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

In the Matter of the Accusation Against:	Case No. 12-2011-217569
PURNIMA RAVI SREENIVASAN, M.D.,	OAH No. 2014050562
Physician and Surgeon's Certificate No. A 82039	
Respondent.	

DECISION AFTER NON-ADOPTION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on October 13, 2014.

Emily L. Brinkman, Deputy Attorney General, represented complainant.

Respondent Purnima Ravi Sreenivasan, M.D., was present and represented by John L. Fleer, Attorney at Law.

Submission of the matter was deferred for receipt of final arguments, which were received, marked for record, and considered. The matter was submitted on November 21, 2014.

The proposed decision of the administrative law judge was considered and non-adopted by the Board on February 5, 2015. Oral arguments were conducted on May 7, 2015. All arguments having been considered, the Board hereby makes the following decision and order:

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer made this accusation in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On February 21, 2003, Physician and Surgeon's Certificate No. A 82039 was issued by the Board to Purnima Ravi Sreenivasan, M.D. (respondent). Respondent's certificate will expire December 31, 2014, unless renewed.

Respondent was previously disciplined following a stipulated decision and order that placed respondent on probation for a period of three years, effective April 23, 2010. The decision required respondent to complete a prescribing practice course, a medical record keeping course, and submit to a practice monitor. Respondent met all the terms and conditions of her probation.

Unprofessional Conduct: Gross Negligence/Negligence/Incompetence -Patient A

3. On March 1, 2011, respondent began treating Patient A (a male born in 1939) at the Windsor Manor Nursing Home (Windsor Manor) after his hospitalization following a car accident. Patient A was hospitalized between February 26, 2011 through March 1, 2011. The admission record for Windsor Manor indicates the patient had a known history of cocaine abuse.

4. On March 4, 2011, respondent completed the history and physical examination form for Patient A noting patient's history of acute asthma and a past medical history of asthma, cocaine abuse, and chronic back pain. Respondent documented a limited physical examination, without noting an examination of the chest or back. The progress note is not very legible. Respondent did not note that the patient complained of any chest pain or low back pain. The treatment plan was for Patient A to undergo physical therapy, occupational therapy, and to see a registered dietician. There is no indication what his current medications were or even if respondent prescribed any new medication for him.

5. On March 21, 2011, respondent saw Patient A. Her handwritten progress is not very legible but does include the note that the patient was doing ok. The progress note contains extensive abbreviations, but seems to indicate that the patient did not complain of chest pain or shortness of breath and he was comfortable. The record does not address any medications prescribed to Patient A.

6. On March 30, 2011, respondent noted in a progress note that the patient wanted to leave the facility. She advised against it. The note indicates the patient is taking Restoril (Restoril is the trade name for temazepam, a hypnotic agent. It is a dangerous drug and a schedule IV controlled substance) for insomnia, but there are no other indications that he was taking any other medication or for what reason.

7. On April 5, 2011, respondent saw Patient A and noted he is doing good (sic) and ambulating well. The progress note is difficult to decipher. There is no indication in the record what medications she prescribed, dose instructions, or why any medications might be needed.

8. On April 8, 2011, respondent's progress note for this encounter with Patient A noted that he was doing ok. The note indicates Patient A would be discharged on "Monday with orders." There was no mention of any medications prescribed.

9. Throughout Patient A's stay at Windsor Manor there are nursing notes indicating nurses conducted pain assessments and listed side effects of the medications he was taking. From the time of his admission, respondent prescribed Restoril (with changes to his scheduled dosing) and Percocet (Percocet is oxycodone with acetaminophen, and is a semisynthetic narcotic pain reliever with actions similar to morphine. It is a dangerous drug and a schedule II controlled substance. It can produce drug dependence.) There are no notations in the progress notes completed by Respondent as to why these medications were prescribed, the patient's pain level (or even complaints of pain), what she hoped the medications would treat in the patient, the patient's response to the medications (success or failures), and whether he had any adverse effects as a result of the medications.

10. During the time Patient A was at Windsor Manor, the California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) shows regular prescriptions and refills for Restoril and Percocet.

11. On April 11, 2011, Patient A was discharged from Windsor Manor. The list of discharge medication included Restoril and Percocet.

12. During Respondent's Medical Board interview on November 19, 2012, respondent stated that she did not recall whether she actually took a detailed history of Patient A. She stated she did not concern herself with past history of drug or alcohol abuse because "as a doctor I provide only medical care." Respondent stated in that interview that she was not concerned with the method that medications she wrote prescriptions for were administered by the nursing home staff, including controlled substances with the instructions "as needed for pain."

13. Respondent billed insurance for medical care provided to Patient A on March 4, 20, 21, April 5, 6 (no progress note for April 6, but there is one for April 8, which was not billed), 11, and 12 (the patient was discharged the day before), on April 11, 2011. The medical records do not support the billing codes respondent used for these encounters.

14. It was established by clear and convincing evidence through the testimony of the Board's experts Nayanatara Rao, M.D. and Eric Allen, M.D. that respondent's medical records relating to the care and treatment of Patient A do not comply with the standard of care and constitute unprofessional conduct. She failed to document a thorough history of the patient's past and present medical history; she failed to document a history of past and current illicit substance and alcohol use/abuse history; she failed to document a medical necessity of the prescription of controlled substances; and she failed to document the components necessary to justify specific billing codes used.

15. It was established by clear and convincing evidence through the testimony of the Board's expert, Dr. Allen, that respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes violates the standard of care and demonstrates lack of knowledge.

Unprofessional Conduct: Gross Negligence/Negligent Acts/Incompetence -Patient B

16. Between September 15, 2009 through December 27, 2011, respondent treated Patient B (a 43-year old female paraplegic at T-6) at two separate short-term nursing homes, Tampico Terrace and Ygnacio Valley Care Center. Patient B suffers from a variety of medical issues, including Crohn's disease, rectovesicular fistula, urostomy, colostomy, urinary diversion, chronic pain, opiate dependence, hypothyroidism, depression, recurrent urinary tract infections (UTI), and recurrent pressure ulcers. She had recurrent hospitalizations for UTI, sepsis, chronic wounds, and pneumonia during the year she was treated at Ygnacio Valley.

17. Respondent treated Patient B off and on at Ygnacio Valley between December 31, 2010 through January 10, 2012. Patient B was originally admitted to Ygnacio Valley from an acute care hospital with severe malnutrition and pressure ulcers. The patient reported a history of drug abuse as noted on a "Resident Progress Note" dated January 17, 2011. Most of the progress notes were written by the nursing staff. During this time frame, the patient was admitted six times to John Muir Medical Center, Walnut Creek, but the reasons for the various hospitalizations are unclear from the Ygnacio Valley records. Each time Patient B returned to Ygnacio Valley, her stay was treated as a new admission. Respondent became her primary care giver on March 14, 2011.

18. Patient B was admitted to Ygnacio Valley from March 25, 2011 through April 12, 2011. On March 30, 2011, respondent completed a "History and Physical" following Patient B's hospitalization for pyelonephritis (kidney infection). Much of the handwritten form is illegible. It includes information that respondent saw the patient and the patient would be treated for wound care. Respondent also completed a "Physician Order" requesting a pain management consultation and psychiatric evaluation if one had not yet been conducted.

19. On April 4, 2011, respondent completed a progress note for her encounter with Patient B. The progress note indicated the patient saw a pain specialist and that the specialist recommended an increase in her morphine dose but that respondent had to complete the prescription. Much of the note is not legible, but the treatment plan includes seeing a specialist for wound care and a protein rich diet for malnutrition. Respondent also completed an order for this encounter with Patient B. The note requested that the pharmacy review all of the patient's medications for possible drug interactions, to discontinue the Flexeril (Cyclobenzaprine -is a muscle relaxant and it is a dangerous drug as defined by law) and start Baclofen (Baclofen is a muscle relaxer and anti-spastic agent. It is a dangerous drug as defined in the law). There are no additional records signed by respondent documenting her care and treatment of Patient B during the time from March 25, 2011 and April 12, 2011. Respondent billed insurance for medical care provided on March 30, and April 4, 2011. The medical records do not support the billing code used for these encounters.

20. Patient B was admitted to Ygnacio Valley from April 13, 2011 through May 16, 2011. On April 14, 2011, respondent completed the history and physical form on Patient

B. Respondent's notes indicate that Patient B was hospitalized for pyelonephritis. Under current diagnosis respondent wrote that she saw the patient on this date, but the plan of care is illegible. Respondent completed a physician order regarding the need for a pain specialist, lab work, nutritional consultation, and a psychotherapy consultation.

21. Respondent also completed physician orders on April 18, May 2, and May 9, 2011. The orders required staff to perform specific tasks related to the care and treatment of this patient. However, there are no associated progress notes or other records documenting any examination of the patient by respondent supporting any orders.

22. There are no additional records signed by respondent documenting her care and treatment of Patient B during this admission. Respondent billed insurance for medical care provided on April 4, and April 11, 2011. There are no records that insurance was billed for services provided on May 2, and May 9, 2011. The medical records do not support the billing codes respondent used for these encounters.

23. Patient B was admitted to Ygnacio Valley from May 17, 2011 through May 21, 2011. On May 17, 2011, respondent completed an initial physician comprehensive assessment for Patient B. The form included checking relevant boxes related to Patient B's care and condition. Respondent did not indicate the plan or treatment goals for the patient. There are no other associated progress notes of records documenting any examination or treatment of the patient by respondent during this encounter.

24. Respondent billed insurance for medical care provided on May 18 and May 20, 2011. However, the medical records do not support the billing codes respondent used for these encounters.

25. Patient B was admitted to Ygnacio Valley from May 24, 2011 through June 19, 2011. On May 24, 2011, respondent completed an initial physician comprehensive assessment for Patient B. The form included checking relevant boxes related to care and condition, but also provided an assessment section allowing the doctor to hand write her findings. Respondent wrote that Patient B was hospitalized with back pain, the remaining note is illegible.

26. There are no other associated progress notes or records documenting any examination or treatment of Patient B by respondent during this admission. Respondent billed insurance for services performed on May 25, 2011, however, there are no records supporting any encounter between Patient B and respondent justifying this bill. Assuming the billing error should refer to the care provided on May 24, 2011, the medical records do not support the billing code respondent used for this encounter.

27. Patient B was admitted to Ygnacio Valley from June 19, 2011 through August 10, 2011. There are no signed medical records from respondent during this admission period. There are physician orders indicating directions for staff from respondent, but there are no medical records documenting any form of evaluation or examination of the patient by

respondent. Respondent billed insurance for medical care provided on June 27, and July 11, 2011, however, there are no medical records to support the billing codes respondent used.

28. Patient B was admitted to Ygnacio Valley from August 13, 2011 through August 23, 2011. On August 13, and 14, 2011, there are physician orders from respondent. They are handwritten and difficult to read, but appear to discuss the patient's wound dressing on her right hip and medication issues. There are no associated progress notes or other records that respondent treated or even saw the patient on these dates. Respondent billed insurance for medical care provided on August 15, 2011, however, there are no medical records to support the billing codes respondent used. Assuming, the billing error should refer to the care provided on either August 13, or 14, 2011, the medical records do not support the billing code respondent used for this encounter.

29. Patient B was admitted to Ygnacio Valley from September 10, 2011 through December 19, 2011. On September 13, 2011, respondent completed the initial physician comprehensive assessment on Patient B. The form included checking relevant boxes related to the patient's care and condition, but also provided an assessment section allowing the doctor to handwrite her findings. Respondent's assessment is mostly illegible but stated: "Patient discussed in detail."

30. Respondent produced electronic medical records for the following patient encounters: October 27, November 15, November 22, December 1, and December 12, 2011. There are additional handwritten notes for several dates. The records are in standard "SOAP" format (Subjective, Objective, Assessment, and Plan) and indicated the patient's current health status. The notes also indicated the patient was preparing for her upcoming discharge from Ygancio Valley to return home. Respondent noted on these forms in the subjective portion that she discussed medications, lab work, and treatment plans with the patient. The notes also indicate the various diagnosis and plans for treatment. Several of the notes contain information relating to the need for the patient to follow-up with doctors after discharge.

31. During respondent's Medical Board interview, she stated that her care of Patient B during the October and November 2011 dates were solely based on her review of recommendations from other medical providers, yet there is no notation in the medical records that respondent reviewed any other records or recommendations from other providers.

32. Respondent billed insurance for services provided on September 13, October 27, November 15, November 22, and December 12, 2011 that correspond to documented medical records. Respondent also billed insurance for services provided on September 19, and 26, October 3, 11, 17, and 21, and November 4, 2011. These dates are not related to any medical documentation. There are no medical records to support the billing codes respondent used. For the encounters that are documented, the medical records do not support the billing codes respondent used of these encounters.

33. Patient B was admitted to Ygnacio Valley from December 24, 2011 through January 10, 2012. On December 27, 2011, respondent completed physician order indicating several items that needed to be addressed by any new health care provider. Specifically, respondent wrote that the patient needs to keep up with her pain appointment on January 14, 2012; all meds to be managed by pain specialist and the pain specialist needs to send triplicates to pharmacy or sign triplicates for all the meds he is prescribing to her; respondent is not responsible any more or any future pain meds. There are no other associated progress notes or other records that respondent treated or even saw Patient B during this admission period. Respondent billed insurance for medical care provided on December 27, 2011. However, the medical record does not support the billing code respondent used for this encounter.

35. During the time Patient B was at Ygnacio Valley, the California Department of Justice CURES and the Patient Profile from Pharmerica Pharmacy show regular prescriptions and refills for Lorazepam (also known as Ativan, is used to treat anxiety. It is a dangerous drug and a schedule IV controlled substance), APAP propoxyphene (is a narcotic pain reliever. It was withdrawn from the market in November 2010. It was a dangerous drug and a schedule IV controlled substance), Fentanyl Transdermal System (also known as Duragesic, is an opioid analgesic and a dangerous drug and schedule II controlled substance), hydromorphone hydrochloride (also known as Dilaudid, is used for pain relief. It is a dangerous drug and a schedule II controlled substance), Zolpidem (also known as Ambien, is a non-benzodiazepine hypnotic. It is a dangerous drug and a schedule IV controlled substance), morphine sulfate (is used in patients who require potent opioid pain relief. It is a dangerous drug and a schedule II controlled substance), Dronabinol (also known as Marinol, is a man-made form of cannabis. It is used to treat loss of appetite. It is a dangerous drug and a schedule III controlled substance), methadone hydrochloride (is a synthetic narcotic pain reliever. It is a dangerous drug and a schedule II controlled substance), Oxycontin (also known as oxycodone hydrochloride, is a pure agonist opioid used for pain relief. It is a dangerous drug and a schedule II controlled substance), hydrocodone APAP (is the generic name for Vicodin, Lortab, and Vicoprofen. It is a semisynthetic narcotic pain reliever and a dangerous drug and schedule III controlled substance), and Diazepam (also known as Valium, is a psychotropic drug used to treat anxiety. It is a dangerous drug and a schedule IV controlled substance). Respondent did not document the medications that she prescribed, the reasons for the prescriptions, any side effects, any changes to the medications, or any additions or deletions of medications following examinations of the patient. There are notations in some of the physician orders completed by staff when certain adjustments to medications were made or when medications were given to the patient but the majority of the physician orders are not legible and do not appear to have been completed by respondent.

36. During respondent's Board interview, she stated that she could not recall whose recommendations she relied on when writing prescriptions, including for significant doses of controlled substances. Respondent also admitted that many of the prescriptions for controlled substances concerned her, but she never discussed her concerns with the physician recommending these medications.

37. Respondent's conduct constitutes unprofessional conduct and gross negligence in that she failed to provide medical documentation for a number of patient encounters; she failed to use the proper billing codes for insurance billings; and she failed to document her care and medical management of Patient B.

38. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao, and Dr. Allen, that respondent's medical records relating to her care and treatment of Patient B do not comply with the standard of care and demonstrates unprofessional conduct, repeated negligent acts, incompetence and furnishing dangerous drugs without an examination. She failed to document every single patient encounter, but billed for undocumented encounters; she failed to document the components necessary to justify billing codes used; she failed to document the basis for prescribing controlled substances or any associated medical examination; she failed to document the treatment plan and objectives for the patient; she failed to document any alternatives to the prescriptions prescribed; she failed to document discussing the risks and benefits of prescribing controlled substances, especially to a patient who admits to drug dependence; she failed to document periodic reviews of the pain medications; she failed to document any review and/or discussion with the pain specialist or other medical provider regarding medications prescribed; and she failed to document the patient's pain level, levels of function, and quality of life, especially in light of the high levels of controlled substances.

39. It was established by clear and convincing evidence through the expert testimony of Dr. Allen that respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes is a departure from the standard of care and shows a lack of knowledge.

Unprofessional Conduct: Gross Negligence/Negligence/Incompetence -Patient C

40. On November 10, 2009, respondent began treating Patient C, a sixty-four year old male with a history of Parkinson's disease, bi-polar disorder, chronic obstructive pulmonary disease (COPD), urinary incontinence, and skin rashes, for in-home health care supportive services. Respondent completed the first electronic clinic note using the SOAP format indicting: "New patient here for refills. Talk about patient's anxiety." The note briefly described his symptoms and anxiety, but there was no further information or documentation regarding Patient C's medical history, current medical treatment and prescriptions. Respondent documented conducting a brief physical examination. Respondent wrote prescriptions for a fungal cream, diflucan (a trade name for fluconazole tablets, is a subclass of synthetic antifungal agents. It is a dangerous drug), and tranxene (a trade name for clorazepate dipotassium, is a benzodiazepine and is indicated for anxiety. It is a dangerous drug and a schedule IV controlled substance). The note indicated that Patient C should follow-up with a psychiatrist and that his additional medical concerns would be dealt with on the next visit.

41. Respondent billed this encounter as a comprehensive examination, but the note does not justify the billing code used. In order to bill a comprehensive examination, the physician must document two of three elements, including a comprehensive history, a comprehensive physical examination appropriate for the medical conditions, and medical decision-making of high complexity.

42. On November 10, 2009, respondent documented a follow-up appointment with Patient C in an electronic record using the SOAP format. Respondent reported the patient's chief complaint for this visit was back pain and he had had lower back pain for several years. Patient C reported the pain at 9 on a scale of 10. The assessment section included a note that for Patient C's pain management she referred him to a specialist. Respondent prescribed 50 milligrams of Tramadol (a narcotic like pain reliever, which is a dangerous drug) every 12 hours as needed for pain.

43. On January 21, 2010 respondent noted a follow-up visit with Patient C for a flu shot and medication refills. The electronic medical record noted in the subjective section that the patient was doing well and had no medical complaints other than anxiety. Respondent documented conducting a review of systems and a general examination. Respondent refilled the patient's traxene prescription for anxiety to 120 pills of 7.5 milligrams every four hours and prescribed lithium carbonate (is indicated for the treatment of manic episodes of bipolar disorder. It is a dangerous drug) for depression.

44. On March 26, 2010, Patient C was admitted to San Marco Nursing Home and Rehabilitation Center (San Marco) because he was no longer able to care for himself at his home. Patient C was admitted with the following diagnosis: bipolar disorder, COPD, anxiety, depression, diabetes, hyperlipidemia, and Parkinson's disorder. Respondent was listed as Patient C's primary care provider.

45. During Patient C's stay at San Marco between March 26, 2010 and February 24, 2011, respondent wrote progress notes and physician orders for Patient C. The records indicated respondent monitored his lab work, his physical condition, non-psychiatric medications, and responded to nursing staff concerns. Respondent also requested consultations for rehabilitation, social work, neurology, and a nutritionist.

46. On January 4, 2011, respondent transferred the patient to an outside emergency room for evaluation and treatment for bipolar issues, acute mania, and severe psychosis. Respondent completed a physician order for the patient indicating that he was back at San Marco by January 10, 2011. On February 25, 2011, San Marco discharged Patient C to a board and care home.

47. On March 2, and 8, 2011, respondent's electronic medical records note follow-up visits with the patient. Patient C's chief complaint was that he was bitten by a dog and anxiety and respondent started buspar (an anti-anxiety medication. It is a dangerous drug). Respondent also conducted a medication review of all of Patient C's current medications.

Respondent wrote that the patient should see a psychiatrist and pain specialist for all future controlled substances.

48. On March 11, 2011, respondent wrote a letter to Patient C terminating him as a patient. The letter indicated that she would treat him on an emergency basis over the next 30 days, but that he needed to find another primary care provider. During respondent's Board interview, she indicated she terminated the patient following advice from her malpractice insurance carrier after the patient threatened to sue her.

49. Respondent's billing records indicate that she started billing for her care of Patient C on November 5, 2009. However, the first medical record provided was dated March 26, 2010. Prescription records and CURES records indicate that respondent began writing prescription for Patient C about November 10, 2009.

50. Respondent used billing codes that do not correspond with the encounters recorded in Patient C's medical record. The codes require documentation of a comprehensive interval history, comprehensive examinations, and medical decision-making of high complexity. This information was not contained in the majority of the medical note written by respondent.

51. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao and Dr. Allen, that respondent's conduct constitutes unprofessional conduct and gross negligence in that respondent failed to provide medical documentation for all patient encounters that were billed.

52. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao, and Dr. Allen, that respondent's medical records relating to her care and treatment of Patient C do not comply with the standard of care and shows unprofessional conduct, repeated negligent acts and incompetence in that respondent failed to document a thorough history of Patient C during the initial evaluation and treatment upon his admission to San Marco, including failure to document failed treatments and prior specialty consultations; and failed to properly and adequately document several medical encounters with Patient C, including failure to conduct periodic reviews of the patient's pain level, treatment and status, and medication adjustments.

Medical Record Keeping

53. Respondent failed to keep adequate and accurate medical records related to the care and treatment of Patients A, B, and C. Respondent's medical records fail to adequately document patient histories, thorough medical examinations, evaluations, continued assessments, treatment plans and objectives, discussion of informed consent, and the rationale for the medications prescribed; respondent's medical records fail to document any medical basis or indication for the ongoing prescription of controlled substances, or to document any physical examinations or findings supporting the clinical diagnosis; and

respondent's hand-written medical records are often illegible making it difficult to determine the care and treatment provided to Patients A, B, and C.

Other Matters

54. In 2010, respondent voluntarily agreed to submit to probation with significant rehabilitation terms. She acknowledged that her record keeping was inadequate and below standard. Respondent complied with all the terms and conditions of her probation. Over time she completely converted to electronic record-keeping for all of her patients, both in her office and at nursing homes. At the end of her three-year probationary period her monitor concluded that her documentation had improved. The patients in this matter either predated respondent's probation or were relatively early in the probationary period. Respondent acknowledged that her record-keeping in regard to the three patients did not meet standards.

55. Respondent attended medical school in India. After she came to the United States in about 2000, she did a residency at Saint Joseph's Family Medicine, Mount Sinai School of Medicine, Clifton, New Jersey. She did a Fellowship in Geriatric Medicine in 2003 – 2004 at the University of Hawaii, Honolulu, Hawaii. She received a Master of Public Health in 2005 from San Jose State University, San Jose, California. She presently has a practice in Walnut Creek, California. She also sees patients at various nursing facilities. She attended the Medical Record Keeping Course given by the University of California, San Diego School of Medicine Continuing Education Program in July 2010 and a prescribing course in July 2010. She also was monitored through the Physician Assessment & Clinical Evaluation program's Professional Enhancement Program by Dustin Lillie, M.D. He testified at the hearing that respondent still needed some improvement in her record keeping, but that she was improving. He opined that on-going monitoring would be helpful.

56. Taking into consideration all the evidence in this matter, it would not be against the public interest to allow respondent to continue to practice medicine under specific terms and conditions of probation including continued monitoring of her electronic medical records as set forth below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 15, cause for disciplinary action exists in the case of Patient A, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

2. By reason of the matters set forth in Finding 16 through 39, cause for disciplinary action exists in the case of Patient B, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c)

repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

3. By reason of the matters set forth in Findings 40 through 52, cause for disciplinary action exists in the case of Patient C, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

4. By reason of the matters set forth in Finding 53, cause for disciplinary action exists in the cases of Patients A, B, and C pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

5. The matters set forth in Findings 54 through 56, have been considered in making the following order. This is consistent with Business and Professions Code section 2229, subdivision (b), which requires that disciplinary action should be "calculated to aid in the rehabilitation of the licensee, . . ." as long at the public can be protected. The terms and conditions of probation are designed to insure that respondent is safe to practice in California.

6. In argument respondent asserted the affirmative defense of laches. Laches requires both prejudice and unreasonable delay. Laches was not established.

ORDER

Physician and Surgeon's Certificate No. A 82039 issued to respondent Purnima Ravi Sreenivasan, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions:

1. Education Courses

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at the areas of (a) opioid prescribing and pain management; (b) professionalism; and (c) medical record keeping, and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Monitoring -Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to ease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

3. Notification

Within (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

4. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. Probation Unit Compliance

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes
Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice
Respondent shall not engage in the practice of medicine in respondent's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal
Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event respondent should leave the State of California to reside or practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

7. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee

upon request at various intervals and either with or without prior notice throughout the term of probation.

8. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or any activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probationary Requirements.

9. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

10. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

This decision shall become effective on: July 3, 2015.

It is so ORDERED: June 3, 2015.

Dev Gnanadev, M.D., Chair
Panel B, Medical Board of California

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

In the Matter of the Accusation Against:	)	
	)	
PURNIMA RAVI SREENIVASAN, M.D.	)	
	)	Case No.: 12-2011-217569
	)	
	)	OAH No.: 2014050625
	)	
	)	
Respondent.	)	
	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written arguments as the parties may wish to submit directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such arguments when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street, Suite 210, Sacramento, CA 95814. Their telephone number is (916) 498-9288.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written arguments.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-2349
Attention: John F. Yelchak

Date: February 5, 2015

Dev Gnanadev, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:	
PURNIMA RAVI SREENIVASAN, M.D.,	Case No. 12-20110-217569
Physician and Surgeon's Certificate No. A 82039	OAH No. 2014050562
Respondent.	

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on October 13, 2014.

Emily L. Brinkman, Deputy Attorney General, represented complainant.

Respondent Purnima Ravi Sreenivasan, M.D., was present and represented by John L. Fleer, Attorney at Law.

Submission of the matter was deferred for receipt of final arguments, which were received, marked for record, and considered. The matter was submitted on November 21, 2014.

FACTUAL FINDINGS

1. Complainant Kimberly Kirchmeyer made this accusation in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On February 21, 2003, Physician and Surgeon's Certificate No. A 82039 was issued by the Board to Purnima Ravi Sreenivasan, M.D. (respondent). Respondent's certificate will expire December 31, 2014, unless renewed.

Respondent was previously disciplined following a stipulated decision and order that placed respondent on probation for a period of three years, effective April 23, 2010. The decision required respondent to complete a prescribing practice course, a medical record

keeping course, and submit to a practice monitor. Respondent met all the terms and conditions of her probation.

Unprofessional Conduct: Gross Negligence/Negligence/Incompetence - Patient A

3. On March 1, 2011, respondent began treating Patient A (a male born in 1939) at the Windsor Manor Nursing Home (Windsor Manor) after his hospitalization following a car accident. Patient A was hospitalized between February 26, 2011 through March 1, 2011. The admission record for Windsor Manor indicates the patient had a known history of cocaine abuse.

4. On March 4, 2011, respondent completed the history and physical examination form for Patient A noting patient's history of acute asthma and a past medical history of asthma, cocaine abuse, and chronic back pain. Respondent documented a limited physical examination, without noting an examination of the chest or back. The progress note is not very legible. Respondent did not note that the patient complained of any chest pain or low back pain. The treatment plan was for Patient A to undergo physical therapy, occupational therapy, and to see a registered dietician. There is no indication what his current medications were or even if respondent prescribed any new medication for him.

5. On March 21, 2011, respondent saw Patient A. Her handwritten progress is not very legible but does include the note that the patient was doing ok. The progress note contains extensive abbreviations, but seems to indicate that the patient did not complain of chest pain or shortness of breath and he was comfortable. The record does not address any medications prescribed to Patient A.

6. On March 30, 2011, respondent noted in a progress note that the patient wanted to leave the facility. She advised against it. The note indicates the patient is taking Restoril (Restoril is the trade name for temazepam, a hypnotic agent. It is a dangerous drug and a schedule IV controlled substance) for insomnia, but there are no other indications that he was taking any other medication or for what reason.

7. On April 5, 2011, respondent saw Patient A and noted he is doing good (sic) and ambulating well. The progress note is difficult to decipher. There is no indication in the record what medications she prescribed, dose instructions, or why any medications might be needed.

8. On April 8, 2011, respondent's progress note for this encounter with Patient A noted that he was doing ok. The note indicates Patient A would be discharged on "Monday with orders." There was no mention of any medications prescribed.

9. Throughout Patient A's stay at Windsor Manor there are nursing notes indicating nurses conducted pain assessments and listed side effects of the medications he was taking. From the time of his admission, respondent prescribed Restoril (with changes to his scheduled dosing) and Percocet (Percocet is oxycodone with acetamenophen, and is a

semisynthetic narcotic pain reliever with actions similar to morphine. It is a dangerous drug and a schedule II controlled substance. It can produce drug dependence.) There are no notations in the progress notes completed by Respondent as to why these medications were prescribed, the patient's pain level (or even complaints of pain), what she hoped the medications would treat in the patient, the patient's response to the medications (success or failures), and whether he had any adverse affects as a result of the medications.

10. During the time Patient A was at Windsor Manor, the California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) shows regular prescriptions and refills for Restoril and Percocet.

11. On April 11, 2011, Patient A was discharged from Windsor Manor. The list of discharge medication included Restoril and Percocet.

12. During Respondent's Medical Board interview on November 19, 2012, respondent stated that she did not recall whether she actually took a detailed history of Patient A. She stated she did not concern herself with past history of drug or alcohol abuse because "as a doctor I provide only medical care." Respondent stated in that interview that she was not concerned with the method that medications she wrote prescriptions for were administered by the nursing home staff, including controlled substances with the instructions "as needed for pain."

13. Respondent billed insurance for medical care provided to Patient A on March 4, 20, 21, April 5, 6 (no progress note for April 6, but there is one for April 8, which was not billed), 11, and 12 (the patient was discharged the day before), on April 11, 2011. The medical records do not support the billing codes respondent used for these encounters.

14. It was established by clear and convincing evidence through the testimony of the Board's experts Nayanatara Rao, M.D. and Eric Allen, M.D. that respondent's medical records relating to the care and treatment of Patient A do not comply with the standard of care and constitute unprofessional conduct. She failed to document a thorough history of the patient's past and present medical history; she failed to document a history of past and current illicit substance and alcohol use/abuse history; she failed to document a medical necessity of the prescription of controlled substances; and she failed to document the components necessary to justify specific billing codes used.

15. It was established by clear and convincing evidence through the testimony of the Board's expert, Dr. Allen, that respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes violates the standard of care and demonstrates lack of knowledge.

Unprofessional Conduct: Gross Negligence/Negligent Acts/Incompetence - Patient B

16. Between September 15, 2009 through December 27, 2011, respondent treated Patient B (a 43-year old female paraplegic at T-6) at two separate short-term nursing homes, Tampico Terrace and Ygnacio Valley Care Center. Patient B suffers from a variety of medical issues, including Crohn's disease, rectovesicular fistula, urostomy, colostomy, urinary diversion, chronic pain, opiate dependence, hypothyroidism, depression, recurrent urinary tract infections (UTI), and recurrent pressure ulcers. She had recurrent hospitalizations for UTI, sepsis, chronic wounds, and pneumonia during the year she was treated at Ygnacio Valley.

17. Respondent treated Patient B off and on at Ygnacio Valley between December 31, 2010 through January 10, 2012. Patient B was originally admitted to Ygnacio Valley from an acute care hospital with severe malnutrition and pressure ulcers. The patient reported a history of drug abuse as noted on a "Resident Progress Note" dated January 17, 2011. Most of the progress notes were written by the nursing staff. During this time frame, the patient was admitted six times to John Muir Medical Center, Walnut Creek, but the reasons for the various hospitalizations are unclear from the Ygnacio Valley records. Each time Patient B returned to Ygnacio Valley, her stay was treated as a new admission. Respondent became her primary care giver on March 14, 2011.

18. Patient B was admitted to Ygnacio Valley from March 25, 2011 through April 12, 2011. On March 30, 2011, respondent completed a "History and Physical" following Patient B's hospitalization for pyelonephritis (kidney infection). Much of the handwritten form is illegible. It includes information that respondent saw the patient and the patient would be treated for wound care. Respondent also completed a "Physician Order" requesting a pain management consultation and psychiatric evaluation if one had not yet been conducted.

19. On April 4, 2011, respondent completed a progress note for her encounter with Patient B. The progress note indicated the patient saw a pain specialist and that the specialist recommended an increase in her morphine dose but that respondent had to complete the prescription. Much of the note is not legible, but the treatment plan includes seeing a specialist for wound care and a protein rich diet for malnutrition. Respondent also completed an order for this encounter with Patient B. The note requested that the pharmacy review all of the patient's medications for possible drug interactions, to discontinue the Flexaril (Cydobenzaprine - is a muscle relaxant and it is a dangerous drug as defined by law) and start Baclofen (Baclofen is a muscle relaxer and anti-spastic agent. It is a dangerous drug as defined in the law). There are no additional records signed by respondent documenting her care and treatment of Patient B during the time from March 25, 2011 and April 12, 2011. Respondent billed insurance for medical care provided on March 30, and April 4, 2011. The medical records do not support the billing code used for these encounters.

20. Patient B was admitted to Ygnacio Valley from April 13, 2011 through May 16, 2011. On April 14, 2011, respondent completed the history and physical form on Patient

B. Respondent's notes indicate that Patient B was hospitalized for pyelonephritis. Under current diagnosis respondent wrote that she saw the patient on this date, but the plan of care is illegible. Respondent completed a physician order regarding the need for a pain specialist, lab work, nutritional consultation, and a psychotherapy consultation.

21. Respondent also completed physician orders on April 18, May 2, and May 9, 2011. The orders required staff to perform specific tasks related to the care and treatment of this patient. However, there are no associated progress notes or other records documenting any examination of the patient by respondent supporting any orders.

22. There are no additional records signed by respondent documenting her care and treatment of Patient B during this admission. Respondent billed insurance for medical care provided on April 4, and April 11, 2011. There are no records that insurance was billed for services provided on May 2, and May 9, 2011. The medical records do not support the billing codes respondent used for these encounters.

23. Patient B was admitted to Ygnacio Valley form May 17, 2011 through May 21, 2011. On May 17, 2011, respondent completed an initial physician comprehensive assessment for Patient B. The form included checking relevant boxes related to Patient B's care and condition. Respondent did not indicate the plan or treatment goals for the patient. There are no other associated progress notes of records documenting any examination or treatment of the patient by respondent during this encounter.

24. Respondent billed insurance for medical care provided on May 18 and May 20, 2011. However, the medical records do not support the billing codes respondent used for these encounters.

25. Patient B was admitted to Ygnacio Valley from May 24, 2011 through June 19, 2011. On May 24, 2011, respondent completed an initial physician comprehensive assessment for Patient B. The form included checking relevant boxes related to care and condition, but also provided an assessment section allowing the doctor to hand write her findings. Respondent wrote that Patient B was hospitalized with back pain, the remaining note is illegible.

26. There are no other associated progress notes or records documenting any examination or treatment of Patient B by respondent during this admission. Respondent billed insurance for services performed on May 25, 2011, however, there are no records supporting any encounter between Patient B and respondent justifying this bill. Assuming the billing error should refer to the care provided on May 24, 2011, the medical records do not support the billing code respondent used for this encounter.

27. Patient B was admitted to Ygnacio Valley from June 19, 2011 through August 10, 2011. There are no signed medical records from respondent during this admission period. There are physician orders indicating directions for staff from respondent, but there are no medical records documenting any form of evaluation or examination of the patient by

respondent. Respondent billed insurance for medical care provided on June 27, and July 11, 2011, however, there are no medical records to support the billing codes respondent used.

28. Patient B was admitted to Ygnacio Valley from August 13, 2011 through August 23, 2011. On August 13, and 14, 2011, there are physician orders from respondent. The are handwritten and difficult to read, but appear to discuss the patient's wound dressing on her right hip and medication issues. There are no associated progress notes or other records that respondent treated or even saw the patient on these dates. Respondent billed insurance for medical care provided on August 15, 2011, however, there are no medical records to support the billing codes respondent used. Assuming, the billing error should refer to the care provided on either August 13, or 14, 2011, the medical records do not support the billing code respondent used for this encounter.

29. Patient B was admitted to Ygnacio Valley from September 10, 2011 through December 19, 2011. On September 13, 2011, respondent completed the initial physician comprehensive assessment on Patient B. The form included checking relevant boxes related to the patient's care and condition, but also provided an assessment section allowing the doctor to handwrite her findings. Respondent's assessment is mostly illegible but stated: "Patient discussed in detail."

30. Respondent produced electronic medical records for the following patient encounters: October 27, November 15, November 22, December 1, and December 12, 2011. There are additional handwritten notes for several dates. The records are in standard "SOAP" format (Subjective, Objective, Assessment, and Plan) and indicated the patient's current health status. The notes also indicated the patient was preparing for her upcoming discharge from Ygancio Valley to return home. Respondent noted on these forms in the subjective portion that she discussed medications, lab work, and treatment plans with the patient. The notes also indicate the various diagnosis and plans for treatment. Several of the notes contain information relating to the need for the patient to follow-up with doctors after discharge.

31. During respondent's Medical Board interview, she stated that her care of Patient B during the October and November 2011 dates were solely based on her review of recommendations from other medical providers, yet there is no notation in the medical records that respondent reviewed any other records or recommendations from other providers.

32. Respondent billed insurance for services provided on September 13, October 27, November 15, November 22, and December 12, 2011 that correspond to documented medical records. Respondent also billed insurance for services provided on September 19, and 26, October 3, 11, 17, and 21, and November 4, 2011. These dates are not related to any medical documentation. There are no medical records to support the billing codes respondent used. For the encounters that are documented, the medical records do not support the billing codes respondent used of these encounters.

33. Patient B was admitted to Ygnacio Valley from December 24, 2011 through January 10, 2012. On December 27, 2011, respondent completed physician order indicating several items that needed to be addressed by any new health care provider. Specifically, respondent wrote that the patient needs to keep up with her pain appointment on January 14, 2012; all meds to be managed by pain specialist and the pain specialist needs to send triplicates to pharmacy or sign triplicates for all the meds he is prescribing to her; respondent is not responsible any more or any future pain meds. There are no other associated progress notes or other records that respondent treated or even saw Patient B during this admission period. Respondent billed insurance for medical care provided on December 27, 2011. However, the medical record does not support the billing code respondent used for this encounter.

35. During the time Patient B was at Ygnacio Valley, the California Department of Justice CURES and the Patient Profile from Pharmerica Pharmacy show regular prescriptions and refills for Lorazepam (also known as Ativan, is used to treat anxiety. It is a dangerous drug and a schedule IV controlled substance), APAP propoxyphene (is a narcotic pain reliever. It was withdrawn from the market in November 2010. It was a dangerous drug and a schedule IV controlled substance), Fentanyl Transdermal System (also known as Duragesic, is an opioid analgesic and a dangerous drug and schedule II controlled substance), hydromorphone hydrochloride (also known as Dilaudid, is used for pain relief. It is a dangerous drug and a schedule II controlled substance), Zolpidem (also known as Ambien, is a non-benzodiazepine hypnotic. It is a dangerous drug and a schedule IV controlled substance), morphine sulfate (is used in patients who require potent opioid pain relief. It is a dangerous drug and a schedule II controlled substance), Dronabinol (also known as Marinol, is a man-made form of cannabis. It is used to treat loss of appetite. It is a dangerous drug and a schedule III controlled substance), methadone hydrochloride (is a synthetic narcotic pain reliever. It is a dangerous drug and a schedule II controlled substance), Oxycontin (also known as oxycodone hydrochloride, is a pure agonist opioid used for pain relief. It is a dangerous drug and a schedule II controlled substance), hydrocodone APAP (is the generic name for Vicodin, Lortab, and Vicoprofen. It is a semisynthetic narcotic pain reliever and a dangerous drug and schedule III controlled substance), and Diazepam (also known as Valium, is a psychotropic drug used to treat anxiety. It is a dangerous drug and a schedule IV controlled substance). Respondent did not document the medications that she prescribed, the reasons for the prescriptions, any side effects, any changes to the medications, or any additions or deletions of medications following examinations of the patient. There are notations in some of the physician orders completed by staff when certain adjustments to medications were made or when medications were given to the patient but the majority of the physician orders are not legible and do not appear to have been completed by respondent.

36. During respondent's Board interview, she stated that she could not recall whose recommendations she relied on when writing prescriptions, including for significant doses of controlled substances. Respondent also admitted that many of the prescriptions for controlled substances concerned her, but she never discussed her concerns with the physician recommending these medications.

37. Respondent's conduct constitutes unprofessional conduct and gross negligence in that she failed to provide medical documentation for a number of patient encounters; she failed to use the proper billing codes for insurance billings; and she failed to document her care and medical management of Patient B.

38. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao, and Dr. Allen, that respondent's medical records relating to her care and treatment of Patient B do not comply with the standard of care and demonstrates unprofessional conduct, repeated negligent acts, incompetence and furnishing dangerous drugs without an examination. She failed to document every single patient encounter, but billed for undocumented encounters; she failed to document the components necessary to justify billing codes used; she failed to document the basis for prescribing controlled substances or any associated medical examination; she failed to document the treatment plan and objectives for the patient; she failed to document any alternatives to the prescriptions prescribed; she failed to document discussing the risks and benefits of prescribing controlled substances, especially to a patient who admits to drug dependence; she failed to document periodic reviews of the pain medications; she failed to document any review and/or discussion with the pain specialist or other medical provider regarding medications prescribed; and she failed to document the patient's pain level, levels of function, and quality of life, especially in light of the high levels of controlled substances.

39. It was established by clear and convincing evidence through the expert testimony of Dr. Allen that respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes is a departure from the standard of care and shows a lack of knowledge.

Unprofessional Conduct: Gross Negligence/Negligence/Incompetence - Patient C

40. On November 10, 2009, respondent began treating Patient C, a sixty-four year old male with a history of Parkinson's disease, bi-polar disorder, chronic obstructive pulmonary disease (COPD), urinary incontinence, and skin rashes, for in-home health care supportive services. Respondent completed the first electronic clinic note using the SOAP format indicting: "New patient here for refills. Talk about patient's anxiety." The note briefly described his symptoms and anxiety, but there was no further information or documentation regarding Patient C's medical history, current medical treatment and prescriptions. Respondent documented conducting a brief physical examination. Respondent wrote prescriptions for a fungal cream, diflucan (a trade name for fluconazole tablets, is a subclass of synthetic antifungal agents. It is a dangerous drug), and tranxene (a trade name for clorazepate dipotassium, is a benzodiazepine and is indicated for anxiety. It is a dangerous drug and a schedule IV controlled substance). The note indicated that Patient C should follow-up with a psychiatrist and that his additional medical concerns would be dealt with on the next visit.

41. Respondent billed this encounter as a comprehensive examination, but the note does not justify the billing code used. In order to bill a comprehensive examination, the physician must document two of three elements, including a comprehensive history, a comprehensive physical examination appropriate for the medical conditions, and medical decision-making of high complexity.

42. On November 10, 2009, respondent documented a follow-up appointment with Patient C in an electronic record using the SOAP format. Respondent reported the patient's chief complaint for this visit was back pain and he had had lower back pain for several years. Patient C reported the pain at 9 on a scale of 10. The assessment section included a note that for Patient C's pain management she referred him to a specialist. Respondent prescribed 50 milligrams of Tramadol (a narcotic like pain reliever, which is a dangerous drug) every 12 hours as needed for pain.

43. On January 21, 2010. respondent noted a follow-up visit with Patient C for a flu shot and medication refills. The electronic medical record noted in the subjective section that the patient was doing well and had no medical complaints other than anxiety. Respondent documented conducting a review of systems and a general examination. Respondent refilled the patient's traxene prescription for anxiety to 120 pills of 7.5 milligrams every four hours and prescribed lithium carbonate (is indicated for the treatment of manic episodes of bipolar disorder. It is a dangerous drug) for depression.

44. On March 26, 2010, Patient C was admitted to San Marco Nursing Home and Rehabilitation Center (San Marco) because he was no longer able to care for himself at his home. Patient C was admitted with the following diagnosis: bipolar disorder, COPD, anxiety, depression, diabetes, hyperlipidemia, and Parkinson's disorder. Respondent was listed as Patient C's primary care provider.

45. During Patient C's stay at San Marco between March 26, 2010 and February 24, 2011, respondent wrote progress notes and physician orders for Patient C. The records indicated respondent monitored his lab work, his physical condition, non-psychiatric medications, and responded to nursing staff concerns. Respondent also requested consultations for rehabilitation, social work, neurology, and a nutritionist.

46. On January 4, 2011, respondent transferred the patient to an outside emergency room for evaluation and treatment for bipolar issues, acute mania, and severe psychosis. Respondent completed a physician order for the patient indicating that he was back at San Marco by January 10, 2011. On February 25, 2011, San Marco discharged Patient C to a board and care home.

47. On March 2, and 8, 2011, respondent's electronic medical records note follow-up visits with the patient. Patient C's chief complaint was that he was bitten by a dog and anxiety and respondent started busbar (an anti-anxiety medication. It is a dangerous drug). Respondent also conducted a medication review of all of Patient C's current medications.

Respondent wrote that the patient should see a psychiatrist and pain specialist for all future controlled substances.

48. On March 11, 2011, respondent wrote a letter to Patient C terminating him as a patient. The letter indicated that she would treat him on an emergency basis over the next 30 days, but that he need to find another primary care provider. During respondent's Board interview, she indicated she terminated the patient following advice from her malpractice insurance carrier after the patient threatened to sue her.

49. Respondent's billing records indicate that she started billing for her care of Patient C on November 5, 2009. However, the first medical record provided was dated March 26, 2010. Prescription records and CURES records indicate that respondent began writing prescription for Patient C about November 10, 2009.

50. Respondent used billing codes that do not correspond with the encounters recorded in Patient C's medical record. The codes require documentation of a comprehensive interval history, comprehensive examinations, and medical decision-making of high complexity. This information was not contained in the majority of the medical note written by respondent.

51. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao and Dr. Allen, that respondent's conduct constitutes unprofessional conduct and gross negligence in that respondent failed to provide medical documentation for all patient encounters that were billed.

52. It was established by clear and convincing evidence through the testimony of the Board's experts, Dr. Rao, and Dr. Allen, that respondent's medical records relating to her care and treatment of Patient C do not comply with the standard of care and shows unprofessional conduct, repeated negligent acts and incompetence in that respondent failed to document a thorough history of Patient C during the initial evaluation and treatment upon his admission to San Marco, including failure to document failed treatments and prior specialty consultations; and failed to properly and adequately document several medical encounters with Patient C, including failure to conduct periodic reviews of the patient's pain level, treatment and status, and medication adjustments.

Medical Record Keeping

53. Respondent failed to keep adequate and accurate medical records related to the care and treatment of Patients A, B, and C. Respondent's medical records fail to adequately document patient histories, thorough medical examinations, evaluations, continued assessments, treatment plans and objectives, discussion of informed consent, and the rationale for the medications prescribed; respondent's medical records fail to document any medical basis or indication for the ongoing prescription of controlled substances, or to document any physical examinations or findings supporting the clinical diagnosis; and

respondent's hand-written medical records are often illegible making it difficult to determine the care and treatment provided to Patients A, B, and C.

Other Matters

54. In 2010, respondent voluntarily agreed to submit to probation with significant rehabilitation terms. She acknowledged that her record keeping was inadequate and below standard. Respondent complied with all the terms and conditions of her probation. Over time she completely converted to electronic record-keeping for all of her patients, both in her office and at nursing homes. At the end of her three-year probationary period her monitor concluded that her documentation had improved. The patients in this matter either predated respondent's probation or were relatively early in the probationary period. Respondent acknowledged that her record-keeping in regard to the three patients did not meet standards.

55. Respondent attended medical school in India. After she came to the United States in about 2000, she did a residency at Saint Joseph's Family Medicine, Mount Sinai School of Medicine, Clifton, New Jersey. She did a Fellowship in Geriatric Medicine in 2003 – 2004 at the University of Hawaii, Honolulu, Hawaii. She received a Master of Public Health in 2005 from San Jose State University, San Jose, California. She presently has a practice in Walnut Creek, California. She also sees patients at various nursing facilities. She attended the Medical Record Keeping Course given by the University of California, San Diego School of Medicine Continuing Education Program in July 2010 and a prescribing course in July 2010. She also was monitored through the Physician Assessment & Clinical Evaluation program's Professional Enhancement Program by Dustin Lillie, M.D. He testified at the hearing that respondent still needed some improvement in her record keeping, but that she was improving. He opined that on-going monitoring would be helpful.

56. Taking into consideration all the evidence in this matter, it would not be against the public interest to allow respondent to continue to practice medicine under specific terms and conditions of probation including a short period of continued monitoring of her electronic medical records as set forth below.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 15, cause for disciplinary action exists in the case of Patient A, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

2. By reason of the matters set forth in Finding 16 through 39, cause for disciplinary action exists in the case of Patient B, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c)

repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

3. By reason of the matters set forth in Findings 40 through 52, cause for disciplinary action exists in the case of Patient C, pursuant to Business and Professions Code sections 2234 (unprofessional conduct), 2234, subdivision (b) (gross negligence), (c) repeated acts of negligence), (d) (incompetence) and 2242 (furnishing drugs without an examination).

4. By reason of the matters set forth in Finding 53, cause for disciplinary action exists in the cases of Patients A, B, and C pursuant to Business and Professions Code section 2266 (failure to maintain adequate and accurate records.)

5. The matters set forth in Findings 54 through 56, have been considered in making the following order. This is consistent with Business and Professions Code section 2229, subdivision (b), which requires that disciplinary action should be "calculated to aid in the rehabilitation of the licensee, . . ." as long at the public can be protected. The terms and conditions of probation are designed to insure that respondent is safe to practice in California.

6. In argument respondent asserted the affirmative defense of laches. Laches requires both prejudice and unreasonable delay. Laches was not established.

ORDER

Physician and Surgeon's Certificate No. A 82039 issued to respondent Purnima Ravi Sreenivasan, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of

the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

8. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

9. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent

of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

10. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation.
Upon successful completion of probation, respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each

calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: 12/17/14

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against: **PURNIMA RAVI SREENIVASAN, M.D.** **228 North Wiget Lane** **Walnut Creek, CA 94598** **Physician's and Surgeon's Certificate No. A82039** Respondent.	Case No. 12-2011-217569 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about February 21, 2003, the Medical Board of California issued Physician's and Surgeon's Certificate Number A82039 to Purnima Ravi Sreenivasan, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2014, unless renewed. Respondent was previously disciplined following a stipulated decision and order that placed Respondent on probation for three years, effective April 23, 2010. The Stipulated Decision and Order required

Respondent to complete a prescribing practices course, a medical record keeping course, and submit to a practice monitor.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board)[1], Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after conclusion of disciplinary action.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Business and Professions Code authorizes the Board to take action against a licensee by revoking, suspending for a period not to exceed one year, placing the

[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" or "Division" shall also be deemed to refer to the Board (Bus. & Prof. Code section 2002).

license on probation and requiring payment of costs of probation monitoring, or taking such other action taken as the Board deems proper.

6. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following: (A) Impaired control over drug use. (B) Compulsive use. (C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

9. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, 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.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5."

10. Section 2242 of the Code states:

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

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

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs

were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

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

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

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

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

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

RELEVANT DRUGS

11. **Acetaminophen with codeine**, also known by the trade names Tylenol No. 3, or Tylenol with Codeine, is a combination of acetaminophen and codeine phosphate. It is a dangerous drug as defined in section 4022 and a schedule III controlled substance as defined by section 11056(e) of the Health and Safety Code. Codeine can produce drug dependence of the morphine type, and therefore has the potential for being abused.

12. **Alprazolam**, also known by the trade name of Xanex, is used for the management of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057(d) of the Health and Safety Code. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence.

13. **Baclofen** is a muscle relaxer and anti-spastic agent. It is a dangerous drug as defined in section 4022.

14. **Buspar** is an anti-anxiety medication. It is a dangerous drug as defined in section 4022.

15. **Clonazepam**, also known as Klonipin, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence.

16. **Diazepam**, also known as Valium, is a psychotropic drug used to treat anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Diazepam can produce psychological and physical dependence and should be prescribed with precaution particularly with addiction-prone patients.

17. **Diflucan**, a trade name for fluconazole tables, is a subclass of synthetic antifungal agents. It is a dangerous drug as defined in section 4022.

18. **Dronabinol**, also known by the trade name Marinol, is a man-made form of cannabis. It is used to treat the loss of appetite, severe nausea, and vomiting. It is a dangerous drug as defined in section 4022 and a schedule III controlled substance as defined by section 11056, subdivision (e) of the Health and Safety Code. It may be habit forming and patients should avoid taking other medications that also affect the central nervous system.

19. **Fentanyl Transdermal System,** also known by the trade name Duragesic, is an opioid analgesic and is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by Health and Safety Code section 11055. Fentanyl is a strong opioid medication and is indicated only for treatment of chronic pain that cannot be managed by lesser means.

20. **Hydrocodone bitartrate**, is a generic name for Vicodin, Lortab, and Vicoprofen. Hydrocodone is semisynthetic narcotic pain reliever. It is a dangerous drug as defined in section 4022 of the Code and a schedule III controlled substance as defined by section 11056(e)(4) of the Health and Safety Code.

21. **Hydromorphone hydrochloride**, also known by the trade name Dilaudid, is primarily used for pain relief. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055(d) of the Health and Safety Code. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution.

22. **Lithium carbonate** is indicated for the treatment of manic episodes of bipolar disorder. It is a dangerous drug within the meaning of section 4022.

23. **Lorazepam**, also known by the trade name Ativan, is used to treat anxiety or anxiety associated with depression. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders.

24. **Lyrica,** a trade name for pregabalin, is an antiepileptic medication. It is a dangerous drug as defined in section 4022 and a schedule V controlled substance as defined by section 11058 of the Health and Safety Code. Lyrica is indicated for management of neuropathic pain associated with diabetic peripheral neuropathy, management of post-therapeutic neuralgia, adjunctive therapy for adult patients with partial onset seizures, and management of fibromyalgia.

25. **Methadone hydrochloride** is a synthetic narcotic pain reliever with actions similar to those of morphine. It also goes by the trade names Methadose and Dolophine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055(c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration, and it should be prescribed and administered with the same degree of caution as morphine.

26. **Morphine sulfate** is for use in patients who require potent opioid pain relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055(b)(1) of the Health and Safety Code. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration.

27. **Oxycodone**, with acetaminophen (Percocet) or with aspirin, is a semisynthetic narcotic pain reliever with actions similar to those of morphine. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055(b)(1) of the Health and Safety Code. Oxycodone can produce drug dependence and, therefore, has the potential for being abused.

28. **Oxycodone hydrochloride**, also known by the trade name Oxycontin, is a pure agonist opioid whose principal therapeutic action is pain relief. It is a dangerous drug as defined in section 4022 and a schedule II controlled substance as defined by section 11055(b)(1) of the Health and Safety Code. Respiratory depression is the chief hazard from all opioid agonist preparations and has the potential for abuse.

29. **Propoxyphene** with acetaminophen is a narcotic pain reliever. It was withdrawn from the United States market in November 2010. It was a dangerous drug as defined in section 4022 and a schedule IV controlled substance and narcotic as defined by section 11057(d) of the Health and Safety Code.

30. **Tramadol** is a narcotic like pain reliever. It is a dangerous drug as defined in section 4022.

31. **Tranxene**, a trade name for clorazepate dipotassium, is a benzodiazepine and is indicated for the treatment of anxiety. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined in section 11057 of the Health and Safety Code.

32. **Restoril**, the trade name for temazepam, is a hypnotic agent. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057(d) of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. Patients using Temazepam should be warned about the possible combined effects with alcohol and other central nervous system depressants. As with any hypnotic, caution must be exercised in administering Temazepam to individuals known to be addiction prone.

33. **Zolpidem tartrate**, also known by the trade name Ambien, is a non-benzodiazepine hypnotic. It is a dangerous drug as defined in section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-

term treatment of insomnia. It is a central nervous system depressant and should be used cautiously in combination with other central nervous system depressants.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross negligence; and/or repeated negligent acts; and/or incompetence/lack of knowledge; based on the care and treatment of Patient A; and/or furnishing controlled substances without the necessary examination of Patient A[2])

34. Respondent is subject to disciplinary action under sections 2234 [unprofessional conduct]; and/or 2234 (b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2234 (d) [incompetence/lack of knowledge]; and/or 2242 [furnishing dangerous drug without examination] of the Code based on her care and treatment of Patient A.

35. On or about March 1, 2011, Respondent began treating Patient A (a male born in 1939) at the Windsor Manor Nursing Home (Windsor Manor) after his hospitalization following a car accident. Patient A was hospitalized between February 26, 2011 through March 1, 2011. The admission record for Windsor Manor indicates that Patient A had a known history of cocaine abuse.

36. On or about March 4, 2011, Respondent completed the History and Physical examination form of Patient A noting, "Mr. [A] seen today. Pt [patient] with hx [history] of acute asthma exacerbate and bronchiolitis. Pt is doing better. On rehab. No complaints. Reviewed all notes. PMH [past medical history]: asthma, cocaine abuse, chronic back pain." Respondent documented a limited physical examination, without noting an examination of the chest or back; however, the progress note is not very legible. Nor did Respondent note that Patient A complained of any chest pain or low back pain. The treatment plan was for Patient A to undergo physical therapy, occupational therapy, and to see a registered dietician. Respondent noted the diagnosis as "Mr. [A] with dx as above. Here for rehab." There is no indication what his current medications were or even if Respondent prescribed any new medications for him.[3]

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[2] Full names of patients will be provided during discovery.

[3] There are electronic "Physician Orders"; however, these records note the prescriptions ordered, directions for use, and dosage. A Registered Nurse noted on the handwritten "Physician's Orders" that Patient A had "chronic back pain, cause unknown" and that an x-ray (continued...)

37. On or about March 21, 2011, Respondent saw Patient A. Her handwritten progress note is not very legible but does include the note that Patient A was "doing ok." The progress note contains extensive abbreviations, but seems to indicate that Patient A did not complain of chest pain or shortness of breath and he was comfortable. Respondent also included the following note, "Chr [chronic] back pain/rehab." Nothing in this record addresses any medications prescribed to Patient A.

38. On or about March 30, 2011, Respondent noted in a progress note—the entry is also fairly illegible and used a large amount of abbreviations—that Patient A wanted to leave the facility for "personal work, advised against, pt with hx [history] of cocaine abuse." The Progress Note indicates that he was taking Restoril for insomnia, but there are no other indications that he was taking any other medications or for what reason.

39. On or about April 5, 2011, Respondent saw Patient A and noted in the progress note, "Mr. [A] is doing good, ambulating well . . . ." The progress note is similar to the prior progress notes, in that it was mostly illegible with a large number of abbreviations used. Respondent wrote "chr back pain – on meds," but there is no indication in the record what medications she prescribed, dose instructions, or why any medications might be needed.

40. On or about April 8, 2011, Respondent's progress note for this encounter with Patient A noted, "the Patient is doing OK." The note is again fairly illegible and used a large amount of abbreviations to indicate the care she provided. The note indicates Patient A would be discharged on "Monday with orders." There was no mention of any medications prescribed.

41. Throughout Patient A's stay at Windsor Manor there are nursing notes indicating nurses conducted pain assessments and listed side effects of the medications he was taking.[4] From the time of his admission, Respondent prescribed Restoril (with changes to his scheduled dosing) and Percocet. There are no notations in the progress notes completed by Respondent why these medications were prescribed, the patient's pain level (or even complaints of pain), what she

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was ordered.

[4] A large portion of the staff and nursing notes are illegible.

hoped the medications would treat in Patient A, Patient A's response to the medications (success or failures), and whether he had any adverse affects as a result of the medications.

42. During the time Patient A was at Windsor Manor, the California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) shows regular prescriptions and refills for Restoril and Percocet.

43. On or about April 11, 2011, Patient A was discharged from Windsor Manor. The list of discharge medications included Restoril "15 milligrams at bedtime" and Percocet "5/325 1 tablet every four hours as needed for pain."

44. During Respondent's Medical Board interview on November 19, 2012 conducted at the Board's Pleasant Hill District Office, Respondent admitted that she did not recall whether she actually took a detailed history of Patient A. Additionally, she stated she did not concern herself with past history of drug or alcohol abuse because "as a doctor I provide only medical care." Additionally, Respondent stated during her interview that she was not concerned with the method that medications she wrote prescriptions for were administered by the nursing home staff, including controlled substances with the instructions "as needed for pain."

45. Respondent billed insurance for medical care provided to Patient A on March 4, 20, 21, April 5, 6, 11, and 12, 2011.[5] The medical records do not support the billing codes Respondent used for these encounters.

46. Respondent's medical records relating to the care and treatment of Patient A do not comply with the standard of care and amounts to unprofessional conduct under sections 2234 [unprofessional conduct]; and/or 2334(b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2242 [furnishing dangerous drugs without an examination], in that she failed:

a) to document a thorough history of Patient A's past and present medical history;

b) to document a history of past and current illicit substance and alcohol use/abuse history;

[5] Respondent billed insurance for treatment provided on April 6, 2011; however, there is no progress note from Respondent for this date of service. There is a progress note for April 8, 2011 which Respondent did not bill for. There are no progress notes for April 11 and 12, 2011; however, Respondent assisted in the discharge of the patient on April 11, 2011.

c) to document a medical necessity for the prescription of controlled substances; and

d) document the components necessary to justify the specific billing code used.

47. Respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes violates the standard of care and shows a lack of knowledge under section 2234(d) [incompetence/lack of knowledge].

48. Respondent's acts or omissions with respect to Patient A, whether jointly or separately or in any combination thereof, constitutes cause for disciplinary action under sections 2234 [unprofessional conduct]; and/or 2334(b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2234(d) [incompetence/lack of knowledge]; and/or 2242 [furnishing dangerous drugs without an examination] of the Code.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross negligence; and/or repeated negligent acts; and/or incompetence/lack of knowledge; based on the care and treatment of Patient B; and/or furnishing controlled substances without the necessary examination of Patient B)

49. Respondent is subject to disciplinary action under sections 2234 [unprofessional conduct]; and/or 2234 (b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2234 (d) [incompetence/lack of knowledge]; and/or 2242 [furnishing dangerous drug without examination] of the Code based on her care and treatment of Patient B.

50. Between September 15, 2009 through December 27, 2011, Respondent treated Patient B[6] (a 43-year old female paraplegic at T-6) at two separate short-term nursing homes, Tampico Terrace[7] and Ygnacio Valley Care Center (Ygnacio Valley)[8].

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[6] Patient B suffers from a variety of medical issues, including: Crohn's disease, rectovesicular fistula, urostomy, colostomy, urinary diversion, chronic pain, opiate dependence, hypothyroidism, depression, recurrent urinary tract infections, and recurrent pressure ulcers. Patient B had recurrent hospitalizations for urinary tract infections, sepsis, chronic wounds, and pneumonia during the year she was treated at Ygnacio Valley.

[7] At the time of the expert's report, the Tampico Terrace records were not available for review.

[8] The medical records for Ygnacio Valley encompassed 1842 pages of records. There were only 16 medical encounters between Respondent and Patient B located in these records.

51. Respondent treated Patient B off and on at Ygnacio Valley between December 31, 2010 though January 10, 2012. Patient B was originally admitted to Ygnacio Valley from an acute care hospital with severe malnutrition and pressure ulcers. Patient B self-reported a history of drug abuse as noted on a "Resident Progress Note"[9] dated January 17, 2011. During this time frame, it appears that Patient B was admitted approximately six times to John Muir Medical Center, Walnut Creek, but the reasons for the various hospitalizations are unclear from the Ygnacio Valley records. Each time Patient B returned to Yganacio Valley, her stay was treated as new admissions.[10]

Admission to Ygnacio Valley from March 25, 2011 through April 12, 2011

52. On or about March 30, 3011, Respondent completed a "History and Physical" following Patient B's hospitalization for pyelonephritis. Much of the handwritten form is illegible and includes information that Respondent saw the patient and that she would be treated for wound care. Respondent also completed a "Physician Order" requesting a pain management consultation and a psychiatric evaluation if one had not yet been conducted.

53. On or about April 4, 2011, Respondent completed a handwritten "Physician Progress Note" for her encounter with Patient B. The progress note indicated that Patient B saw a pain specialist "today" and that the specialist recommended an increase in her morphine dose but that Respondent had to complete the prescription. A large portion of the note is not legible, but appears to include treatment plans (i.e. see a specialist for wound care and protein rich diet for malnutrition). Respondent also completed a handwritten "Physician Order" for this encounter with Patient B. The note requested that the pharmacy review all of Patient B's medications for possible drug interactions, to discontinue the Flexaril and to start Baclofen.

54. There are no additional records signed by Respondent documenting her care and treatment of Patient B during this admission period. Respondent billed insurance for medical care

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[9] The majority of the "Resident Progress Notes" appear to be written by the nursing staff; however, most of the notes are completely illegible and are not organized in any logical manner.

[10] Patient B was first admitted to Ygnacio Valley between December 31, 2010 to January 24, 2011. Dr. Dhugga was listed as the primary care giver for Patient A during this admission. The first notation indicating Respondent was Patient B's primary care giver was March 14, 2011.

provided on March 30 and April 4, 2011. However, the medical records do not support the billing code Respondent used for these encounters.

Admission to Ygnacio Valley from April 13, 2011 through May 16, 2011

55. On or about April 14, 2011, Respondent completed the "History and Physical" form on Patient B. Respondent's handwritten notes are illegible and indicate that Patient B was hospitalized for pyelonephritis. Under the "current diagnosis" section, Respondent wrote that she saw Patient B on this date but the plan of care is illegible. Respondent also completed a "Physician Order" regarding the need for a pain specialist, lab work, nutritional consultation, and a psychotherapy consultation.

56. Respondent also completed "Physician Orders" on April 18, May 2, and May 9, 2011. The orders required staff to perform specific tasks related to the care and treatment of Patient B; however, there are no associated progress notes or other records documenting any examination of Patient B by Respondent supporting any orders.

57. There are no additional records signed by Respondent documenting her care and treatment of Patient B during this admission.[11] Respondent billed insurance for medical care provided on April 4 and April 11, 2011. There are no records that insurance was billed for the services provided on May 2 and May 9, 2011. However, the medical records do not support the billing codes Respondent used for these encounters.

Admission to Ygnacio Valley from May 17, 2011 through May 21, 2011

58. On or about May 17, 2011, Respondent completed an "Initial Physician Comprehensive Assessment" for Patient B. The form included checking relevant boxes related to Patient B's care and condition. Respondent did not indicate the plan or treatment goals for Patient B. There are no other associated progress notes or records documenting any examination or treatment of Patient B by Respondent during this encounter.

[11] For all admission periods at Ygnacio Valley, "Physician Order" records were provided; however, the majority are not legible nor appear to be signed by Respondent. The Complainant has identified the "Physician Orders" specifically completed by Respondent.

59. Respondent billed insurance for medical care provided on May 18[12] and May 20, 2011. However, the medical records do not support the billing codes Respondent used for these encounters.

Admission to Ygnacio Valley from May 24, 2011 through June 19, 2011

60. On or about May 24, 2011, Respondent completed an "Initial Physician Comprehensive Assessment" for Patient B. The form included checking relevant boxes related to care and condition, but also provided an Assessment section allowing the doctor to handwrite her findings. Respondent wrote that Patient B was hospitalized with back pain, the remaining note is illegible.

61. There are no other associated progress notes or records documenting any examination or treatment of Patient B by Respondent during this admission.

62. Respondent billed insurance for services performed on May 25, 2011; however, there are no records supporting any encounter between Patient B and Respondent justifying this bill. Assuming, the billing error should refer to the care provided on May 24, 2011, the medical records do not support the billing code Respondent used for this encounter.

Admission to Ygnacio Valley from June 19, 2011 through August 10, 2011

63. There are no signed medical records from Respondent during this admission period. There are "Physician Orders" indicating directions for staff from Respondent, but there are no medical records documenting any form of evaluation or examination of Patient B by Respondent.

64. Respondent billed insurance for medical care provided on June 27 and July 11, 2011; however, there are no medical records to support the billing codes Respondent used.

Admission to Ygnacio Valley from August 13, 2011 through August 23, 2011

65. On or about August 13 and 14, 2011, there are "Physician Orders" from Respondent. They are handwritten and difficult to read, but appear to discuss Patient B's wound dressing on her right hip and medication issues. There are no associated progress notes or other records that Respondent treated or even saw Patient B on these dates.

[12] The billing may be inaccurate as this entry may relate to the encounter between Patient B and Respondent the previous day of May 17, 2011.

66. Respondent billed insurance for medical care provided on August 15, 2011; however, there are no medical records to support the billing codes Respondent used. Assuming, the billing error should refer to the care provided on either August 13 or 14, 2011, the medical records do not support the billing code Respondent used for this encounter.

Admission to Ygnacio Valley from September 10, 2011 through December 19, 2011

67. On or about September 13, 2011, Respondent completed the "Initial Physician Comprehensive Assessment" on Patient B. The form included checking relevant boxes related to Patient B's care and condition, but also provided an Assessment section allowing the doctor to handwrite her findings. Respondent's assessment is mostly illegible but stated: "Patient discussed in detail."

68. Respondent produced electronic medical records for the following patient encounters: October 27, 2011, November 15, 2011, November 22, 2011, December 1, 2011, and December 12, 2011. There are additional handwritten notes for several dates. The records are in standard SOAP format[13] and indicated the patient's current health status. The noted also indicated Patient B was preparing for her upcoming discharge from Ygancio Valley to return home. Respondent noted on these forms in the subjective portion that she discussed medications, lab work, and treatment plans with the patient. The notes also indicate the various diagnosis' and plans for treatment. Several of the notes contain information relating to the need for Patient B to follow-up with doctors after discharge.

69. During Respondent's Medical Board interview, she stated that her care of Patient B during these October and November 2011 dates were solely based on her review of recommendations from other medical providers, yet there was no notation in the medical records that Respondent even reviewed any other records or recommendations from other providers.

70. Respondent billed insurance for services provided on September 13, October 27, November 15, November 22, and December 12, 2011 that correspond to documented medical records. Respondent also billed insurance for services provided on the following dates that are

[13] SOAP is an acronym used by medical providers to document patient encounters in medical records. SOAP stands for Subjective, Objective, Assessment, and Plan.

not related to any medical documentation provided: September 19 and 26, October 3, 11, 17, and 21, and November 4, 2011. There are no medical records to support the billing codes Respondent used. For the encounters that are documented, the medical records do not support the billing codes Respondent used for these encounters.

Admission to Ygnacio Valley from December 24, 2011 through January 10, 2012

71. On or about December 27, 2011, Respondent completed "Physician Order" indicating several items that needed to be addressed by any new health care provider. Specifically, Respondent wrote, "(2) FYI – pt [patient] needs to keep up with her pain appt [appointment] on 1/14/2012; (3) All pain meds to be managed by pain specialist & the pain specialist needs to send triplicates to pharmacy or sign triplicate for all the med he is prescribing to her. (4) Dr. Sreen [Sreenivasen] is not responsible any more or any future pain med."

72. There are no other associated progress notes or other records that Respondent treated or even saw Patient B during this admission period.

73. Respondent billed insurance for medical care provided on December 27, 2011. However, the medical record does not support the billing code Respondent used for this encounter.

Prescription History

74. During the time Patient B was at Ygnacio Valley, the California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) and the Patient Profile from Pharmerica Pharmacy show regular prescriptions and refills for Lorazepam, APAP propoxyphene, Fentanyl Transdermal System, hydromorphone hydrochloride, Zolpidem, morphine sulfate, Dronabinol, methadone hydrochloride, Oxycontin, hydrocodone APAP, and Diazepam.

75. Respondent did not document the medications that she prescribed, the reasons for the prescriptions, any side effects, any changes to the medications, or any additions/deletions of medications following examinations of Patient B. There are notations in some of the "Physician Orders" completed by staff when certain adjustments to medications were made or when

medications were given to the patient but the majority of the "Physician Orders" are not legible, nor appear to have been completed by Respondent.

76. During Respondent's Board interview, she stated that she prescribed Patient B's medications based on the recommendations of other medical providers treating Patient B. Respondent could not recall whose recommendations she relied on when writing prescriptions, including for significant doses of controlled substances. Respondent also admitted that many of the prescriptions for controlled substances concerned her, but she never discussed her concerns with the doctor allegedly recommending these medications.

77. Respondent is guilty of unprofessional conduct under sections 2234 [unprofessional conduct] and 2234(b) [gross negligence] in that Respondent failed to:

a) provide medical documentation for several patient encounters;

b) use the proper billing codes to justify the billing to the insurance;

c) and, overall, failed to document her care and medical management of Patient B.

78. Respondent's medical records relating to her care and treatment of Patient B do not comply with the standard of care and shows unprofessional conduct under sections 2234 [unprofessional conduct]; and/or 2234(c) [repeated negligent acts]; and/or 2234(d) [incompetence/lack of knowledge]; and/or section 2242 [furnishing dangerous drugs without an examination] in that she failed to:

a) document every single patient encounter, despite billing for encounters;

b) document the components necessary to justify the specific billing codes used;

c) document the basis for prescribing controlled substances or any associated medical examination;

d) document the treatment plan and objectives for Patient B;

e) document any alternatives to the prescriptions prescribed;

f) document discussing the risks and benefits of prescribing controlled substances, especially to a patient who admits to have drug dependence;

g) document periodic reviews of the pain medications she prescribed;

h) document any review and/or discussion with the pain specialist or other medical provider regarding medications Respondent prescribed;

i) and, failed to document the patient's pain level, levels of function, and quality of life, especially in light of the high levels of controlled substances.

79. Respondent's use of specific billing codes without documenting a comprehensive history and physical and comprehensive examination, along with adequate follow-up progress notes violates the standard of care and shows a lack of knowledge under section 2234(d).

80. Respondent's acts or omissions with respect to Patient B, whether jointly or separately or in any combination thereof, constitutes cause for disciplinary action under sections 2234 [unprofessional conduct]; and/or 2334(b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2234 (d) [incompetence/lack of knowledge]; and/or 2242 [furnishing dangerous drugs without an examination] of the Code.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross negligence; and/or repeated negligent acts; and/or incompetence/lack of knowledge based on the care and treatment of Patient C)

81. Respondent is subject to disciplinary action under sections 2234 [unprofessional conduct]; and/or 2234 (b) [gross negligence]; and/or 2234(c) [repeated negligent acts]; and/or 2234 (d) [incompetence/lack of knowledge] of the Code based on her care and treatment of Patient C.

82. On or about November 10, 2009, Respondent began treating Patient C (a sixty-four year old man with a history of Parkinson's disease, bi-polar disorder, Chronic Obstructive Pulmonary Disease (COPD), urinary incontinence, and skin rashes) for in-home health care supportive services. Respondent completed the first electronic clinic note using the SOAP format indicating: "New patient here for refills. Talk about patient's anxiety." The note briefly described his symptoms and anxiety, but there was no further information or documentation regarding Patient C's medical history, current medical treatment and prescriptions. Respondent documented conducting a brief physical examination. Respondent wrote prescriptions for a

fungal cream, diflucan, and tranxene. The note indicated that Patient C should follow-up with a psychiatrist and that his additional medical concerns would be dealt with on "the next visit."

83. Respondent billed this encounter as a comprehensive examination using code 99215, but the note does not justify the billing code used. In order to bill a comprehensive examination using this code, the doctor must document two of three elements, including a comprehensive history, a comprehensive physical examination appropriate for the medical conditions, and medical decision-making of high complexity.

84. On or about November 18, 2009, Respondent documented a follow-up appointment with Patient C in an electronic record using the SOAP format. Respondent reported that Patient C's chief complaint for this visit was back pain and he had had lower back pain for several years. Patient C reported the pain at 9 on a scale of 10. The Assessment section included a note that for Patient C's pain management she referred him to a specialist. Respondent prescribed 50 milligrams (mg) of Tramadol every 12 hours as needed for pain.

85. On or about January 21, 2010, Respondent noted a follow-up visit with Patient C for a flu shot and medication refills. The electronic medical record noted in the Subjective section, that Patient C was doing well and had no medical complaints other than anxiety. Respondent documented conducting a "review of systems" and a general examination. Respondent refilled Patient C's traxene prescription to 120 pills of 7.5 mg every four hours and prescribed lithium carbonate for depression.

86. On or about March 26, 2010, Patient C was admitted into San Marco Nursing Home and Rehabilitation Center (San Marco) because he was no longer able to care for himself at his home.[14] Patient C was admitted with the following diagnosis: bipolar disorder, COPD, anxiety, depression, diabetes, hyperlipidemia, and Parkinson's disorder. Respondent was listed as Patient C's primary care provider.

[14] The medical records for San Marco contain 843 pages of records. Only 22 "Physician Orders" were located in these records completed by Respondent documenting her encounters and care of Patient C.

87. During Patient C's stay at San Marco between March 26, 2010 and February 24, 2011, Respondent wrote progress notes and/or "Physician Orders" for Patient C. The records indicated Respondent monitored his lab work, his physical condition, non-psychiatric medications, and responded to nursing staff concerns. Respondent also requested consultations for rehabilitation, social work, neurology, and a nutritionist.

88. On or about January 4, 2011, Respondent transferred Patient C to an outside emergency room for evaluation and treatment for bipolar issues, acute mania, and severe psychosis. Respondent completed a "Physician Order" for Patient C indicating that he was back at San Marco by January 10, 2011.

89. On or about February 25, 2011, San Marco discharged Patient C to a board and care home.

90. On or about March 2 and 8, 2011, Respondent's electronic medical records note follow-up visits with Patient C. Patient C's chief complaint was that he was bitten by a dog and needed medication and a tetanus shot. The record indicated that Patient C was on klonopin for anxiety and that she started him on buspar. Respondent also conducted a medication review of all of Patient C's current medications. Respondent also wrote that Patient C should see a psychiatrist and pain specialist for all future controlled substances.

91. On or about March 11, 2011, Respondent wrote a letter to Patient C terminating him as a patient. The letter indicated that she would treat him on an emergency basis over the next thirty days, but that he needed to find another primary care provider. During Respondent's Board interview, she indicated she terminated Patient C following advice from her malpractice insurance carrier following Patient C's threats to sue her.

92. Respondent's billing records indicate that she started billing for her care of Patient C on November 5, 2009; however, the first medical record provided was dated March 26, 2010. Prescription records and CURES records indicate that Respondent first began writing prescriptions for Patient C around November 10, 2009.

93. Respondent used billing codes that do not correspond with the encounters recorded in Patient C's medical record. The codes require documentation of a comprehensive interval

history, comprehensive examinations, and medical decision-making of high complexity. This information was not contained in the majority of medical notes written by Respondent.

94. Respondent is guilty of unprofessional conduct under section 2234 [unprofessional conduct] and 2234(b) [gross negligence] in that Respondent failed to provide medical documentation for all patient encounters that were billed.

95. Respondent's medical records relating to her care and treatment of Patient C do not comply with the standard of care and shows unprofessional conduct under sections 2234 [unprofessional conduct]; and/or 2234(c) [repeated negligent acts]; and/or 2234 (d) [incompetence/lack of knowledge] in that she failed to:

a) document a thorough history of Patient C during the initial evaluation and treatment upon his admission to San Marco, including failing to document prior failed treatments and prior specialty consultations;

b) properly and adequately document several medical encounters with Patient C;

c) and, failed to keep timely, accurate, and legible medical records of Patient C, including the failure to conduct periodic reviews of the patient's pain level, treatment and status, and medication adjustments.

96. Respondent's acts or omissions with respect to Patient C, whether jointly or separately or in any combination thereof, constitutes cause for disciplinary action under sections 2234 [unprofessional conduct]; and/or 2234(c) [repeated negligent acts], and/or 2234 (d) [incompetence/lack of knowledge] of the Code.

FORTH CAUSE FOR DISCIPLINE

(Medical Record Keeping)

97. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to keep adequate and accurate medical records related to the care and treatment of Patients A, B, and C, as alleged in paragraphs 34 through 96, which are herein incorporated by reference, as if fully set forth below.

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a) Respondent's medical records fail to adequately document patient histories, thorough medical examinations, evaluations, continued assessments, treatment plans and objectives, discussion of informed consent, and the rationale for the medications prescribed;

b) Respondent's medical records fail to document any medical basis or indication for the ongoing prescription of controlled substances, or to document any physical examinations or findings supporting the clinical diagnosis;

c) Respondent's medical records are largely illegible making it difficult to determine the care and treatment she provided to Patients A, B, and C.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 82039, issued to Purnima Ravi Sreenivasan, M.D.;

2. Revoking, suspending or denying approval of Purnima Ravi Sreenivasan, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Purnima Ravi Sreenivasan, M.D., to pay the Medical Board of California the costs of probation, if placed on probation;

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

DATED: December 24, 2013

KIMBERLY KIRCHMEYER
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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