine for cough and congestion by the two prescribers of the clinic. The therapy was
25 not individualized for each patient.
- 26 • Respondent Kim should have questioned why a pain clinic is prescribing excessive amounts
27 of cough medications and referring them to a pain management specialist.

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1 **BACKGROUND RE BOARD INVESTIGATION**

2 **AND INSPECTION OF PHARMACY ON OCTOBER 27, 2015**

3 22. The Board received a notification from Cardinal Health indicating that Cardinal
4 Health suspended sales of controlled substances to Ross Medical Pharmacy due to irregular
5 controlled substance ordering at the pharmacy. The Board became aware of the arrest and federal
6 indictment of Dr. M.G. as described in an article released by the U.S. Attorney's Office. Details
7 of the article included the following:

- 8 • The article stated federal authorities arrested five defendants, including Dr. M.G., linked
9 to a narcotics trafficking ring, "that sold illegal prescriptions for cash and obtained drugs
10 that were shipped to Texas for sale on the black market."
- 11 • The article stated the operation was based in the Southfork Medical Clinic and alleged the
12 clinic was a "pill mill" where Dr. M.G. wrote prescriptions, "without a legitimate medical
13 purpose."
 - 14 ○ The article explained Dr. M.G. issued more than 10,000 prescriptions over a 15
15 month period and nearly 80 percent of the prescriptions were for hydrocodone or
16 alprazolam.
- 17 • The article described undercover operations conducted at Southfork Medical Clinic in
18 which Dr. M.G. gave undercover operators prescriptions for oxycodone and
19 promethazine/codeine syrup, "in exchange for the person returning to the clinic with the
20 bottles of the prescribed cough syrup."

21 23. On February 4, 2016, the U.S. Attorney's Office issued another press release
22 indicating Dr. M.G. "pleaded guilty to one count of illegally distributing oxycodone and one
23 count of money laundering." The article stated as part of her guilty plea, Dr. M.G. admitted "that
24 she issued prescriptions [for controlled substances] to Southfork 'patients' at the instructions of
25 the owner of the clinic...and that she knew the 'patients' did not actually need the drugs."
26 Additionally, Dr. M.G. acknowledged she "intentionally prescribed the drugs outside the usual
27 course of professional practice and without a legitimate medical purpose."

28 24. An inspection and investigation at Ross Medical Pharmacy determined that the
pharmacy did not fulfill its corresponding responsibility to dispense only legitimate prescriptions
in filling controlled substance prescriptions written by Dr. M.G. The Board's Inspector contacted
an employee at Cardinal Health who explained that Cardinal Health evaluated dispensing at Ross
Medical Pharmacy and determined the percentage of controlled substances purchased in cash was

1 significantly higher than the percentage of non-controlled substances purchased in cash. Frequent
2 cash payments for controlled substances are a red flag for potential drug diversion and abuse.

3 25. The California Controlled Substance Utilization and Review and Evaluation System
4 (CURES) database contains information about controlled substance prescriptions filled in
5 California, as reported by pharmacies. On August 11, 2015, the Board's Inspector requested and
6 reviewed a CURES report showing controlled substance prescriptions filled by Ross Medical
7 Pharmacy from August 1, 2012 to August 11, 2015, which showed the following:

- 8 • Dr. M.G. was the most frequent prescriber of controlled substances dispensed at Ross
9 Medical Pharmacy during the query period.
 - 10 ○ Ross Medical Pharmacy dispensed 5,806 controlled substance prescriptions
11 written by Dr. M.G. during the query period. Additionally, all of Dr. M.G.'s
12 prescriptions included in this report were filled between 11/28/2012 and
13 12/17/2013.
 - 14 ○ Over 98% of Dr. M.G.'s controlled substance prescriptions dispensed by Ross
15 Medical Pharmacy during the query period were alprazolam 2 mg, carisoprodol
16 350 mg, or a hydrocodone/acetaminophen combination.
 - 17 ○ Over 99% of Dr. M.G.'s controlled substance prescriptions were purchased in
18 cash, meaning not billed to prescription insurance.

19 26. The Board's investigation revealed the following facts: Between November 28,
20 2012 and December 17, 2013, Ross Medical Pharmacy filled 7,730 controlled substance
21 prescriptions written by Dr. M.G., despite multiple factors of irregularity indicating the
22 prescriptions were not written for legitimate medical indications and in the normal course of
23 practice. Objective factors suggesting the medical illegitimacy of these prescriptions included:

- 24 • The vast majority, 92.55%, of Dr. M.G.'s prescriptions filled at Ross Medical Pharmacy
25 were written for controlled substances.
 - 26 ○ The majority of Dr. M.G.'s prescriptions at Ross Medical Pharmacy were
27 commonly abused controlled substances.
 - 28 ■ Alprazolam 2 mg tablets, promethazine/codeine syrup, and carisoprodol
350 mg made of 56.67% of Dr. M.G.'s prescriptions at Ross Medical
Pharmacy.
 - Hydrocodone/acetaminophen combinations in various strengths accounted
for 34.42% of Dr. M.G.'s total prescribing.
- 98.93% of Dr. M.G.'s prescriptions were purchased in cash, meaning not billed to
prescription insurance.

- 1 • There were at least 81 instances when Ross Medical Pharmacy processed prescriptions for
2 multiple patients receiving the same cocktail of medications from Dr. M.G. in short
3 periods of time, sometimes consecutively.
- 4 • There were at least 47 patients of Dr. M.G. with addresses on file at Ross Medical
5 Pharmacy which were significantly outside of the pharmacy's normal trading area
6 including many patients with addresses of record more than 100 miles away from Ross
7 Medical Pharmacy.
- 8 • There were many instances in which more than one patient with the same address received
9 the same or similar prescriptions from Dr. M.G. on the same day.
- 10 • Many of Dr. M.G.'s patients had the same or similar addresses on file at Ross Medical
11 Pharmacy. The dispensing records contained at least 13 addresses used as addresses of
12 record for 7 to 30 of Dr. M.G.'s patients. Additionally, the dispensing histories of the
13 patients with shared addresses were similar.

14 27. Additionally, Ross Medical Pharmacy failed to assume its corresponding
15 responsibility when, despite being registered to view the information in the CURES database, it
16 failed to access or evaluate Patient Activity Reports for patients with insurance coverage who
17 purchased controlled substances in cash. Ross Medical Pharmacy's failure to consult this
18 available reference resulted in dispensing controlled substances to patients who engaged in doctor
19 shopping and polypharmacy activity.

20 **CAUSE FOR DISCIPLINE**

21 **(Violation of Corresponding Responsibility to Verify Prescriptions)**

22 28. Respondents Ross Medical Pharmacy and Kim are subject to disciplinary action
23 under Code section 4301, subdivisions (d) and (j) for violating Health and Safety Code section
24 11153, subdivision (a), and Code section 4301, subdivision (o), and California Code of
25 Regulations, title 16, section 1761, subdivisions (a) and (b), in that between November 28, 2012
26 and December 17, 2013, Respondents failed to assume corresponding responsibility by failing to
27 validate the legitimacy of the prescriptions and/or reviewing the patients' drug therapy, by
28 dispensing prescriptions without regard to objective factors, and/or by dispensing
irregular/uncertain prescriptions. Complainant refers to and incorporates all the allegations
contained in paragraphs 17-27, as though set forth fully.

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PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 39267, issued to Ross Medical Pharmacy, Seung Yol Kim;
2. Revoking or suspending Pharmacist License RPH No. 40147, issued to Seung Yol Kim;
3. Ordering Seung Yol Kim to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,
4. Taking such other and further action as deemed necessary and proper.

DATED: 11/13/16 Virginia Herold

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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