

**UNITED STATES DISTRICT COURT
DISTRICT OF NEW MEXICO**

UNITED STATES OF AMERICA,

Plaintiff,

v.

Case No. 1:26-CV-01362

**RICK Q. WILSON a/k/a
HENRY QUINTERO,**

Defendant.

**COMPLAINT FOR VIOLATION OF
THE CONTROLLED SUBSTANCES ACT**

Plaintiff, the United States of America, brings this action for civil penalties against Defendant Rick Q. Wilson for violation of the Comprehensive Drug Abuse Prevention and Control Act of 1970, also known as the Controlled Substances Act, 21 U.S.C. §§ 801-971, and the regulations promulgated thereunder (“**the CSA**”). As set forth herein, the United States’ claims arise out of the issuance by Wilson of thousands of purported prescriptions, without any legitimate medical purpose, for addictive benzodiazepines (such as Xanax and Valium) and other controlled substances in violation of the CSA. The United States seeks to recover from Defendant the maximum civil penalties allowable. In support of its claims, the United States alleges as follows:

JURISDICTION AND VENUE

1. This Court has jurisdiction over this action pursuant to 21 U.S.C. §§ 842(c) and 28 U.S.C. §§ 1331, 1345, and 1355.

2. Venue is proper in the District of New Mexico pursuant to 28 U.S.C. §§ 1391, 1395(a) in that the events and omissions described and giving rise to the claims asserted herein occurred in the District of New Mexico.

PARTIES

3. Plaintiff is the United States of America, suing on behalf of the United States Department of Justice, Drug Enforcement Administration (“**DEA**”).

4. Defendant Rick Q. Wilson, a resident of California, practiced psychology in New Mexico at all times relevant to the allegations contained herein.

LEGAL, REGULATORY AND CLINICAL FRAMEWORK

Controlled Substances Act

5. The CSA defines a controlled substance as drugs or other substances that are included in one of five schedules and classified based upon the potential for abuse, danger, and medicinal value. 21 U.S.C. §§ 802, 811, 812. Because controlled substances by definition are drugs with the potential for abuse, the comprehensive scheme is designed to prevent the “diversion” – *i.e.*, the illegal misuse – of controlled substances, including benzodiazepines and other substances at issue in this dispute.

6. Under the CSA, persons who manufacture, distribute or dispense controlled substances must register with the Attorney General of the United States through the Drug Enforcement Administration (**the “DEA”**). 21 U.S.C. §§ 802, 822; 21 C.F.R. § 1301.11. The DEA assigns each registrant a registration number.

7. The CSA prohibits a person “who is subject to the requirements of part C to distribute or dispense a controlled substance in violation of section 829 of this title.” 21 U.S.C. § 842(a)(1).

8. Part C refers to the registration of manufacturers, distributors, and dispensers of controlled substances. 21 U.S.C. § 821 *et seq.*

9. The term “dispense” means to deliver a controlled substance to an ultimate

user . . . , including the prescribing . . . of a controlled substance. . . .” 21 U.S.C. § 802 (10).

10. When a prescriber writes a prescription, regardless of the prescription’s validity, the prescriber “dispenses” that substance for purposes of the CSA. *United States v. Azmat*, 805 F.3d 1018, 1034 (11th Cir. 2015).

11. Under Section 829, and 21 C.F.R. § 1306.04(a), a controlled substance may not be dispensed without a prescription issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice, subject to certain exceptions which are not applicable here.

12. A “‘practitioner’ means a . . . person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices . . . , to distribute, dispense, . . . a controlled substance in the course of professional practice . . .” 21 U.S.C. § 802 (21).

13. “An order purporting to be a prescription issued not in the usual course of professional treatment . . . is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.” 21 C.F.R. § 1306.04.

14. A violation of 21 C.F.R. § 1306.04(a) is a violation of 21 U.S.C. § 829.

15. A violation of 21 U.S.C. § 829 is a violation of 21 U.S.C. § 842(a)(1).

16. Violations of 21 U.S.C. § 842(a)(1) are subject to penalties, as set forth in Section 842(c)(1)(a), namely:

(c) Penalties

(1)(A) Except as provided in subparagraph (B), (C), or (D) of this paragraph and paragraph (2), any person who violates this section shall,

with respect to any such violation, be subject to a civil penalty of not more than \$25,000.

21 U.S.C. § 842.

17. The penalties are regularly adjusted for inflation, and the maximum penalty is determined at the time it is assessed. 28 C.F.R. § 85.5. At the time of this filing, the maximum penalty assessed after July 3, 2025 for each violation of 21 U.S.C. § 842(a)(1), is \$82,950.

18. “Each violation may result in a civil penalty.” *United States v. Appalachian Reg’l Healthcare, Inc.*, 246 F. Supp. 3d 1184, 1192 (E.D. Ky. 2017).

19. The CSA holds DEA registered persons strictly liable for violations of Section 842(a)(1).

20. The civil remedies in the CSA help combat the diversion of controlled substances that are commonly sold and used illegally.

Psychologist Prescribing in New Mexico

21. Psychologists are not medical doctors.

22. New Mexico is one of a small minority of states that authorizes prescribing privileges for psychologists.

23. California, Rick Wilson’s home state, does not authorize prescribing privileges for psychologists.

24. The New Mexico Board of Psychology Examiners is authorized under New Mexico law to grant limited prescribing privileges to psychologists who satisfy certain requirements, such as the completion of pharmacological training. NMSA 1978, § 61-9-17.1.

25. The scope of prescribing authority conferred upon psychologists under Section 61-9-17.1 is limited to psychotropic medication. Psychotropic medication under Section 61-9-17.1 means “a controlled substance or dangerous drug that may not be dispensed or administered

without a prescription but is limited to only those agents related to the diagnosis and treatment or management of mental, nervous, emotional, behavioral, substance use or cognitive disorders, including the management of or protection from side effects that are a direct result from the use of those agents, whose use is consistent with the standards of practice for clinical psychopharmacology.”

26. Prescribing psychologists are also obligated under New Mexico law to follow certain prescribing practices, including maintaining an “ongoing collaborative relationship with the health care practitioner who oversees the patient’s general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition and significant changes in the patient's medical or psychological condition are discussed.” NMSA 1978, § 61-9-17.2.

27. In addition, prescribing psychologists “shall only prescribe drugs and treatments that are consistent with the standards of practice of clinical psychopharmacology.” N.M. Admin. Code, § 16.22.21.8.

Benzodiazepines

28. Benzodiazepines are psychotropic medications that effectively modify mood and behavior and are prescribed to treat anxiety, among other ailments. Benzodiazepines are marketed under brand names like Xanax (generic name alprazolam) and Valium (generic name diazepam).

29. Benzodiazepines are controlled substances. 21 C.F.R. § 1308.14.

30. In the treatment of mental health disorders like anxiety, it is standard practice for practitioners to initially prescribe “first line” treatments and/or medications, such as counseling, or substances like Lexapro or Cymbalta, that are not controlled substances and are safe, non-

addictive and generally not divertible.

31. Benzodiazepines, which pose risks of abuse, addiction and diversion, *see* 21 U.S.C. § 811(c), are “second line” treatments generally appropriate under accepted standards of practice for short term use or when first line medications are ineffective.

32. Xanax is manufactured in four primary strengths, .25 mg, .5 mg, 1 mg, and 2 mg. Utilizing lower dosages aids in avoiding dependency and withdrawal symptoms. The risk of diversion is elevated for Xanax 2 mg, known on the streets as Xannies/Zannies, Xanbars/Zanbars, or Z-bars.

33. Benzodiazepines are central nervous system (“CNS”) depressants, meaning they may slow breathing.

34. Opioids are also CNS depressants. “In combination, opioids and benzodiazepines can decrease breathing to the point that a person dies.” *United States v. Henson*, 9 F.4th 1258, 1264 (10th Cir. 2021).

Clinical guidelines and guidance from the United States Food and Drug Administration (“FDA”) emphasize caution in prescribing benzodiazepines to patients with a history of opioid abuse. In a 2016 Drug Safety Communication, FDA stated that “health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms.” FDA Drug Safety Communication (Aug. 31, 2016) (available at: <https://web.archive.org/web/>

[20251214114458/https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-serious-risks-and-death-when-combining-opioid-pain-or](https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-warns-about-serious-risks-and-death-when-combining-opioid-pain-or) (last accessed Apr. 28, 2026)).

36. In a 2017 Drug Safety Communication from FDA regarding prescribing methadone and other opioid addiction medications to patients taking benzodiazepines, the FDA advised (among other things) that health care professionals “taper[] the benzodiazepine or CNS depressant to discontinuation if possible,” “coordin[ate] care to ensure other prescribers are aware of the patient’s buprenorphine or methadone treatment,” and “monitor[] for illicit drug use, including urine or blood screening.” FDA Drug Safety Communication (Sept. 20, 2017) (available at: <https://web.archive.org/web/20260203085024/https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications> (last accessed Apr. 28, 2026)).

37. Under New Mexico law, prescribers are obligated to “identify, document and be aware of a patient currently...receiving opioids and benzodiazepines concurrently.” Practitioners treating such a patient, “using professional judgment based on prevailing standards of practice, shall take action as appropriate to prevent, mitigate, or resolve any potential problems or risks that may result in opioid misuse, abuse, or overdose.” N.M. Admin. Code § 16.10.14.8.

Diagnosis of Anxiety

38. There is established criteria utilized by clinicians to diagnose general anxiety disorder, as set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) (the “**Manual**.”).

39. The Manual “is a basic text used... by courts as a source of medical diagnostic

standards.” *Bell v. Mass. Mut. Life Ins. Co.*, 20-cv-3013 PAB-NRN, 2023 WL 2457779, at *1 n.1 (D. Colo. Mar. 10, 2023) *citing Moore v. Texas*, 581 U.S. 1, 7 (2017).

40. Diagnosis under the Manual entails a three part conjunctive inquiry, requiring that (i) the patient must have excessive anxiety and worry, about multiple events or activities, occurring more days than not, for at least six months, (ii) the person finds it difficult to control the worry, and (iii) the anxiety and worry are associated with three (or more) of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating, irritability, muscle tension, disturbed sleep. Manual at 19 (available at: <https://psychiatryonline.org/doi/epub/10.1176/appi.books.9780890425596> (last accessed Apr. 28, 2026)).

41. The treatment plan arising from an anxiety diagnosis should be individualized, but based on standard practices, including pharmacological treatment consistent with first line prescribing principles.

FACTS GIVING RISE TO THIS COMPLAINT

Defendant’s Licensure

42. Defendant operated a psychology practice in Albuquerque, New Mexico at 711 Encino Place, NE, between February of 2017 and December of 2020.

43. Defendant held a New Mexico psychology license, controlled substances license, and prescription certificate during all times relevant to the allegations contained in this Complaint.

44. Defendant was registered with the United States Department of Justice, Drug Enforcement Administration (“DEA”) under DEA number MW2518326, during all times relevant to the allegations contained in this Complaint.

45. Defendant issued 21,038 controlled substance prescriptions at his Albuquerque practice between February 8, 2017 and December 30, 2020. These controlled substance prescriptions are the subject of this lawsuit.

46. Numerous complaints were filed against Defendant with state licensing authorities, including the New Mexico Board of Pharmacy, the New Mexico Board of Psychologist Examiners, and the New Mexico Medical Board. These complaints alleged violations of state laws and regulations related to Defendant's psychology practice in Albuquerque.

47. Under a settlement agreement with the New Mexico Board of Psychologist Examiners dated December 30, 2020, Defendant surrendered his state controlled substances registration and prescription certificate. Defendant also voluntarily relinquished his DEA registration, number MW2518326, pursuant to the 2020 settlement.

48. Under a settlement agreement with the New Mexico Board of Psychologist Examiners dated October 18, 2024, Defendant agreed to pay a fine of \$10,000 and was "precluded" from applying for a psychology license "in the future."

Defendant's New Mexico Practice

49. The United States, through the DEA, issued subpoena number MM-21-07544 to Defendant in May of 2021. After the Tenth Circuit enforced the subpoena in a decision dated May, 2023, Defendant provided the United States with Defendant's treatment records for 41 patients. Analysis of those records informs the allegations contained herein.

50. Defendant served an especially at-risk patient population. Of the 41 patients whose records the Government reviewed, two-thirds had substance abuse disorders, and more than half of the patients (21) were documented to be taking an opioid for opioid addiction (like methadone). And, although many patient charts did not mention the patient's work status, at

least one-third were either unemployed or disabled.

Red Flags/Indicia of Unlawful Prescriptions

51. The presence of certain circumstances, called “red flags,” constitute indications that a prescription may not be legitimate under 21 C.F.R. § 1306.04(a). *United States v. Iwas*, No. 18-20769, 2023 WL 6702114, at *2 (E.D. Mich. Oct. 12, 2023) (“A ‘red flag’ is simply a set of circumstances indicating a prescription or set of prescriptions may not be legitimate.”).

52. The Government’s investigation identified the presence of numerous red flags related to Dr. Wilson’s New Mexico practice.

53. Defendant never resided in New Mexico during his tenure in the state as a prescribing psychologist. He visited the state no more than two times per month.

54. Despite his infrequent presence in New Mexico, Defendant ranked as one of the State’s most prolific prescribers of benzodiazepine prescriptions. Defendant issued the second highest number of benzodiazepine prescriptions in New Mexico between October 2016 and March 2017.

55. Defendant conducted limited patient examinations. The treatment records he created are repetitious and devoid of details, with an almost complete absence of evidence of clinical judgment.

56. Defendant saw a large volume of patients during the days he was present in New Mexico; the top ten one-day patient volumes are as follows:

<u>Date</u>	<u>Number of Patients</u>
December 13, 2018	54
October 10, 2019	51
January 10, 2019	49
December 16, 2019	48
January 31, 2019	48
July 11, 2018	48

August 13, 2019	47
October 8, 2019	46
April 12, 2019	46
October 16, 2018	46

57. Defendant’s patient records evidence a failure to meet basic professional standards with respect to diagnosis. The records show that Defendant did not conduct any serious diagnostic inquiry or make individualized determinations about specific patients.

58. In some instances, Defendant disregarded contrary diagnostic evidence in records from other practitioners. Of the 41 patients whose records the Government reviewed, all 41 had the same diagnoses – “severe anxiety, chronic.”

59. Defendant engaged in formulaic or pattern prescribing. All 41 of the patients whose records the Government reviewed were prescribed at least one benzodiazepine, primarily Xanax.

60. The United States reviewed Defendant’s prescribing practices between March 2017 and December 2020. Of the 21,038 controlled substances prescriptions written by Defendant, 12,145, or 57.7% were for Xanax, which is a second line treatment recommended for short-term use. Of the Xanax prescriptions, 82.7% were for 2 mg tablets – the highest dosage and most divertible substance.

61. Benzodiazepines are recommended for short-term use due to risks of dependence, tolerance, cognitive impairment and withdrawal symptoms.

62. Defendant routinely prescribed benzodiazepines to his patients for extended periods.

63. Defendant prescribed his Xanax patients an average (mean) of 522 days of medication. The ten highest prescription durations, measured in days, for the period after March 1, 2017 are: 1,519, 1,470, 1,444, 1,440, 1,440, 1,440, 1,430, 1,420, 1,405, and 1,402.

64. Defendant did not create individualized treatment plans for his patients. He used the same treatment plan repeatedly — “monthly individual psychotherapy and medication review and prescription.”

65. The patient documentation indicates that no psychotherapy was provided.

66. Defendant did not consider first line treatments for anxiety.

67. For example, a patient presented with prescriptions of Lexapro (a first line medication) and methadone. Defendant didn’t continue the Lexapro and instead opted for Valium (generic name diazepam), a benzodiazepine, and two other substances, without explanation in the treatment records.

68. Defendant also issued a high volume of Ambien prescriptions; he prescribed the anti-insomnia medication to 21 of the 41 patients, which was in addition to their benzodiazepine prescriptions.

69. Defendant issued a total of 4,789 Ambien prescriptions.

70. Ambien is a CNS depressant.

71. Combining Ambien and benzodiazepines elevates the risks inherent in utilizing multiple CNS depressants.

72. The appropriate first line treatment for insomnia is educating the patient on good sleep hygiene.

73. If the first line treatment fails, resort to short-term, low-dose medications may be implicated.

74. Defendant failed to document in the treatment notes a valid basis for the Ambien prescriptions.

75. Ambien is recommended for short-term use. Extended use can lead to tolerance,

dependence, memory loss, complex sleep behaviors, and worsening insomnia.

76. Defendant routinely prescribed Ambien to his patients for extended periods.

77. Defendant prescribed his Ambien patients an average (mean) of 390 days of medication. The ten highest prescription durations, measured in days, for the period after March 1, 2017 are: 1,500, 1,470, 1,390, 1,350, 1,350, 1,350, 1,320, 1,320, 1,274, and 1,270.

78. Defendant also failed to document in the treatment notes any consideration of first line insomnia treatments, and the documentation allegedly supporting insomnia diagnoses is limited to a list of symptoms, there is no documented history to determine the nature of the insomnia and thus the precise diagnosis and appropriate treatment.

79. Defendant did not conduct a clinical assessment of the implications of prescribing both Ambien and benzodiazepines.

80. Defendant did not provide patients with informed consent regarding combining benzodiazepines and Ambien.

81. Defendant also issued prescriptions telephonically without seeing the patient in person.

82. One patient reported seeing Defendant just twice in two years while receiving 24 controlled substance prescriptions.

83. Defendant prescribed substances to patients where he knew, or had reason to believe, that the patient was addicted to drugs, but nevertheless continued to prescribe controlled substances.

84. For instance, Defendant's prescribing was unaffected by positive drug screens for opioids and other substances contained in patients' files. Despite positive drug screens for substances like heroin and other illicit opioids, Defendant continued to issue prescriptions for

high doses of benzodiazepines.

85. In addition to failing to act on the drug screens provided to him by other providers, Defendant did not administer or require his patients to submit to drug screens.

86. There is also no evidence in the patient records that Defendant utilized New Mexico's Prescription Monitoring Program (the "**PMP**").

87. The PMP is a database maintained by the State of New Mexico of all controlled substance prescriptions issued in the State. New Mexico law obligates prescribers of controlled substances to review the PMP "before a practitioner prescribes or dispenses for the first time" and "a minimum of once every three months for the continuous use of a controlled substance." N.M. Admin. Code § 16.10.14.8.

88. New Mexico also obligates the prescriber "to document the receipt and review of [PMP] reports in the patient's medical record." *Id.*

89. Defendant's willful disregard for the use of the PMP and drug screens enabled diversion of controlled substances and is violative of standard practices.

90. After January 1, 2018, Defendant did not accept health insurance, and generally demanded and accepted only cash payments from his customers, with the exception of prescriptions issued telephonically, for which he accepted credit card payments.

91. Cash payments are a red flag because patients, especially low-income or unemployed patients, some of whom had insurance, would prefer to use insurance to defray health care costs. In addition, acceptance of solely cash shields the prescriber from insurer scrutiny and oversight.

92. Defendant did not schedule patients, meaning patients were served on a first come, first-served basis.

93. Patients typically arrived prior to the opening of the clinic and waited for hours to see Defendant. This unusual arrangement is a red flag because most patients would not wait for hours without an appointment to see a medical practitioner for a few minutes.

94. There is no evidence in Defendant's treatment notes that he provided patients with informed consent by advising of risk factors and side effects of the prescriptions he issued.

95. Defendant increased or decreased dosages of controlled substances but failed to provide counseling to patients.

96. Similarly, for patients on methadone, Defendant failed to advise patients as to the risks of combining benzodiazepines and Ambien with opioids.

97. For patients with positive drug screens for other CNS depressants, including heroin, Defendant continued to prescribe benzodiazepines without informing patients of the dangers inherent in that combination.

98. Defendant also ignored or failed to act on drug tests showing that his patients weren't using the prescriptions he wrote, which is an indication that the medication is being diverted.

99. For example, a patient presented to Defendant in October 2017 with a 15+ year history of narcotic addiction. Defendant prescribed Xanax 2 mg, three times per day. The patient was receiving methadone treatment from a medication-assisted treatment program ("MAT"). In September of 2018, Defendant received copies of drug screen results from the MAT for the patient from April, May, June, July and August of 2018. Despite being prescribed Xanax 2 mg, three times per day throughout that period, the drug screen revealed the presence of no benzodiazepines for every month from May through August. This is an indication of diversion; the patient didn't use the prescription and instead likely sold it on the street.

Defendant makes no reference to the negative drug screen in his treatment records, and despite being on notice of the possibility of diversion, continued to prescribe Xanax 2 mg into 2020 for this patient.

100. Defendant also failed to meaningfully collaborate with other practitioners providing care to his patients, despite being obligated to do so under New Mexico law as a prescribing psychologist.

101. In one instance, a patient who was also a new mother, was receiving treatment for opioid abuse disorder through a MAT program. The patient's caregivers were concerned about her history of opioid addiction and her concurrent use of benzodiazepines prescribed by Defendant. The patient's MAT caregivers made multiple attempts to coordinate care with Defendant, but were unsuccessful. On one occasion, the patient's team of caregivers scheduled a teleconference with Defendant, and after confirming he would attend, Defendant did not answer the MAT caregivers' calls. This patient died five days after Defendant issued the patient's final prescriptions for Xanax and the Ambien. OMI identified the "toxic effects of fentanyl, alprazolam, buprenorphine." Alprazolam is the generic name for Xanax.

102. The patient described in the previous paragraph is just one of the twenty patients who died within 30 days of receiving a prescription from Defendant.

103. The State of New Mexico Office of Medical Investigator ("**OMI**") determined causes of death for all twenty patients. Nineteen of the deaths were caused by drug toxicity; drug toxicity was a contributing factor to the twentieth death. Evidence of patient deaths is an indication that that the prescriptions written to those patients were inconsistent with accepted medical norms. *United States v. Schwartz*, 702 F. App'x 748, 756 (10th Cir. 2017).

104. All of the treatment records reviewed indicate that Defendant's controlled

substances prescriptions lacked a legitimate medical purpose and were not issued in the usual course of practice.

105. Based on the foregoing allegations, Defendant knew or had reason to know that his prescribing practices were resulting in diversion of controlled substances.

106. The practices alleged above illustrate Defendant's issuance of prescriptions without a legitimate medical purpose and outside the usual course of practice. Defendant's failure to issue valid diagnoses, develop and implement treatment plans, and justify his prescribing decisions render the prescriptions unlawful under the CSA.

107. This is particularly true with respect to Defendant's issuance of benzodiazepine and Ambien prescriptions. The patient records and red flags show that Defendant systematically provided invalid prescriptions to any customer willing to give him cash.

Patient Examples

Patient One

108. The practices and red flags described above are illustrated and further alleged by the following anonymized patient examples.

109. Patient One presented to Defendant in September 2019. The records indicate that Patient One presented to Defendant with diagnoses from previous providers of Post Traumatic Stress Disorder ("PTSD"), anxiety and bipolar disorder. Defendant made two diagnoses, for "severe anxiety, chronic" and "insomnia." Defendant did not document his consideration of Defendant's prior diagnoses. The basis for Defendant's diagnoses in the treatment notes is a list of "anxiety symptoms," there is no evidence of the exercise of clinical judgment by Defendant in reaching his diagnoses. There is no consultation with Patient One's other providers.

110. The treatment plan drafted by Defendant for Patient One states in conclusory

fashion: “monthly individual psychotherapy and medication review and prescription.” There is no evidence of clinical judgment by Defendant in developing this treatment plan.

111. Patient One’s treatment records do not indicate that psychotherapy was provided.

112. Defendant documented that Patient One was being treated with methadone. Defendant prescribed Xanax 2 mg, two times per day. Defendant did not document an explanation or the clinical basis for beginning an opioid-dependent patient on a second line CNS depressant. Defendant did not document consideration of first line treatments. Defendant did not indicate in the treatment notes any drug screen or review of the PMP, even though Defendant was on notice of Patient One’s ongoing use of methadone, which is an opioid. Defendant did not indicate that he obtained informed consent; *i.e.*, that Defendant apprised Patient One of the risks inherent in combining a high-dose benzodiazepine with an opioid.

113. A month later, in October 2019, Defendant saw Patient One a second time. The treatment note suggests Patient One is progressing, stating “Patient continues to diminish signs/symptoms with effective treatment.” And, “Prescription regimen is effective at quelling symptoms of anxiety without problematic side effects.” Defendant did not further elucidate. The one sentence treatment plan from the September intake note is unchanged. There is no evidence that psychotherapy was furnished.

114. The next treatment note, from November of 2019, contains the same statements regarding “signs/symptoms” and “quelling symptoms of anxiety.” Despite these statements indicating Patient One’s progress, Defendant increased the Xanax 2 mg prescription from twice per day to three times per day, meaning Patient One’s monthly prescription increased from 60 to 90 total pills. Defendant did not explain in the treatment records – of a clinical nature or otherwise – this increased dosage. Defendant did not indicate that he apprised Patient One of the

risks associated with an increased benzodiazepines dosage in light of Patient One's ongoing methadone treatment. Defendant did not document a PMP review or a drug screen. The treatment notes contain no substantive clinical or evaluative content.

115. The next treatment note, from December of 2019, contains the same statement saying the "prescription regimen is effective at quelling symptoms." The maximal Xanax prescription of 2 mg three times per day is unchanged. The note contains no other substantive content.

116. Three weeks after the December note, and three months after starting treatment with Defendant, Patient One died from drug toxicity due to heroin and methadone. Benzodiazepines were detected in Patient One's system. There is no reference in Defendant's treatment records related to the death of Patient One.

117. All of the prescriptions issued by Defendant to Patient One were invalid under 21 C.F.R. § 1306.04. Because Defendant failed to properly diagnose or treat Patient One, administer drug screens, or develop a valid clinical basis for the prescriptions he wrote for Patient One, the prescriptions lack a legitimate medical purpose and were issued outside the course of professional practice.

Patient Two

118. Patient Two presented to Defendant in December 2019. Defendant's patient records for Patient Two at intake included existing diagnoses from other providers of Post Traumatic Stress Disorder ("PTSD"), anxiety and "major depression." Defendant made two diagnoses, for "severe anxiety, chronic" and "insomnia"— the same diagnoses as Patient One. Defendant did not mention in the intake documentation Defendant's prior diagnoses. The basis for the diagnosis in the treatment notes is a list of "anxiety symptoms," that is almost identical to

the list in Patient One's intake documentation. There is no evidence of clinical judgment by Defendant in reaching his diagnoses. There is no consultation with Patient Two's other providers.

119. The treatment plan documented by Defendant for Patient Two states in conclusory fashion: "monthly individual psychotherapy and medication review and prescription." It is identical to Patient One's treatment plan. There is no evidence of the exercise of clinical judgment by Defendant in developing this treatment plan. Defendant never provided Patient Two with psychotherapy.

120. During intake, Patient Two reported "blind dosing" methadone, meaning the quantity being ingested by the patient was unclear. Patient Two also exhibited pill-seeking behavior, as Defendant recorded in the treatment notes that Patient Two sought "higher dose" benzodiazepines. The paperwork in Patient Two's patient file from a previous provider revealed previous abuse of heroin, which is an opioid. Defendant began Patient Two on the benzodiazepine Valium, 5 mg, two times per day, and Ambien. Defendant offered no explanation or the clinical basis for beginning an opioid-dependent patient on a second line CNS depressant. Defendant did not document consideration of first line treatments even though Patient Two's anxiety was being treated with Lexapro (a first line non-controlled substance) prior to seeing Defendant. Defendant does not indicate in the treatment notes that he ordered a drug screen or reviewed the PMP, even though Defendant was on notice of Patient Two's "blind dosing" of methadone and previous abuse of heroin. Nor does Defendant indicate that he obtained informed consent; *i.e.*, that Defendant apprised Patient Two of the risks inherent in combining benzodiazepines with an opioid.

121. In the next treatment note, from January 2020, Defendant increased the diazepam 2

mg prescription from twice per day to three times per day, meaning Patient Two's monthly Valium prescription increased from 60 to 90 total pills. Defendant offers no explanation in the treatment records – of a clinical nature or otherwise – for this increased dosage. There is no indication – of any kind – that Defendant apprised Patient Two of the risks associated with an increased benzodiazepine dose in light of Patient Two's ongoing methadone treatment and evidence of past heroin abuse. There is no reference to, or evidence of, a PMP review of a drug screen. The treatment notes contain no substantive clinical or evaluative content.

122. Defendant wrote the last prescription for Patient Two for Valium and Ambien in February of 2020.

123. Three weeks after Defendant issued the February 2020 prescription, and three months after starting treatment with Defendant, Patient Two died from cardiac arrest. According to OMI, drug toxicity, in the form of methadone, Xanax, and Valium were “significant contributory factors.” This illustrates the consequences of failing to administer a drug screen or check the PMP; Xanax was in Patient Two's system and would have triggered a positive result.

124. Defendant did not acknowledge the death of Patient Two in the treatment records.

125. All of the prescriptions issued by Defendant to Patient Two were invalid under 21 C.F.R. § 1306.04. Because Defendant failed to properly diagnose or treat Patient Two, administer drug screens, check the PMP, or develop a valid clinical basis for the prescriptions he wrote for Patient Two, the prescriptions lack a legitimate medical purpose and were issued outside the course of professional practice.

Patient Three

126. In February 2018, Patient Three received the diagnosis of “severe anxiety, chronic” and “insomnia.” The same diagnoses that Defendant gave to Patients One and Two. Defendant

documented for Patient Three the same one-sentence treatment plan as for Patients One and Two. Defendant, without clinical justification, prescribed Patient Three the benzodiazepine lorazepam 2 mg (brand name Ativan) twice per day, and Ambien. In March of 2018, Defendant's treatment note indicates "patient continue to diminish signs/symptoms with effective treatment" and "patient continues to [sic] well with current prescription regimen."

127. In April of 2018, Defendant repeated the positive phrases about "signs/symptoms" and the "current prescription regimen," but increased Patient Three's Ativan dose from 2 times per day to 3 times per day. Defendant does not explain in the treatment records – of a clinical nature or otherwise –this increased dosage. Defendant does not indicate that he secured informed consent from Patient Three for the increased dosage. There is no reference to, or evidence of, a PMP review of a drug screen. The treatment notes contain no substantive clinical or evaluative content.

128. In August of 2019, the treatment note indicates for the first time that Patient Three was using methadone. There is no comment about this development in the treatment notes. Defendant continued to prescribe Ativan 3 mg, three times per day, without comment. Defendant did not review the PMP or require the patient to submit a drug screen. Defendant did not warn Patient Three about the dangerousness of simultaneously ingesting opioids and benzodiazepines.

129. In November of 2019, Defendant received the results of six drug screens (from March 2019 through October 2019) for Patient Three from a different provider. The drug screens revealed the presence of the methadone and benzodiazepines, plus opiates and cocaine.

130. Despite having these drug screens, and having reason to know that Patient Three was using a variety of controlled substances, Defendant took no action. Defendant did not

reference in the treatment the positive tests. Defendant did not alter his prescribing practices. Defendant did not review Patient Three's PMP or order a drug screen.

131. Defendant continued to prescribe Patient Three Ativan 3 mg, three times per day and Ambien through at least April of 2020.

132. Defendant prescribed Ativan to Patient Three for more than two years.

133. Ativan, like other benzodiazepines, is not recommended for long-term use and is generally for short-term relief of anxiety.

134. Defendant provided no clinical justification for the prolonged use of Ativan.

135. Defendant prescribed Ambien to Patient Three for more than two years.

136. Ambien is not recommended for long-term use.

137. Defendant provided no clinical justification for the prolonged use of Ambien.

138. The prescriptions issued by Defendant to Patient Three were invalid under 21 C.F.R. § 1306.04. Defendant failed to properly diagnose and treat Patient Three. The prescriptions issued to Patient Three lacked a legitimate medical purpose and were issued outside the course of professional practice.

CLAIM FOR RELIEF
Controlled Substances Act

139. The United States re-alleges and incorporates by reference the foregoing allegations.

140. By virtue of the acts described above, Defendant repeatedly and systematically violated 21 U.S.C. § 829 (a)(1) and 21 C.F.R. § 1306.04(a).

141. Defendant is liable to the United States for a civil penalty for each occasion on which the defendant committed a violation.

PRAYER FOR RELIEF

WHEREFORE, the United States demands judgment against Defendant as follows:

A. A civil penalty for each of the prescriptions for a controlled substances dispensed in violation of the CSA; and

B. For such other relief at law and at equity as the Court deems just and reasonable.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, the United States demands a trial by jury in this action of all issues so triable.

Respectfully submitted,

TODD BLANCHE
Acting Attorney General

RYAN ELLISON
First Assistant United States Attorney
District of New Mexico

/s/ Sean M. Cunniff
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CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS
United States of America
(b) County of Residence of First Listed Plaintiff
(c) Attorneys (Firm Name, Address, and Telephone Number)
Sean M. Cunniff, AUSA, USAO- DNM, 201 Third St. NW Suite 900 Albuquerque, NM 87102, (505) 224-1473

DEFENDANTS
Rick Q. Wilson
County of Residence of First Listed Defendant
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.
Attorneys (If Known)
Brian Grayson, Grayson Law Firm 3901 Georgia St NE Suite A-2-A, Albuquerque, NM 87110 (505) 273-8570

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)
1 U.S. Government Plaintiff
2 U.S. Government Defendant
3 Federal Question (U.S. Government Not a Party)
4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
PTF DEF
Citizen of This State 1 X 1
Citizen of Another State 2 2
Citizen or Subject of a Foreign Country 3 3
Incorporated or Principal Place of Business In This State 4 4
Incorporated and Principal Place of Business In Another State 5 5
Foreign Nation 6 6

IV. NATURE OF SUIT (Place an "X" in One Box Only) Click here for: Nature of Suit Code Descriptions.

Table with columns: CONTRACT, REAL PROPERTY, CIVIL RIGHTS, TORTS, PRISONER PETITIONS, FORFEITURE/PENALTY, LABOR, IMMIGRATION, BANKRUPTCY, SOCIAL SECURITY, FEDERAL TAX SUITS, OTHER STATUTES. Includes various legal categories like Personal Injury, Labor, Intellectual Property Rights, etc.

V. ORIGIN (Place an "X" in One Box Only)
1 Original Proceeding
2 Removed from State Court
3 Remanded from Appellate Court
4 Reinstated or Reopened
5 Transferred from Another District (specify)
6 Multidistrict Litigation - Transfer
8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
21 U.S.C. § 842(a)(1); 21 U.S.C. § 829
Brief description of cause:
Penalties under the Controlled Substances Act

VII. REQUESTED IN COMPLAINT:
CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$ CHECK YES only if demanded in complaint: JURY DEMAND: X Yes No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE DOCKET NUMBER

DATE SIGNATURE OF ATTORNEY OF RECORD SEAN CUNNIFF Digitally signed by SEAN CUNNIFF Date: 2026.04.30 16:10:09 -0600

FOR OFFICE USE ONLY
RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

- I.(a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.
- (b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)
- (c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".
- II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
 United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here. United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
 Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
 Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below; **NOTE: federal question actions take precedence over diversity cases.**)
- III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.
- IV. Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: [Nature of Suit Code Descriptions](#).
- V. Origin.** Place an "X" in one of the seven boxes.
 Original Proceedings. (1) Cases which originate in the United States district courts.
 Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
 Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
 Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
 Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
 Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
 Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.
- VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.
- VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
 Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
 Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.
- VIII. Related Cases.** This section of the JS 44 is used to reference related cases, if any. If there are related cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.