(Authority: Government in the Sunshine Act, 5 U.S.C. 552b)

Vicktoria J. Allen,

Deputy Secretary of the Commission.

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FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The public portions of the applications listed below, as well as other related filings required by the Board, if any, are available for immediate inspection at the Federal Reserve Bank(s) indicated below and at the offices of the Board of Governors. This information may also be obtained on an expedited basis, upon request, by contacting the appropriate Federal Reserve Bank and from the Board's Freedom of Information Office at *https://www.federalreserve.gov/foia/request.htm.* Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)).

Comments received are subject to public disclosure. In general, comments received will be made available without change and will not be modified to remove personal or business information including confidential, contact, or other identifying information. Comments should not include any information such as confidential information that would not be appropriate for public disclosure.

Comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors, Ann E. Misback, Secretary of the Board, 20th Street and Constitution Avenue NW, Washington, DC 20551–0001, not later than March 12, 2025.

A. Federal Reserve Bank of Chicago (Colette A. Fried, Assistant Vice President) 230 South LaSalle Street, Chicago, Illinois 60690–1414. Comments can also be sent electronically to *Comments.applications@chi.frb.org:*

1. *Bosshard Financial Group, Inc., La Crosse, Wisconsin;* to merge with Bosshard Banco, Ltd., La Crosse, Wisconsin, and thereby indirectly acquire Intercity State Bank, Schofield, Wisconsin, and The First National Bank of Bangor, Bangor, Wisconsin.

Board of Governors of the Federal Reserve System.

Michele Taylor Fennell,

Associate Secretary of the Board.

[FR Doc. 2025–02420 Filed 2–7–25; 8:45 am]

BILLING CODE P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

[Docket No. 23–5]

David Bockoff, M.D.; Decision and Order

I. Introduction

On October 25, 2022, the United States Department of Justice (Agency) issued an Order to Show Cause and Immediate Suspension of Registration (collectively, OSC) to David Bockoff, M.D., (Respondent) of Beverly Hills, California. OSC, at 1, 8. The OSC immediately suspended, and proposes the revocation of, Respondent's Drug Enforcement Administration (DEA) registration, No. BB4591839, ''because . . . [Respondent's] continued registration constitutes 'an imminent danger to the public health or safety,' '' and ''because . . . [Respondent's] continued registration is inconsistent with the public interest, as that term is defined in 21 U.S.C. 823[(g)(1)].'' [1] *Id.* at 1 (citing 21 U.S.C. 824(d) and (a)(4)).

Respondent timely requested a hearing. Request for Hearing (November 4, 2022), at 1; Prehearing Ruling (November 30, 2022), at 1. DEA Administrative Law Judge (ALJ) Teresa A. Wallbaum conducted a four-day hearing at the DEA Hearing Facility, attended by Respondent and his Counsel by video teleconference, on January 19, 20, 23, and 24, 2023. Recommended Rulings, Findings of Fact, Conclusions of Law, and Decision of the Administrative Law Judge (RD), at 2. On May 2, 2023, the ALJ issued her RD recommending revocation of Respondent's registration.[2] *Id.* at 43.

Having thoroughly analyzed the record and applicable law, the Agency summarizes its findings and conclusions: (1) DEA (the Government) presented a *prima facie* case, (2) Respondent attempted, but failed, to rebut the Government's *prima facie* case, and (3) substantial and uncontroverted record evidence, including the testimony of the Government's expert witness, shows Respondent's violations of applicable law go to the core of the Controlled Substances Act (CSA). Accordingly, the Agency will revoke Respondent's registration. *Infra* Order.

II. California Physicians' and Surgeons' Standard of Care

According to the CSA, ''[e]xcept as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally . . . to . . . distribute, . . . dispense, or possess with intent to . . . distribute[ ] or dispense, a controlled substance.'' 21 U.S.C. 841(a)(1). The CSA's implementing regulations state that a lawful controlled substance order or prescription is one that is ''issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.'' 21 CFR 1306.04(a).

The OSC is addressed to Respondent at his registered address in California. Therefore, the Agency also evaluates Respondent's actions according to California law, including the applicable California standard of care.[3] Authorities in the ''Legal Requirements'' and ''Standard of Care'' sections of the OSC give Respondent notice of the bases for the OSC's allegations and, accordingly, are the authorities that the Agency is using to adjudicate those allegations. OSC, at 2–3; *infra.*

The first California authority listed in the OSC's ''Legal Requirements'' section is California Health and Safety Code § 11153(a). During the time period alleged in the OSC, that California provision, similar to the CSA, required that a ''prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice.'' Cal. Health & Safety Code § 11153(a) (West 2023–24); OSC, at 2.

[1] Effective December 2, 2022, the Medical Marijuana and Cannabidiol Research Expansion Act, Public Law 117–215, 136 Stat. 2257 (2022) (Marijuana Research Amendments or MRA), amended the Controlled Substances Act (CSA) and other statutes. Relevant to this matter, the MRA redesignated 21 U.S.C. 823(f), cited in the OSC, as 21 U.S.C. 823(g)(1). Accordingly, this Decision cites to the current designation, 21 U.S.C. 823(g)(1), and to the MRA-amended CSA throughout.

[2] Neither party filed exceptions to the RD.

[3] *See Gonzales* v. *Oregon,* 546 U.S. 243, 269–71 (2006); *see also* OSC, at 2–3. The versions of the California authorities cited in this Decision/Order were in effect from at least January 2020 through June 2022, the time period alleged in the OSC. OSC, at 3–8.

The provision explicitly includes two examples of prescriptions that are not legal. First, in salient part, ''an order purporting to be a prescription which is issued not in the usual course of professional treatment'' and, second, ''an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.'' Cal. Health & Safety Code § 11153(a). A violation of this provision is punishable by imprisonment, fine, or both. *Id.* § 11153(b).

Further, California authorities cited in the OSC define unprofessional conduct relevant to the OSC's allegations. OSC, at 2. According to the California Business and Professions Code, it is unprofessional conduct to prescribe a dangerous drug ''without an appropriate prior examination and a medical indication.'' [4] Cal. Bus. & Prof. Code § 2242(a) (West 2023–24); OSC, at 2; Tr. 261–63 (Government's expert witness, Dr. Munzing, testifying). The California Business and Professions Code also states that ''[r]epeated acts of clearly excessive prescribing . . . of drugs or treatment . . . is unprofessional conduct for a physician.'' [5] Cal. Bus. & Prof. Code § 725(a) (West 2023–24); OSC, at 2. The same California Code states that unprofessional conduct includes a physician's ''failure . . . to maintain adequate and accurate records relating to the provision of services.'' Cal. Bus. & Prof. Code § 2266 (West 2023–24); OSC, at 2.

After researching and analyzing the California standard of care, and reviewing the testimony of Dr. Munzing, the Agency credits Dr. Munzing's standard of care testimony in this matter as an accurate reflection of California law. Accordingly, the Agency agrees with the RD's assessment of Dr. Munzing's testimony, and affords Dr. Munzing's testimony full and controlling weight. *See also* RD, at 9–14; *infra* section III.A.

III. Findings of Fact [6]

A. The Government's Case

The Government presented three witnesses—two Diversion Investigators and its expert, Dr. Timothy Munzing. After Respondent stated that he had no objection, the ALJ accepted Dr. Munzing ''as an expert in the practice of medicine in California, including, but not limited to, the applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine, which is what he was proffered as an expert in the government's prehearing statement and his witness summary.'' [7] Tr. 224. Having thoroughly analyzed the record and applicable law, the Agency agrees with the RD that Dr. Munzing ''presented as a knowledgeable and reliable expert witness'' whose testimony about the applicable standard of care and its application to specific individuals and circumstances was ''detailed'' and ''consistent.'' RD, at 9; *supra* section II. The Agency agrees with the RD's assessment that Dr. Munzing is a ''reliable and credible witness'' whose testimony deserves ''full and controlling weight'' and, accordingly, also affords Dr. Munzing's testimony full and controlling weight. RD, at 10; *supra* section II.

B. Respondent's Case

Although his filed submissions and statements indicate an intention to present an affirmative case, Respondent, in the end, chose not to testify or to call any witness.[8] Tr. 615 (Respondent's Counsel stating that ''[t]here's an independent criminal investigation. And, I'm assuming you figured that out, given this case. And so, we are choosing not to'' put on a case). Respondent successfully accomplished the admission of three documents, RX 8, RX 12, and RX 13. *Supra* section II, *infra* section III.C.2.a. His counsel cross-examined all of the Government's witnesses and presented an opening statement and a closing argument.[9] Tr.

[4] The California Code's definition of ''dangerous drug'' includes any drug whose dispensing without a prescription is prohibited by federal law. Cal. Bus. & Prof. Code § 4022 (West 2023–24).

Further, regarding ''unprofessional conduct,'' the California Business and Professions Code references the provisions of Division 2, Chapter 5, and Article 12 for what constitutes ''unprofessional conduct,'' and states that the Medical Board of California ''shall take action against any licensee who is charged with unprofessional conduct.'' *Id.* § 2234 (West 2023–24), *see also id.* § 2241.5(a) and (b) (West 2023–24), that Respondent successfully offered into the record as RX 13 (''A physician . . . may prescribe for . . . a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain including, but not limited to, intractable pain. . . . No physician . . . shall be subject to disciplinary action for prescribing . . . dangerous drugs or prescription controlled substances in accordance with this section.''); *but see id.* § 2241.5(c) (explicitly excepting from its disciplinary action prohibition violations of section 2234 (regarding gross negligence, repeated negligent acts, or incompetence), § 2241 (regarding treatment of an addict), and § 2242 (regarding performing an appropriate prior examination and the existence of a medical indication for prescribing dangerous drugs), among others).

Respondent also successfully offered California Health and Safety Code § 124961 (West 2023–24) (RX 12) (Pain Patient's Bill of Rights). The Agency notes that the primary foci of this provision are the rights of a ''pain patient,'' and that, regarding practitioners like Respondent, its subsection (f) states that ''[n]othing in this section shall do either of the following: (1) Limit any reporting or disciplinary provisions applicable to licensed physicians . . . who violate prescribing practices or other provisions set forth in the Medical Practices Act, Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or the regulations adopted thereunder)'' and ''(2) Limit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state that regulate dangerous drugs or controlled substances.''

[5] Such clearly excessive prescribing is a misdemeanor punishable by fine, imprisonment, or both. Cal. Bus. & Prof. Code § 725(b) (West 2023–24). The section also states that 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,'' and ''[n]o physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with section 2241.5.'' *Id.* §§ 725(c) and (d).

[6] The Agency incorporates the parties' Stipulations and accepts them as fact. RD, at 4, n.4; *see also* Prehearing Ruling, at 2–3. Among other things, the parties' stipulations state that oxycodone, methadone, fentanyl, meperidine, morphine sulfate, and oxymorphone are Schedule II controlled substances, that ketamine is a Schedule III controlled substance, and that carisoprodol and alprazolam are Schedule IV controlled substances. Prehearing Ruling, at 2–3. The first and second stipulations address Respondent's DEA registration and its status. *Id.* at 2.

[7] The first DI (DI1) testified about the search of Respondent's office for medical records and authenticated the medical records that the Government gathered into Government Exhibits (GX) for the hearing. Tr. 30–62. Respondent did not object to the admission of any of those GX and the ALJ admitted all of them. *Id.* at 38–62.

The Agency agrees with the RD that DI1's ''testimony was sufficiently detailed, plausible, and internally consistent to be afforded full credibility,'' and further agrees with the RD to give DI1's testimony full weight. RD, at 5.

The second DI who testified, the lead of the two, (DI2) addressed the investigative steps taken to follow up on the lead that DEA's Los Angeles Field Division received about Respondent. *E.g.* Tr. 72–78, 86–87, 95–97, 113–19, 130–32; *see also* RD, at 5. The Agency agrees with the RD's assessment that Respondent's Counsel's attempts to impeach DI2 were not successful. RD, at 6–7.

The Agency agrees with the RD that DI2 ''presented as an objective, credible witness with no motive to fabricate,'' and that she testified ''clear[ly], consistent[ly], and specific[ally].'' *Id.* at 7. The Agency, therefore, gives DI2's testimony ''full weight.'' *Id.*

[8] Further, Respondent failed to comply with hearing deadlines and processes, resulting in a ruling by the ALJ that disallowed his ability to call an expert to testify on his behalf. Respondent did not request interlocutory review of this ruling, and neither his opening statement nor his closing argument mentions this ALJ ruling.

[9] Respondent's closing argument, on January 24, 2023, involved Counsel's use of ''slides.'' *E.g.,* Tr. 658, 659. As he did not move the slides into evidence, they are not available to the Agency for this adjudication. It is noteworthy that, on January 20th, the second day of the hearing, after a short break at about noon (Eastern), the ALJ provided ''general notice to the parties'' that ''an

17–26 (opening statement), Tr. 657–84 (closing argument). Although he indicated that he would, Respondent did not submit a brief or other written, final argument after the hearing.[10] The Agency carefully reviewed and analyzed Respondent's position in this adjudication, evidenced through items such as his filings, his cross-examinations of the Government's witnesses, the documents he successfully moved into evidence, and his opening statement and closing argument at the hearing. In sum, the Agency concludes that Respondent's arguments are not based on admitted record evidence, are not persuasive, and/or do not successfully rebut the record evidence sponsored by the Government or the Government's *prima facie* case. *Infra* sections III.C.2. and IV.B. Accordingly, and as discussed further throughout, the Agency does not credit Respondent's arguments.

C. Allegation That Respondent Issued Prescriptions for Controlled Substances Beneath the Applicable Standard of Care and Outside the Usual Course of Professional Practice

Having read and analyzed the transmitted record, the Agency finds substantial and uncontroverted record evidence that Respondent, between January 2020 and June 2022, repeatedly issued controlled substance prescriptions in California beneath the applicable standard of care and outside the usual course of professional practice.[11] *See also* RD, at 14–33. The record includes evidence of many such controlled substance prescriptions documented in the thousands of pages of the voluminous, transmitted record.[12] Examples of Respondent's illegal prescribing are set out below.

1. Examples of Respondent's Unlawful Controlled Substance Prescribing From January 2020 Through June 2022

The Agency finds substantial, uncontroverted record evidence of multiple controlled substance prescriptions that Respondent issued for multiple individuals from January 2020 through June 2022 beneath the applicable standard of care and outside the usual course of professional practice.

a. Examples of Unlawful Prescribing to Individual 1

The Agency finds substantial, uncontroverted record evidence that on January 24, 2020, Respondent issued two oxycodone (Schedule II) prescriptions to Individual 1: (1) oxycodone HCl ER 80 mg, #240 (thirty-day supply), with the instructions to ''take one tablet by mouth every three to four hours for severe pain''; and (2) oxycodone HCl 30 mg, #240 (thirty-day supply), with instructions to ''take one tablet by mouth every three to four hours as needed for severe breakthrough pain.'' GX 2c, at 3–4. These prescriptions were issued without a single substantive medical data point, note, or comment in Individual 1's medical record associated with the date of this office visit. GX 2a, at 137.[13] The office visit records state only that Individual 1 will ''. . . bring old records 'again' that 'office lost.' '' *Id.*

Dr. Munzing testified that Respondent's January 24, 2020 controlled substance prescribing for Individual 1 was beneath the applicable standard of care. Tr. 296–305, 306–12. Regarding the January 24, 2020 progress notes for Individual 1, Dr. Munzing testified that, ''there's no information. . . . [I]t says it's an office visit but there's no history, there's no vital signs, there's no exam. . . . [T]here's no listing of diagnoses and no listing of medication. . . . There's nothing else. . . . It is missing more details in regards to the updated condition. It is lacking anything regarding are there any adverse or side effects. It has a minimal examination, but very minimal. There is no assessment listed. There is no management plan listed. . . . It also does not list even what the medications the patients were taking at any of these specific dates and visits.'' Tr. 299–310. Based on this substantial, uncontroverted record evidence, including the expert testimony of Dr. Munzing, the Agency finds that Respondent issued these two Schedule II controlled substance prescriptions to Individual 1 beneath the applicable standard of care and outside the usual course of professional practice.[14]

Dr. Munzing went on to testify about the standard of care for a follow-up visit and concluded that Respondent prescribed subsequent controlled substances beneath that standard of care as well. Tr. 264–65. Dr. Munzing testified that during follow-up visits, physicians ''use something called the five A's as a mnemonic. You know, analgesics: so, how's your pain doing? Activity, functional level. How are you functioning with, with the treatment, not just the medication treatment but the treatment that we have you doing. Are you having any adverse or side effects from the medications? How is the affect of the patient, you know, standing, sitting before you? Do they look high, or do they look like they're falling asleep, or are they actively engaged appropriately in the conversation? And any potential aberrant behaviors, whether it be either

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administrative law judge is not required to comb through the record in search for information. Given the size and complexity of this record,'' the ALJ continued, she wants ''to just state that upfront during the hearing so that you are aware that if you want . . . [her] to consider things, please address them through your witnesses otherwise there is no guarantee that it is going to be considered because this is just, as you can see, it is a large record. It is going to be a complex record.'' *Id.* at 306–07. The ALJ did not ''want anybody to be surprised by that,'' she stated, as she wanted ''to give both sides notice of that general principle that . . . [she] will be adhering to in this case.'' *Id.* at 307.

[10] Eleven individuals who claim Respondent is their doctor sought to intervene in the administrative proceeding to dissolve the order that immediately suspended Respondent's registration, among other things. Emergency Motion—Request a Hearing to Move to Intervene (November 22, 2022). The ALJ denied that stay request and their request to participate in the hearing. Order Denying Patients' Emergency Motion to Intervene (December 2, 2022); *see also* Order Denying Patients' Request to Participate in Prehearing Conference (November 28, 2022). At the beginning of the hearing, the ALJ stated that the eleven ''sought a stay of these proceedings in the D.C. Circuit Court'' and that ''[t]hat stay request was denied last night.'' Tr. 10. As the ALJ does not have authority to alter the immediate suspension of a registration, the ALJ correctly denied the relief that the eleven requested.

[11] During the prehearing phase, Respondent sought federal court relief in the Central District of California from the immediate suspension of his registration (ISO), including a temporary restraining order (TRO). *Bockoff* v. *Garland, et al.,* No. 2:22–cv–09046 (December 15, 2022). The Federal Court denied Respondent's request for a TRO stating, among other things, that Respondent ''concedes that there were issues with his recordkeeping but argues that he did in fact conduct appropriate medical evaluation [sic], testing, and monitoring to justify the high dosages of controlled substances that he prescribed.'' Order Denying Plaintiff's Application for a Temporary Restraining Order, at 3.

[12] To maintain the focus on relevant evidence, the Agency is not considering the references in Respondent's closing argument that pertain to a period before or after the period alleged in the OSC.

[13] The record evidence indicates that each page of Respondent's medical record form should have been used for two patient interactions; however, regarding Individual 1, Respondent used one page of the medical record form to inadequately record nine interactions with Individual 1 from May 13, 2019 to January 24, 2020. *Id.*

[14] Dr. Munzing testified about the standard of care for a legacy patient, *i.e.,* someone who was previously treated by someone different, such as Individual 1, and concluded that Respondent prescribed controlled substances to Individual 1 beneath that standard of care. Tr. 272, 355–58 (Dr. Munzing testifying that Respondent was still required to take a detailed history, confirm the treatment was actually happening, independently evaluate the treatment's appropriateness, determine that the medications were truly prescribed, perform a urine drug test to confirm what medications were actually being taken, and independently determine how to treat the person); *see also* Tr. 339–45 (Dr. Munzing testifying about the lack of an appropriate informed consent by Individual 1 anywhere in Respondent's medical records for the controlled substances that Respondent was issuing Individual 1); *see also id.* at 325–33 (Dr. Munzing testifying about the insufficiency of Respondent's examinations of Individual 1 prior to the period covered in the OSC).

the patient saying, well, I got this medicine from someone else, or aberrant behaviors identified by whether it be the CURES reports or urine drug tests, et cetera.'' Tr. 480–83.[15]

On February 24, 2020, Respondent re-issued to Individual 1 the same two oxycodone prescriptions from January 24, 2020. GX 2b, at 59. Again, Dr. Munzing testified that he did not ''see any assessment at all,'' that ''[t]here is no plan . . . as best that . . . [he] can see,'' that the minimal-to-no documentation means that there is no medication list, no impression documented, and no drug-testing/monitoring addressed until after June 22, 2020. Tr. 316; *see also* Tr. 313–24. Accordingly, the Agency finds substantial, uncontroverted record evidence that Respondent's issuance of the two oxycodone prescriptions on February 24, 2020,[16] was also beneath the applicable standard of care. Tr. 313–24. Notably, this illegal controlled substance prescribing by Respondent gave Individual 1 access to 480 Schedule II tablets in a thirty-day period. *Supra.*

b. Examples of Unlawful Prescribing to Individual 2

The Agency finds substantial, uncontroverted record evidence of illegal controlled substance prescribing regarding Individual 2. The Agency finds that there is substantial, uncontroverted record evidence that on March 18, 2020, Respondent added a new Schedule II controlled substance prescription, methadone HCl 5 mg, #70 (thirty-day supply), to two other controlled substance prescriptions that he had already prescribed to Individual 2 six days before on March 12, 2020, namely, morphine sulfate ER 100 mg, #90 (thirty-day supply) and oxycodone HCl 30 mg, #120 (thirty-day supply). GX 3c, at 7, 9, 10. Dr. Munzing testified that the medical record form that Respondent created for the associated encounter with Individual 2 contained information for encounters on January 16, 2020, March 12, 2020, May 7, 2020, June 29, 2020, August 28, 2020, and October 22, 2020. Tr. 374–80; *see also* GX 3b, at 63. However, Respondent's medical records do not include any entry for March 18, 2020, the date the methadone 5 mg prescription was issued. Tr. 374–76.

Regarding Respondent's addition of methadone 5 mg to the controlled substance prescriptions that he was issuing Individual 2, Dr. Munzing testified that Respondent's medical records for Individual 2, ''just under'' the March 12, 2020 date say ''not getting much help from clonidine.''[17] Tr. 374; *see also* Tr. 375.[18] Dr. Munzing testified, ''[c]lonidine is not a pain medication[, so] it [does not] explain why methadone is started.'' Tr. 376. Dr. Munzing's testimony lists multiple other items missing from Respondent's medical record for Individual 2 associated with the addition of methadone 5 mg, including: an appropriate history, vital signs, a physical examination, an assessment, a specific plan, and documentation of Respondent's discussion with Individual 2 about the increased risk to Individual 2 of increasing the morphine milligram equivalent by adding methadone 5 mg.[19] Tr. 376–77.

The further substantial, undisputed record evidence is that on April 10, 2020, Respondent increased the dosage of the methadone HCl he had prescribed for Individual 2 from 5 mg to 10 mg, with instructions that increased Individual 2's daily methadone dose to 30 mg. GX 3c, at 17; Tr. 379. The Agency notes that Respondent's medical records for Individual 2 during this time period do not show an entry for any day in April 2020, let alone an entry for April 10, 2020, specifically. GX 3b, at 63; GX 3c, at 23 (CURES Consolidated Report showing that the methadone 10 mg prescription for Individual 2 was filled on April 14, 2020).

The Agency credits Dr. Munzing's testimony and finds substantial, uncontroverted record evidence that Respondent issued the March 18, 2020 and April 14, 2020 methadone prescriptions to Individual 2 beneath the applicable standard of care and outside the usual course of professional practice. Tr. 376–80. Moreover, Respondent's illegal morphine sulphate, oxycodone, and methadone controlled substance prescribing to Individual 2 gave Individual 2 access to 280 Schedule II controlled substance tablets in a thirty-day period. *Supra.*

c. Examples of Unlawful Prescribing to Individual 3

The Agency finds substantial, uncontroverted record evidence of illegal controlled substance prescribing regarding Individual 3. Substantial record evidence shows that on March 13, 2020, Respondent prescribed methadone HCl 5 mg, #70 (thirty-day supply) to Individual 3. GX 4d, at 30, 42. Dr. Munzing credibly testified that there is nothing on the January 13, 2020 through April 9, 2020 page of Respondent's medical record notes for Individual 3 documenting why Respondent issued the methadone HCl 5 mg prescription to Individual 3 on March 13, 2020. Tr. 420–23. The Agency, therefore, finds substantial, uncontroverted record evidence that Respondent's medical records for Individual 3, dated January 13, 2020, and March 13, 2020, do not include, as the applicable standard of care requires, Respondent's medical analyses, impressions, justifications, or rationales for prescribing methadone to Individual 3 on March 13, 2020.[20] Tr. 420–23; *see also* GX 4b, at 675; RD, at 20–21.

[15] The Agency further finds that the record also includes substantial, uncontroverted evidence of Respondent's controlled substance-related negative experience. For example, substantial, uncontroverted record evidence shows that Respondent ordered urine drug screens (UDS) for Individual 1 in March of 2020 and in March of 2021, yet failed to document how, if at all, he addressed the screens' aberrant results. GX 2a, at 59–60; Tr. 345–46. Given the seriousness, going to the core of the CSA, of the examples set out in this section, any one of which, alone, is sufficient to support the revocation of Respondent's registration, there is no need for the Agency to detail any other examples of Respondent's negative controlled substance-related experience.

[16] In addition, Respondent re-issued the same two Schedule II controlled substance prescriptions (oxycodone) to Individual 1 monthly thereafter, at least through September 18, 2020. GX 2c, at 5–40.

[17] Dr. Munzing testified that he cannot read Respondent's handwriting in red ink next to ''OV: 3–12–20'' and directly after '' 'allergic' to'' something. Tr. 375. The word that Dr. Munzing could not make out appears to possibly be ''buprenorphine.''

[18] Dr. Munzing also testified that Respondent appears to have indicated in Individual 2's medical record that Respondent prescribed 20 mg of methadone per day when, in fact, according to CURES he was prescribing 30 mg per day. Tr. 379. Further, Dr. Munzing also testified that, on Respondent's medical record entry for Individual 2's office visit on May 7, 2020, the month after Respondent increased Individual 2's methadone dosage from 5 mg to 10 mg, ''there's no[t] even mention of methadone or any of the controlled substances listed there.'' *Id.;* GX 3c, at 17 (Respondent's increased dosage of methadone for Individual 2 issued on April 10, 2020, methadone HCl 10 mg, #90 (thirty-day supply)).

[19] The Agency does not credit Respondent's closing argument defense that he obtained a signed consent form from Individual 2 to prescribe methadone. Even if Respondent had a signed consent form, it does not excuse Respondent's failure to comply with the applicable standard of care that requires Respondent to note in the medical record why he decided to prescribe a controlled substance.

[20] Dr. Munzing, when asked if he would agree that ''the huge majority of patients that . . . [Respondent] was treating, in fact, he was treating them for intractable pain,'' testified that he thinks Respondent ''thought he was treating them for intractable pain,'' but that the ''documentation doesn't really support that.'' Tr. 550–51. In explaining, Dr. Munzing used Individual 3 as an example. His testimony counterposes Respondent's evaluation and management of Individual 3 against those of Individual 3's gastroenterologist who, in 2018, had not seen Individual 3 ''for quite some time, ordered some tests, ordered some imaging studies that we have no idea what those studies, the results of those studies. We haven't seen those in the medical records. . . . The gastroenterologist who had seen . . . [Individual 3] many years before said . . . I really haven't seen you for quite some

Similarly, the Agency finds substantial, uncontroverted record evidence that the following month, on April 9, 2020, Respondent increased the dosage of the methadone HCl prescribed to Individual 3 to 10 mg and the frequency from once a day to three times a day. GX 4d, at 51, 54; GX 4b, at 674. Again, Dr. Munzing testified that Respondent issued the April 9, 2020 prescription to Individual 3 without any explanation for the increased dosage in Respondent's corresponding medical record notes. Tr. 423–27. The Agency, therefore, finds that based on the substantial, uncontroverted record evidence, Respondent's April 9, 2020 medical record note does not include, as the applicable standard of care requires, Respondent's medical analyses, impressions, justifications, or rationales for increasing the methadone dosage for Individual 3 on that date. Tr. 423–27; *see also* RD, at 21.

Accordingly, based on the documentary record evidence and crediting the record testimony of Dr. Munzing, the Agency finds substantial, uncontroverted record evidence that in March and April of 2020, Respondent prescribed methadone for Individual 3 beneath the applicable standard of care and outside the usual course of professional practice. Tr. 422–27. Further, Respondent's illegal controlled substance prescribing to Individual 3 gave Individual 3 access to 70 Schedule II tablets for a thirty-day period.

d. Examples of Unlawful Prescribing to Individual 4

The Agency finds substantial, uncontroverted record evidence of illegal controlled substance prescribing regarding Individual 4. Substantial record evidence shows that on January 17, 2020, Respondent issued three controlled substance prescriptions to Individual 4: (1) alprazolam 2 mg, a benzodiazepine, #60 (thirty-day supply); (2) oxycodone 30 mg, #60 (fifteen-day supply); and (3) methadone 10 mg, #90 (fifteen-day supply). GX 6e, at 3–5; Tr. 489–90. The Agency finds that Respondent's medical record for Individual 4 associated with these three controlled substance prescriptions is dated January 10, 2020. Tr. 490–91; GX 6c, at 63. The Agency further finds substantial, uncontroverted record evidence that Respondent's medical record notes associated with the issuance of these three controlled substance prescriptions ''lack[s] . . . a lot of information that would be expected and would be required.'' Tr. 490–91 (Dr. Munzing testifying); *see also* RD, at 24–25. Accordingly, the Agency finds that, based on the documentary record evidence and the record testimony of Dr. Munzing, the substantial, uncontroverted record evidence shows that Respondent issued these three controlled substance prescriptions to Individual 4 beneath the applicable standard of care and outside the usual course of professional practice. Tr. 490–91. Further, Respondent's illegal controlled substance prescribing to Individual 4 gave Individual 4 access to 390 controlled substance tablets for a thirty-day period, of which 300 tablets were Schedule II and 90 tablets were Schedule IV.

e. Examples of Unlawful Prescribing to Individual 5

The Agency finds substantial, uncontroverted record evidence of illegal controlled substance prescribing regarding Individual 5. Substantial, uncontroverted record evidence shows that on January 7, 2020, Respondent issued four controlled substance prescriptions to Individual 5: (1) oxymorphone HCl ER 20 mg, #240 (thirty-day supply); (2) oxymorphone HCl 10 mg, #180 (thirty-day supply); (3) carisoprodol 350 mg, #90 (thirty-day supply); and 4) buprenorphine HCl 8 mg, #60 (thirty-day supply). GX 5c, at 1–8; Tr. 473–75. The Agency finds that the office visit associated with Respondent's issuance of these four controlled substance prescriptions was on January 7, 2020. GX 5b, at 82; Tr. 475–76. Although Respondent recorded that Individual 5 visited his office on January 7, 2020, he wrote nothing after the date of the office visit in Individual 5's medical records. GX 5b, at 82; RD, at 26. Dr. Munzing testified that Respondent's controlled substance prescribing to Individual 5 on January 7, 2020, was beneath the applicable standard of care because Respondent failed to document Individual 5's medical history, vital signs, and medications; an appropriate physical examination of Individual 5; an updated assessment of Individual 5; and a treatment plan for Individual 5. Tr. 476.

The Agency, therefore, finds that based on the substantial, uncontroverted record evidence and the testimony of Dr. Munzing, Respondent issued the four controlled substance prescriptions on January 7, 2020, beneath the applicable standard of care and outside the usual course of professional practice. Tr. 476; *see also* RD, at 26. Further, Respondent's illegal controlled substance prescribing for Individual 5 gave Individual 5 access to 570 controlled substance tablets for a thirty-day period, of which 420 tablets were Schedule II, 60 tablets were Schedule III, and 90 tablets were Schedule IV.

In sum, the Agency finds substantial, uncontroverted record evidence of multiple controlled substance prescriptions that Respondent issued for multiple individuals from January 2020 through June 2022 beneath the applicable standard of care and outside the usual course of professional practice.

2. Respondent's Arguments Against the Government's Evidence

Respondent sought to impugn the Government's evidence, including Dr. Munzing's credibility and testimony, in multiple ways.[21] Regarding Dr. Munzing's testimony about Respondent's medical records of his controlled substance prescribing, Respondent argues that Dr. Munzing is not in a position to formulate an expert opinion on the matter because he was not present during Respondent's interactions with any of the five individuals discussed in the OSC. Tr. 310–11 (Respondent arguing that ''Dr. Munzing continues to conflate what is in the records and what happened at the actual exam. He acts as though, and testifies as such, that he knows what happened at this examination and that just simply is not true unless he has interviewed someone or is looking at other notes. He is perfectly capable, and it is proper for him to talk about the sufficiency of the medical records. And there is no indication in the records that these things occur. But that is not what he is saying. He is saying that these things never happened. And I do not believe there is a basis for that in the record nor do I believe he has a basis to make such a statement.''), *id.* at 319–20 (Respondent arguing that Dr. Munzing ''continues to act as though the fact that something doesn't appear in the record means it didn't happen when in fact the evidence is to the contrary.''), *id.* at 344 (Respondent arguing that Dr. Munzing ''clearly specifically is conflating the standard of care for informed consent with the standard of care for documentation''). The Agency does not

time and you haven't had any recent workup. So, I don't believe the gastroenterologist was assuming that . . . [Individual 3] had intractable pain. He felt that we need to find out what's going on.'' Tr. 550, 552.

[21] The Agency carefully evaluated each of Respondent's objections based on the parameters of the OSC's allegations—between January 2020 through June 2022. *E.g.,* Tr. 326, 332, 358. None of the findings in this Decision are based on evidence dated outside of the OSC's January 2020 through June 2022 parameter. Evidence dated outside of the parameter is only considered for context, as appropriate given the OSC's allegations. *Supra* section III.C.1.

credit this category of Respondent's objections.

Section 2266 of the California Business and Professions Code is clear: it is unprofessional conduct for a physician to fail ''to maintain adequate and accurate records relating to the provision of services.'' *Supra* section II. The ALJ handled Respondent's arguments correctly. Tr. 311 (ALJ stating that ''there is agency case law that says if it is not in a document, then it did not happen''); RD, at 4, n.5 (citing prior Agency decisions, stating that they ''make clear'' that a controlled substance prescription is issued beneath the applicable standard of care and outside the usual course of professional practice when a registrant fails to create adequate documentation of his controlled substance prescribing, including of all of the steps that led to his issuing each controlled substance prescription), *see also* RD, at 38 (citing prior Agency decisions); Tr. 360–61 (ALJ ruling that Dr. Munzing ''is reviewing documentation. He can make conclusions based on that documentation regarding the standard of care and I just didn't want to leave anybody with a misunderstanding of how I was approaching it. I'm not viewing it as just a recordkeeping violation and I will allow respondent to address on cross examination his point that Dr. Munzing is relying on documentation and was obviously not present during the examinations.'').

Respondent further argues that he is allowed to write ''follow-up prescriptions'' without ''these intense examinations'' that Dr. Munzing ''has previously described.'' *Id.* at 324–25. The Agency thoroughly reviewed California's standard of care and finds no support in it for Respondent's argument. *Supra* sections II and III.C.1.a.

Regarding the Government's allegation that Respondent's monitoring through UDS was beneath the applicable standard of care and outside the usual course of professional practice, Respondent argues that the ''Government's theory has now shifted from the OSC. Now they say that . . . [Respondent] did not adequately address aberrant results.'' Tr. 679. Based on the multiple references to UDS and UDS-related allegations in the OSC, the Agency does not credit Respondent's argument that the Government's theory about UDS ''shifted from the OSC.'' [22]

Respondent's argument about the OSC's UDS allegations then states that ''the logical inference from looking at the patient files is that . . . [Respondent] addressed the issue with his patients to his satisfaction, sufficient to make him comfortable to continue prescribing. The notion that he ignored aberrant results is absurd. Why would . . . [Respondent] be doing regular urine drug screening to just ignore the results. It does not make any sense.'' [23] *Id.* at 679. The Agency has not credited this argument in the past, and it does not credit Respondent's iteration of it now. *E.g., Benton D. Wynn, M.D.,* 87 FR 24,228, 24,234–35 (2022); *Craig S. Rosenblum, M.D.,* 87 FR 21,181, 21,203 (2022); *John X. Qian, M.D.,* 87 FR 8039, 8051–52 (2022).

Regarding Respondent's continued controlled substance prescribing as his medical records improved, Dr. Munzing acknowledges that the ''medical records improved a lot.'' Tr. 537. When Respondent's Counsel retorted that Respondent ''did nothing wrong'' after his medical records improved and ''had come into compliance,'' Dr. Munzing answered that ''[i]f the prescribing continued as it was, . . . I still don't agree that the prescribing was . . . okay.'' *Id.* at 537–38. Respondent's argument that improved medical records also mean that the underlying controlled substance prescribings then become legitimate is a *non sequitur.* The Agency does not credit Respondent's argument that his improved medical records mean that his controlled substance prescribing then fell within the applicable standard of care and the usual course of professional practice.

The Agency addresses Respondent's other arguments below, starting with the arguments based on Respondent's three exhibits, and then categorizing Respondent's remaining arguments into those concerning Dr. Munzing and those concerning DEA's investigation. In sum, the Agency does not credit any of Respondent's arguments. *See also, e.g.,* RD, at 4, 7–10, 26, 38–40.

a. Respondent's Arguments Based on His Three Exhibits

As already discussed, Respondent successfully offered three documents into evidence. First, RX 8 is titled ''How to Prescribe Controlled Substances to Patients During the COVID–19 Public Health Emergency'' (Pandemic Prescribing).[24] This one-page document states that DEA ''adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients.'' RX 8, at 1. It is a ''guidance document'' that is ''not binding and lack[s] the force and effect of law, unless expressly authorized by statute or expressly incorporated into a contract, grant, or cooperative agreement.'' *Id.* Pandemic Prescribing states that its ''policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.'' *Id.* Pandemic Prescribing states that, ''[u]nder federal law, all controlled substance prescriptions must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice. 21 CFR 1306.04(a).'' *Id.* It continues that, ''[i]n all circumstances when prescribing a controlled substance, including those summarized below, the practitioner must use his/her sound judgment to determine that s/he has sufficient information to conclude that the issuance of the prescription is for a *bona fide* medical purpose.'' *Id.* Its prefatory content concludes by stating that ''[p]ractitioners must also comply with applicable state law.'' *Id.* Finally, Pandemic Prescribing cites to the DEA Diversion internet address and ''relevant law and regulations'' for ''[f]ull details.'' *Id.*

According to RX 8, how a practitioner evaluates a patient, from March 31, 2020 through the duration of the public health emergency, depends on whether

[22] The Agency notes that the OSC includes multiple references to, and allegations about, UDS and Respondent's use or lack of use of UDS. Regarding Individual 2 and Individual 1, the OSC states that Respondent ''failed to order regular urine drug screening, and failed to properly address the results.'' OSC, at 4, 7. Regarding Individual 3, Individual 4, and Individual 5, the OSC states that Respondent ''failed to order regular urine drug screening.'' *Id.* at 5, 6, 7. The OSC also states that the CDC Guidelines for the Prescription of Opioids for Chronic Pain ''direct clinicians to address aberrant urine drug screen results with the patients.'' *Id.* at 3.

[23] This Decision and Order do not reach the OSC's allegations about Respondent's use or non-use of UDS. *Infra* n.35.

Respondent employs a similar argument concerning whether Respondent had ongoing management plans as required by the California standard of care. Concerning Dr. Munzing's testimony that he does not see Respondent's management plan for Individual 1, Respondent argues that Dr. Munzing ''is complaining [sic] what the plan should be and whether or not the plan is documented. He is acting and testifying as though the fact that information does not appear in the medical records means that this didn't happen. . . . I would say exactly the opposite. The fact that . . . [Respondent] put the word plan in here indicates he has a plan, and he has talked about it with his patient on this day. Whether or not this is a documentation issue is a separate argument that we can make at a later date and time. But he continues to act as though the fact that something doesn't appear in the record means it didn't happen when in fact the evidence is to the contrary.'' Tr. 319–20. The Agency rejects this and similar arguments by Respondent as *non sequiturs.*

[24] Respondent's Counsel references an expert, Dr. H., but Dr. H. did not testify, nor did Respondent seek the admission of any written opinion by Dr. H. *See, e.g.* Tr. 594.

the practitioner previously examined the patient in person. *Id.* If so, then the ''[p]ractitioner may conduct any needed follow-up evaluation by any method in person, telemedicine, telephone, email, etc.'' *Id.* If not, then a Practitioner who is prescribing ''buprenorphine for maintenance or detoxification treatment of an opioid use disorder . . . [e]valuate[s the] patient . . . in person, or via telemedicine using a real-time, two-way, audio-visual communications device.'' *Id.* If the practitioner has not previously examined the patient in person and is not prescribing buprenorphine for maintenance or detoxification treatment of an opioid use disorder, then the practitioner ''[e]valuates [the] patient . . . in person or via telemedicine using a real-time, two-way, audio-visual communications device.'' *Id.* In short, the DEA document about prescribing controlled substances during the COVID–19 public health emergency does not dispense with the legal standards of the required evaluation; it expands the options available to practitioners for conducting the required evaluation. *Id.*

The Agency finds substantial record evidence that Dr. Munzing's testimony accurately describes the content of Pandemic Prescribing. *See, e.g.,* Tr. 610–11. The Agency further finds substantial record evidence that Dr. Munzing's testimony accurately identifies which of Respondent's medical records concern in-person visits and which of Respondent's medical records describe telehealth interactions. *See, e.g., id.* at 609 (Dr. Munzing's testimony explaining that Respondent's medical records identify whether the note concerns an in-person visit or a telehealth interaction, and how they do so). Respondent, nevertheless, during his closing argument criticizing Dr. Munzing, argues that he ''talked a lot about in[-]person examinations and the need for the practitioner to lay hands on a patient if you're seeing them in person. But he ignored the DEA's own guidelines for the COVID pandemic that said in person visits were not required during the pandemic.'' Tr. 680. The Agency carefully considered this argument of Respondent and concludes that it is not a valid criticism of Dr. Munzing. On the one hand, Respondent's argument, cited in full above, accurately states that Dr. Munzing testified about the patient examination required by the applicable standard of care. This is to Dr. Munzing's credit.

On the other hand, Respondent's argument asserts, without support or citation to the record, that Dr. Munzing ''ignored'' Pandemic Prescribing. As already discussed, the record evidence shows the opposite and, therefore, the Agency does not credit this Respondent criticism of Dr. Munzing. Further, the Decision's findings that the Government established a *prima facie* case and that Respondent did not successfully rebut it are based solely on Respondent's in-person interactions. The Agency concludes that those in-person interactions and associated controlled substance prescribings do not comply with the applicable standard of care. *Supra* sections II and III, *infra* sections IV and V.

The second item that Respondent successfully moved into evidence is RX 12, a copy of section 124961 of the California Health and Safety Code. According to this provision, titled the ''Pain Patient's Bill of Rights,'' a ''patient who suffers from severe chronic intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her pain,'' and ''has the option to choose opiate medications to relieve that pain without first having to submit to an invasive medical procedure,'' among other things. Cal. Health & Safety Code § 124961(a) and (b). The provision also includes clauses addressing practitioners, such as ones explicitly stating that a ''patient's physician may refuse to prescribe opiate medication,'' and that a ''physician who uses opiate therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve the patient's pain, as long as that prescribing is in conformance with Section 2241.5 of the Business and Professions Code.'' *Id.* § 124961 (c) and (d).

Indeed, Respondent successfully moved into evidence, as RX 13, section 2241.5 of the California Business and Professions Code, a provision mentioned in section 124961 multiple times. *Infra.* Section 124961 references section 2241.5 when it states that, ''[n]othing in this section shall be construed to alter any of the provisions set forth in Section 2241.5 of the Business and Professions Code.'' *Id.* § 124961 (preface). Section 124961 further states, explicitly, that it shall not ''[l]imit any reporting or disciplinary provisions applicable to licensed physicians and surgeons who violate prescribing practices or other provisions set forth in the Medical Practice Act,'' and that it shall not ''[l]imit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state that regulate dangerous drugs or controlled substances.'' *Id.* § 124961 (preface) and (f)(2).

The Agency finds that the provisions of section 124961, while called the ''Pain Patient's Bill of Rights,'' do not alter the standard of care applicable to physicians treating those ''Pain Patients.'' For example, the provisions afford a patient ''who suffers from severe chronic intractable pain . . . the option to request or reject the use of any or all modalities in order to relieve his or her pain.'' *Id.* § 124961(a). At the same time, though, the section explicitly states that practitioners may refuse to prescribe opioids, and that practitioners who do prescribe opioids must continue to comply with all associated state and federal legal requirements when doing so. *Id.* § 124961(c) and (f)(2). In other words, the Agency finds that the provision does not alter a practitioner's responsibility to comply with the applicable standard of care.

In addition, the provisions of RX 13, section 2241.5, include permission for a ''physician and surgeon . . . [to] prescribe for . . . a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain . . . including, but not limited to, intractable pain.'' Cal. Bus. & Prof. Code § 2241.5(a). It also includes protections from disciplinary action for a physician who prescribes dangerous drugs or controlled substances ''in accordance with this section,'' and caveats that the section does not impact medical board action against a physician who, among other things, engages in unprofessional conduct including gross negligence, repeated negligent acts, or incompetence, violates the requirement to perform an appropriate prior examination before prescribing a dangerous drug, prescribes in violation of California law, or fails to comply with all state controlled substance recordkeeping requirements. *Id.* § 2241.5(b) and (c).

Regarding RX 12 and RX 13, Respondent, during his cross-examination of Dr. Munzing and his closing oral argument, primarily focuses on the prohibition of disciplinary action ''for prescribing or administering a controlled substance in the course of treatment of a person for intractable pain'' and how the ''clear'' California ''public policy in favor of making sure patients have access to adequate treatment for their pain . . . would be severely undermin[ed]'' if Respondent's registration were revoked. *E.g.,* Tr. 554, 683. Respondent places much less, if any, emphasis on the fact that neither of these California statutes, or Pandemic Prescribing, authorizes a registrant to violate the applicable standard of care

when prescribing a controlled substance. *Supra.* This fact is of the utmost importance for the appropriate adjudication of the OSC and leads to the inescapable conclusion that neither RX 8, RX 12, nor RX 13 justifies or excuses Respondent's violations of the applicable standard of care while prescribing controlled substances.

b. Respondent's Additional Arguments Concerning Dr. Munzing

Respondent levels multiple, additional criticisms against Dr. Munzing.[25] After carefully considering each of them, the Agency credits none of them. *See also* RD, at 7–8.

Respondent argues that Dr. Munzing does not have the expertise, as a career employee of Kaiser who is not board certified in pain, to testify about Respondent's controlled substance prescribing for individuals with intractable pain. *E.g.,* Tr. 546–47. When given the opportunity during the hearing to address the Government's proffering of Dr. Munzing as an expert, however, Respondent twice stated that he had no objection to the acceptance of Dr. Munzing as an expert. *Id.* at 205, 224. Upon Respondent's final ''no objection'' response to the ALJ regarding qualifying Dr. Munzing as an expert, the ALJ accepted Dr. Munzing as an expert ''in the practice of medicine in California, including, but not limited to, the applicable standards of care in California for the prescribing of controlled substances within the usual course of the professional practice of medicine, *which is what he was proffered as an expert in the [G]overnment's prehearing statement and his witness summary* [emphasis added].'' *Id.* at 224.

Respondent had more than two months' notice of the Government's proposed parameters for Dr. Munzing's testimony. *Id.; see also* Government Prehearing Statement (November 16, 2022), at 5–6. Accordingly, this notice and Respondent's ''no objection'' responses to the ALJ about the Government's proffering Dr. Munzing as its expert foreclose Respondent's subsequent, closing argument challenges to Dr. Munzing's expert qualifications. They further foreclose Respondent's closing argument assertions that, ''Dr. Munzing's opinion about the California standard of care is unreliable,'' including that Dr. Munzing ''rambled'' and testified to best practices, not necessarily to the applicable standard of care.[26] *Id.* at 667. The Agency, as already discussed, finds that the testimony of Dr. Munzing, on which this Decision is based, is fully consistent with the applicable standard of care; it is not ''rambling'' and it does not confuse the Agency as to the difference between the applicable standard of care and matters that are not incumbent on registrants, like Respondent, to follow. *Supra* sections II and III.C.1, *infra* section IV.B; *see also* RD, at n.10. Accordingly, the Agency does not credit the ''rambling'' and ''best practices'' criticisms that Respondent levels against Dr. Munzing's expert testimony.

The Agency does not credit Respondent's closing argument and statements during Dr. Munzing's testimony criticizing Dr. Munzing because he never examined, interviewed, or otherwise interacted with any of the individuals who saw Respondent and whose medical records are referenced in the OSC. *E.g.,* Tr. 312–13 (Dr. Munzing testifying that he did not speak to anybody whose medical records by Respondent he reviewed), *id.* at 592–93 (Dr. Munzing testifying that he reviewed the materials about the five individuals referenced in the OSC), *id.* at 311 (Respondent's Counsel stating that Dr. Munzing ''acts as though, and testifies as such, that he knows what happened at this examination and that just simply is not true unless he has interviewed someone or is looking at other notes'' and that Dr. Munzing ''is saying that these things never happened. And I do not believe there is a basis for that in the record nor do I believe he has a basis to make such a statement.''), *id.* at 666–67 (Respondent's Counsel arguing that Dr. Munzing's testimony ''lacks foundation'' because he does not know how Respondent ''actually examined his patients,'' ''[h]e has never examined these patients nor has he or anyone else from the DEA ever attempted to speak to them''), *id.* at 678 (Respondent's Counsel arguing that ''notably, Dr. Munzing never testified that the course of treatment for these patients was inappropriate in any way. He merely testified that it was not adequately documented.''); *id.* at 311–12 (ALJ overruling Respondent's objection, stating that, ''[t]he point is well taken . . . I would like precision here. I will note that there is agency case law that says if it is not in a document, then it did not happen. . . . [W]hat he [Dr. Munzing] is saying is his reading of the . . . records, that is not documented anywhere in these notes and that should be documented in these notes,'' but interrupted by Respondent's Counsel stating that, ''I fully accept that, Your Honor'').

As already discussed in the standard of care section, the Agency finds that Dr. Munzing's testimony accurately conveys and applies the applicable standard of care to the record evidence he was asked to address. *Supra* section II. Accordingly, Dr. Munzing's credible testimony informs this Decision's finding that the Government established a *prima facie* case and that Respondent did not successfully rebut it.[27] *Supra*

[25] The record shows that the ALJ clearly, explicitly, and repeatedly afforded Respondent the opportunity to ask the Government's witnesses questions during cross-examination. *E.g.* Tr. 342, 482.

[26] In this portion of Respondent's closing argument, Respondent's Counsel states: ''Fourth, Dr. Munzing's opinion about the California standard of care is unreliable. During his testimony, it was not clear when something he was opining on was what he viewed as a best practice or something that actually fell below the standard of care. As Your Honor knows, there is a wide range of conduct that falls within the standard of care. Revocation is only appropriate if his practices fell outside the balance of legitimate medical practice and outside the ordinary course of professional practice. Dr. Munzing's opinions were not focused on that narrow issue, were often rambling, and did not reliably establish a violation of the standard of care. In fact, at times, when the Court posed direct questions to Dr. Munzing about the standard of care, he was evasive and did not directly answer the questions.'' Tr. 667.

[27] The Agency notes that Respondent's oral closing argument cites only three specific exhibit references: GX 3b, at 161 and 163 and GX 3b, at 129. Tr. 658–84. Respondent claims that these documents date back to 2012 and 2013 to 2015, respectively. *Id.* at 670. While the Agency confirms that GX 3b, at 161 and 163 concern matters dating from 2012, there is no visible date on the page at GX 3b, at 129. Further, according to Respondent's closing argument, GX 3b, at 161 and 163 show that Individual 2 ''first came to see . . . [Respondent] in 2012 and at that time, Individual 2 was already on opioid medications from another doctor.'' *Id.* The Agency confirms Respondent's statement only to the extent that GX 3b, at 161 is a page showing 2012 CURES data, indicating that Individual 2 filled oxycodone HCl 30 mg and apap/oxycodone 325 mg-10 mg prescriptions on April 15, 2012 and August 18, 2012, respectively, issued by a physician other than Respondent. The Agency also confirms that GX 3b, at 163, consisting of CURES data, indicates that Individual 2 filled oxycodone hydrochloride 30 mg prescriptions on August 1, 2012 and August 29, 2012 issued by the same other physician. Regarding GX 3b, at 129, Respondent's closing argument states that the page ''shows that there is a significant gap in medical records for [Individual 2], and that's because . . . [Individual 2] was not receiving opioids during that time.'' *Id.* The Agency does not agree with Respondent's representation of GX 3b, at 129. GX 3b, at 129 is an undated LabCorp form with Individual 2's name and check marks next to comprehensive metabolic panel and CBC blood tests. There is no legible reference to an opioid on the page. GX 3b, at 129.

The third specific exhibit that Respondent references during his closing argument is GX 2a, at 136, concerning Individual 1. Tr. 663. According to Respondent's closing argument, it is ''not true'' that Respondent did not attempt to reduce controlled substance use by utilizing safer alternatives.'' *Id.* Instead, Respondent ''attempted to taper the patients down and in some cases, he was successful in doing so.'' *Id.* It is immediately after these words that the closing argument references GX 2a, at 136, stating that this page ''shows [Individual 1's] previous doctor prescribed the trinity combination

sections II., III.A., and III.C.1; *see also* RD, at 7–14.

Respondent criticizes Dr. Munzing's consulting work, including his work for United States law enforcement, stating that it compromises the independence Dr. Munzing needs to be a credible witness in this adjudication. *See, e.g.,* Tr. 514–17, 563–74. Further, Respondent, based on Dr. Munzing's *curriculum vitae,* GX 7, criticizes Dr. Munzing for lecturing about ''collaborating'' with law enforcement, suggesting that it shows ''inappropriate collaboration'' with law enforcement. GX 7, at 13; *e.g.,* Tr. 514–17. The Agency considered these criticisms of Dr. Munzing's independence and does not credit them for multiple reasons, namely because the Agency finds that Dr. Munzing's standard-of-care testimony conforms to the applicable standard of care and Dr. Munzing credibly and consistently applied the standard of care to the facts in this case. *Supra* section II; *see also* RD, at 7–9.

Similarly, Respondent asked Dr. Munzing about whether he had foreknowledge of the search warrant, including whether he had a role in drafting the search warrant for Respondent's medical records, about whether he was involved in the Government's deployment of undercover officers during its investigation of Respondent, and about financial aspects of his service as a medical consultant to law enforcement, including insinuating financial irregularities by Dr. Munzing.[28] *E.g.,* Tr. 575–92, 611–14. Although Respondent was given the opportunity and tried, the Agency finds that he did not successfully articulate the relevance of these questions. Even if he had been successful, Dr. Munzing's credible and consistent testimony is that he played no role in the search warrant drafting, that he did not see the search warrant affidavit before the September 2021 search took place, that he would not typically discuss whether to send undercover officers into a registrant's office, and that he ''does not believe'' that he discussed sending undercover officers into Respondent's office before the investigators took that action.[29] *Id.* at 521–22, 517.

Further, as already discussed, the Agency finds that Dr. Munzing's testimony accurately states the applicable standard of care, and accurately applies that standard of care to the record evidence that he was asked to address and that forms the bases of this Decision's findings of fact and conclusions of law. *See also* RD, at 8–10.

c. Respondent's Arguments Concerning DEA's Investigation

Respondent also challenges the process used during the Government's investigation of him and the ensuing issuance of the OSC. *E.g.,* Tr. 525–30. For example, Respondent argues that DEA issued the OSC before it possessed all of Respondent's medical records and, therefore, Respondent posits, before it had a basis to allege that Respondent's controlled substance prescribing violates the applicable standard of care. *E.g., id.* at 620–25 (Respondent arguing that DEA's search warrant affidavit falsely states that the search warrant is necessary because Respondent's medical practice is ''illegitimate'' when DEA did not possess all of the records needed to reach such a conclusion). The Agency finds that the questions Respondent raises about DEA's investigation of his practice are not creditable. The Agency certainly understands that Respondent would have preferred for DEA to have possessed all of Respondent's medical records at once, for DEA to have assessed that Respondent's medical recordkeeping improved after he became aware of DEA's investigation of his practice, and for the Agency not to have suspended Respondent's registration due to Respondent's improved recordkeeping.[30] The Agency disagrees, though, as it recently reasserted. *Morris & Dickson Co., LLC,* 88 FR 34,523, 34,539–40 (2023) (''[T]he Agency has also made it abundantly clear that remediation alone is not adequate to avoid a sanction and that limited-to-no-weight is given to remedial measures when the effort is not made until after enforcement begins. *See Mireille Lalanne, M.D.,* 78 FR 47,750, 47,777 (2013) (quoting *Liddy's Pharmacy, L.L.C.,* 76 FR 48,887, 48,897 (2011) (''The Agency has recognized that a cessation of illegal behavior only when 'DEA comes knocking at one's door,' can be afforded a diminished weight borne of its own opportunistic timing.'')); *see also Southwood Pharm. Inc.,* 72 FR at 36,503 (giving no weight to respondent's 'stroke-of-midnight decision' to cease supplying suspect pharmacies with controlled substances

to him. . . . [Respondent] did not do so. He prescribed oxycodone HCl and oxycodone.'' *Id.*

The Agency examined GX 2a, at 136. The page is a ''consolidated report'' from CURES. It shows that Individual 1 filled controlled substance prescriptions issued by three doctors, the most recent being Respondent, from October 16, 2018 to April 20, 2019. There are two prescriptions that Individual 1 filled immediately before Respondent started prescribing for Individual 1 on March 14, 2019: oxycodone HCl 30 mg, 120 tablets for a fifteen day supply, and oxycodone HCl 80 mg, 45 tablets, also for a fifteen day supply. GX 2a, at 136. There is no indication on GX 2a, at 136 that this physician ''prescribed the trinity combination'' to Individual 1. *Id.*

Further, the exhibit does not show that Respondent ''attempted to taper'' Individual 1 ''down and . . . was successful in doing so.'' *Id.* Instead, it shows the opposite. The page shows that Individual 1 filled four controlled substance prescriptions issued by Respondent: on March 20, 2019, Individual 1 filled a controlled substance prescription issued by Respondent for oxycodone HCl 80 mg, 240 tablets for a thirty-day supply; on March 28, 2019, Individual 1 filled a controlled substance prescription issued by Respondent for oxycodone HCl 30 mg, 240 tablets for a thirty-day supply; and again, on April 18, 2019, Individual 1 filled a controlled substance prescription issued by Respondent for oxycodone HCl 80 mg, 240 tablets for a thirty-day supply; and on April 20, 2018, Individual 1 filled a controlled substance prescription issued by Respondent for oxycodone HCl 30 mg, 240 tablets for a thirty-day supply. *Id.*

Accordingly, based on the face of GX 2a, at 136, the Agency disagrees with Respondent's characterization of it. *Id.* The Agency finds that GX 2a, at 136 shows that Respondent continued the prior physician's prescribing of oxycodone HCl 30 mg, although Respondent extended the prescribing from a fifteen-day supply to a thirty-day supply, thus making twice the number of tablets available to Individual 1 upon the filling of one prescription. *Id.* As for the oxycodone HCl 80 mg prescribing, while the Agency also finds that Respondent extended this prescribing for Individual 1 from a fifteen-day to a thirty-day supply, the Agency further finds that Respondent tripled the dosage, from three tablets a day (forty-five tablets for a fifteen-day supply) to eight tablets a day (two hundred forty tablets for a thirty-day supply). *Id.* Since the data appearing on GX 2a, at 136 are from a period that is outside the period alleged in the OSC, however, this Decision's finding that the Government established a *prima facie* case and that Respondent did not successfully rebut it are not based on those data.

Further, despite Respondent's argument that the ''voluminous'' number of his medical records shows that ''there is no doubt that . . . [Respondent] was carefully treating people,'' the Agency finds that there is no necessary correlation between the number of pages in a medical record and the medical record's compliance with legal standards. *Supra* sections II. and III.C.1., *infra* section IV.B.

[28] As for Respondent's questions about the financial arrangements associated with Dr. Munzing's consulting work, the Agency finds that Respondent merely insinuated financial irregularities; he did not offer any evidence, let alone proof, of them.

[29] The Agency agrees with the ALJ that the pending criminal investigation matters that Respondent raised are not relevant to this administrative adjudication. *E.g.,* Tr. 518–20 (Respondent arguing that Respondent's physical examinations of undercover officers are relevant and the ALJ responding that ''they have at best nominal relevance''); *see also id.* at 615 (Respondent's Counsel stating that the existence of an ''independent criminal investigation'' is the reason for Respondent's decision not to ''put on a case'' to defend himself against the OSC).

[30] The Agency is not saying that an OSC is inappropriate if a registrant shows improvement in medical record keeping.

In this matter, as Dr. Munzing testified, Respondent's medical record keeping improved, but the Agency does not find substantial record evidence that Respondent's controlled substance prescribing conforms to the applicable standard of care. Tr. 537–38 (Dr. Munzing testifying).

and to employ a compliance officer''); *infra* section V.[31]

After carefully reviewing the record, the Agency concludes that Respondent's arguments and defenses are not creditable, and do not successfully rebut the Government's case.

IV. Discussion

A. The Controlled Substances Act

Pursuant to the CSA, ''[a] registration . . . to . . . distribute[ ] or dispense a controlled substance . . . may be suspended or revoked by the Attorney General upon a finding that the registrant . . . has committed such acts as would render his registration under . . . [21 U.S.C. 823] inconsistent with the public interest as determined by such section.'' 21 U.S.C. 824(a)(4). In the case of a ''practitioner,'' Congress directed the Attorney General to consider five factors in making the public interest determination. 21 U.S.C. 823(g)(1)(A–E).[32] The five factors are considered in the disjunctive. *Gonzales* v. *Oregon,* 546 U.S. 243, 292–93 (2006) (Scalia, J., dissenting) (''It is well established that these factors are to be considered in the disjunctive,'' citing *In re Arora,* 60 FR 4447, 4448 (1995)); *Robert A. Leslie, M.D.,* 68 FR 15,227, 15,230 (2003). Each factor is weighed on a case-by-case basis. *Morall* v. *Drug Enf't Admin.,* 412 F.3d 165, 173–74 (D.C. Cir. 2005). Any one factor, or combination of factors, may be decisive. *Penick Corp.* v. *Drug Enf't Admin.,* 491 F.3d 483, 490 (D.C. Cir. 2007); *Morall,* 412 F.3d. at 185 n.2; *David H. Gillis, M.D.,* 58 FR 37,507, 37,508 (1993).

According to DEA regulations, ''[a]t any hearing for the revocation . . . of a registration, the . . . [Government] shall have the burden of proving that the requirements for such revocation . . . pursuant to . . . 21 U.S.C. [§] 824(a) . . . are satisfied.'' 21 CFR 1301.44(e); *see also Morall,* 412 F.3d. at 174.

In this matter, while all of the 21 U.S.C. 823(g)(1) factors have been considered, the Agency finds that the Government's evidence in support of its *prima facie* public interest revocation case is confined to factors B and D.[33] Government's Proposed Findings of Fact and Conclusions of Law, at 19–28; *see also* RD, at 35–40.

B. Unlawful Prescribing and Public Interest Analysis

Factors B and/or D—Respondent's Experience in Dispensing Controlled Substances and Compliance With Applicable Laws Related to Controlled Substances

According to the CSA's implementing regulations, a lawful prescription for controlled substances is one that is ''issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.'' 21 CFR 1306.04(a); *see Gonzales* v. *Oregon, supra,* 546 U.S. at 274, *United States* v. *Hayes,* 595 F.2d 258 (5th Cir. 1979), *rehearing den.,* 598 F.2d 620 (5th Cir. 1979), *cert. denied,* 444 U.S. 866 (1979). Applicable California law, similar to applicable federal law, provides that ''prescriptions for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. Cal. Health & Safety Code § 11153(a); OSC, at 2; *supra* section II. Applicable California law also provides that it is unprofessional conduct to prescribe a controlled substance, or other ''dangerous drug,'' ''without an appropriate prior examination and a medical indication.'' Cal. Bus. & Prof. Code § 2242(a); OSC, at 2; *supra* section II. Further, California law states that ''unprofessional conduct'' by a physician includes the physician's ''failure . . . to maintain adequate and accurate records relating to the provision of services.'' Cal. Bus. & Prof. Code § 2266; OSC, at 2; *supra* section II.

As already noted, there is substantial, uncontroverted record evidence of violations of applicable law. *Supra* sections II and III.C.1. Those violations go to the heart of this Agency's law enforcement mission.

Having thoroughly analyzed the record evidence and applicable law, the Agency finds substantial, uncontroverted record evidence that Respondent issued multiple controlled substance prescriptions without, for example, having conducted an appropriate prior examination and establishing a medical indication, and that Respondent did not maintain adequate and accurate records, or maintained no records at all, relating to his controlled substance prescribing. *Supra* sections II and III.C.1; *e.g.* Tr. 296–324, 355–58, 374–80, 420–27, 490–91, 473–75.[34] In addition, as already discussed, the Agency finds that Respondent's case, including his arguments, three admitted exhibits, and challenges to the Government's evidence, does not rebut this substantial record evidence. *Supra* sections III.B. and III.C.2. Accordingly, the Agency concludes that Respondent issued multiple controlled substance prescriptions other than for a legitimate medical purpose while acting in the usual course of professional practice, prescribed controlled substances without an appropriate prior examination and a medical indication, and failed to maintain adequate and accurate records relating to the provision of services, thus committing multiple violations of California law and, therefore, of federal law. Cal. Health & Safety Code § 11153(a), Cal. Bus. & Prof. Code § 2242(a), Cal. Bus. & Prof. Code § 2266, 21 CFR 1306.04(a); *supra* sections II and III.C.1; *see also* RD, at 7–10, 14–15, 20–21, 24–26, 28–29. Substantial record evidence of any one of the founded violations is sufficient for the Agency to revoke Respondent's registration.

In sum, the Agency finds substantial record evidence that the Government established a *prima facie* case that Respondent violated federal and state law. Accordingly, the Agency finds that the Government established a *prima facie* case, that Respondent did not successfully rebut that *prima facie* case, and that there is substantial record evidence supporting the revocation of Respondent's registration. 21 U.S.C. 824(a)(4) and 823(g)(1)(B) and (D).[35]

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[31] Improved medical recordkeeping is insufficient to resolve all of the OSC's allegations.

[32] The five factors of 21 U.S.C. 823(g)(1)(A–E) are:

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

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

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

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

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

[33] Neither Respondent nor the Government argues that he/it offered evidence relevant to Factors A, C, or E. Although the Agency considered Factors A, C, and E, it finds that they are not relevant to this adjudication. *Accord* RD, at 16.

[34] Indeed, Respondent admitted maintaining inadequate medical records. *Supra* n.11 (Respondent ''concedes that there were issues with his recordkeeping but argues that he did in fact conduct appropriate medical evaluation [sic], testing, and monitoring to justify the high dosages of controlled substances that he prescribed.'') This admission does not constitute an unequivocal acceptance of responsibility. *Infra* section V.

[35] Given the egregiousness and number of these violations, violations that go to the core of the Controlled Substances Act's purpose to ''conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances,'' the Agency is adjudicating only the OSC allegations of issuing controlled substance prescriptions beneath the applicable standard of care and outside the usual course of professional practice, and is not reaching the other OSC allegations. *Gonzales* v. *Oregon,* 546 U.S. 243, 269 (2006). While the Agency is adjudicating a subset of the OSC's allegations, each of them, alone, is sufficient to support revocation of Respondent's registration.

V. Sanction

Where, as here, the Government has met its *prima facie* burden of showing that Respondent's continued registration is inconsistent with the public interest due to its numerous violations pertaining to controlled substances, the burden shifts to Respondent to show why it can be entrusted with a registration. *Morall,* 412 F.3d. at 174; *Jones Total Health Care Pharmacy,* 881 F.3d at 830; *Garrett Howard Smith, M.D.,* 83 FR 18882 (2018). The issue of trust is necessarily a fact-dependent determination based on the circumstances presented by the individual respondent. *Jeffrey Stein, M.D.,* 84 FR 46968, 46972 (2019); *see also Jones Total Health Care Pharmacy,* 881 F.3d at 833. Moreover, as past performance is the best predictor of future performance, DEA Administrators have required that a registrant who has committed acts inconsistent with the public interest must accept responsibility for those acts and demonstrate that it will not engage in future misconduct. *Jones Total Health Care Pharmacy,* 881 F.3d at 833 (citing authority including *Alra Labs., Inc.* v. *Drug Enf't Admin.,* 54 F.3d 450, 452 (7th Cir. 1995) (''An agency rationally may conclude that past performance is the best predictor of future performance.''). ''[T]hat consideration is vital to whether continued registration is in the public interest.'' *MacKay* v. *Drug Enf't Admin.,* 664 F.3d 808, 820 (10th Cir. 2011). A registrant's acceptance of responsibility must be unequivocal. *Jones Total Health Care Pharmacy,* 881 F.3d at 830–31. In addition, a registrant's candor during the investigation and hearing has been an important factor in determining acceptance of responsibility and the appropriate sanction. *Id.* Further, DEA Administrators have found that the egregiousness and extent of the misconduct are significant factors in determining the appropriate sanction. *Id.* at 834 and n.4. DEA Administrators have also considered the need to deter similar acts by the respondent and by the community of registrants. *Jeffrey Stein, M.D.,* 84 FR at 46972–73.

Regarding these matters, Respondent did not testify, and there is no indication in the record that Respondent takes responsibility, let alone unequivocal responsibility, for the founded, egregious violations involving his controlled substance prescribing.[36] *Supra* sections II, III.C, and IV; *cf. Osmin A. Morales,* 88 FR 75,309, 75,311–12. Instead, Respondent's case consists of one baseless or irrelevant argument after another, often seemingly to deflect attention away from his unlawful controlled substance prescribing. *E.g.* Tr. 672–73 (Respondent's closing argument statements that he used CURES to ''check[ ]'' whether a patient is ''taking medications . . . prescribed to him'' and that the ''dozens, if not hundreds of these CURES printouts'' show that Respondent ''was carefully monitoring the medication that the patients were taking and carefully issuing prescriptions and making sure patients were taking the drugs at the right time and in the correct quantities'');[37] RD, at 37 (''Despite Respondent's efforts at misdirection, the evidence is overwhelming that Respondent prescribed high-dosage opioids . . . and other powerful controlled substances, without a medical diagnosis to justify the prescription—there was, *inter alia,* no meaningful medical or mental health history taken, no adequate physical examination conducted, and no pain management plan recorded.'').

The interests of specific and general deterrence weigh in favor of revocation. Respondent has not convinced the Agency that he understands that his controlled substance prescribing fell short of the applicable standard of care, and that substandard controlled substance prescribing has serious negative ramifications for the health, safety, and medical care of individuals who come to him for medical treatment. *See, e.g., Garrett Howard Smith, M.D.,* 83 FR at 18910 (collecting cases) (''The egregiousness and extent of the misconduct are significant factors in determining the appropriate sanction.''). As such, it is not reasonable to believe that Respondent's future controlled substance prescribing will comply with legal requirements. Indeed, Respondent's own actions suggest that he has no intention of complying fully with the CSA and the California standard of care in the future. Tr. 537–38 (Respondent inexplicably suggesting that he ''did nothing wrong'' after his medical records improved).

Further, given the foundational nature and vast number of Respondent's violations, a sanction less than revocation would send a message to the existing and prospective registrant community that compliance with the law is not a condition precedent to maintaining a registration.

Accordingly, the Agency shall order the sanction the Government requested, as contained in the Order below.

Order

Pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 824(a)(4), I hereby revoke DEA registration No. BB4591839 issued to David Bockoff, M.D. Further, pursuant to 28 CFR 0.100(b) and the authority vested in me by 21 U.S.C. 823(g)(1), I hereby deny any pending application of David Bockoff, M.D., for a DEA Registration in California. This Order is effective March 12, 2025.

Signing Authority

This document of the Drug Enforcement Administration was signed on February 3, 2025, by Acting Administrator Derek Maltz. That document with the original signature and date is maintained by DEA. For administrative purposes only, and in compliance with requirements of the Office of the Federal Register, the undersigned DEA Federal Register Liaison Officer has been authorized to sign and submit the document in electronic format for publication, as an official document of DEA. This administrative process in no way alters the legal effect of this document upon publication in the **Federal Register**.

Heather Achbach,

Federal Register Liaison Officer, Drug Enforcement Administration.

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[36] Respondent's admitting ''issues with his recordkeeping'' is not accepting responsibility, let alone unequivocally accepting responsibility. *Supra* n.34.

[37] CURES only shows that a controlled substance prescription was filled. It does not show what then happened to the pills in that filled controlled substance prescription.

LIBRARY OF CONGRESS

U.S. Copyright Office

[Docket No. 2025–1]

Issues Related to Performing Rights Organizations

AGENCY: U.S. Copyright Office, Library of Congress.

ACTION: Notice of inquiry.

SUMMARY: The U.S. Copyright Office is collecting information regarding issues related to performance rights organizations (''PROs'') and the Copyright Act's public performance right for musical works. It is initiating this inquiry at Congress's request to gather information on questions related to the increase in the number of PROs and the licensing revenue distribution practices of PROs.

DATES: Written comments must be received no later than 11:59 p.m.