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

In the Matter of the Accusation Against:	)	
Danny Faraz Farahmandian, M.D.	)	**Case No. 800-2015-013731**
Physician's and Surgeon's Certificate No. A 72189	)	
Respondent	)	

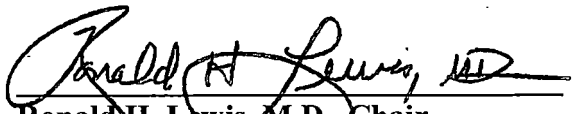
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on May 3, 2019.

IT IS SO ORDERED: April 4, 2019.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **Danny F. Farahmandian, M.D.** **Physician's and Surgeon's Certificate No. A 72189 ,** **Respondent.**	**Case No. 800-2015-013731** **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Tan N. Tran, Deputy Attorney General.

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2. Respondent Danny F. Farahmandian, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, Esq., whose address is: Doyle Schafer McMahon, LLP, 5440 Trabuco Road, Irvine, California, 92620.

3. On or about June 22, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 72189 to Danny F. Farahmandian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-013731 and will expire on May 31 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-013731 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on or about March 13, 2018. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-013731 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-013731. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2015-013731, and that he has thereby subjected her Physician's and Surgeon's Certificate No. A 72189 to disciplinary action.

10. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 72189 issued to Danny F. Farahmandian, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Until Respondent successfully completes the Clinical Competence Assessment Program, as described in term # 8 below, Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as listed in Schedule(s) II and III of the California Uniform Controlled Substances Act, except in a hospital setting as follows: Respondent will be permitted to approve short term continuance of Schedule II and III medications deemed necessary by the discharging physician as reflected in transfer orders from the physician to post-acute hospitals until the patient has been assessed by a physician.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that

Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. 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. 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.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months

after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. 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(s), 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 Board, 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 for approval by the Board or its designee.

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 cease 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(s) 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, and whether Respondent is practicing medicine safely. 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.

8. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data

obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

STANDARD CONDITIONS

9. NOTIFICATION. Within seven (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.

10. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

11. 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.

12. 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.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

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(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient'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 thirty (30) calendar days.

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.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. 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 other 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 Probation Requirements.

16. 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.

17. 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.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining 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. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 3/5/19

Danny F. Farahmandian, M.D.
Respondent

I have read and fully discussed with Respondent the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: March 5, 2019

Raymond J. McMahon, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 3/6/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

TAN N. TRAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-013731

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO March 13 2018
BY: Sody Wright ANALYST

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

In the Matter of the Accusation Against: **Danny Faraz Farahmandian, M.D.** **16133 Ventura Boulevard, # 360** **Encino , CA** **91436** **Physician's and Surgeon's Certificate** **No. A 72189,** Respondent.	Case No. 800-2015-013731 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about June 22, 2000, the Medical Board issued Physician's and Surgeon's Certificate Number A 72189 to Danny Faraz Farahmandian, 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 May 31, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), 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 the conclusion of disciplinary actions.

"(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 Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline 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 Board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

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7. 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."

8. 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."

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9. Section 725 of the Code states:

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – 6 Patients)

10. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code for the commission of acts or omissions involving gross negligence in the care and treatment of Patients 1 through 6.[1] The circumstances are as follows:

Patient 1

11. Patient 1 (or "patient") is a seventy-six year-old female who treated with Respondent from about 2013 through 2016.[2] The patient had various maladies, including a history of chronic

[1] The patients are identified numerically to protect their privacy.

[2] These are approximate dates, based on the records available. The patient may have also treated with Respondent before and after these dates.

low back pain with spinal stenosis, fibromyalgia, COPD (Chronic Obstructive Pulmonary Disease), anxiety disorder, hypothyroidism, GERD (Gastroesphageal Reflux Disease), migraines, Attention Deficit Disorder (ADD), ovarian cancer, hypertension, osteoporosis, and obesity. Respondent concurrently prescribed benzodiazepines and opiates to treat this patient.

12. Specifically, Respondent had been prescribing both hydrocodone/acetaminophen for the patient's joint pain and Alprazolam (Xanax) for her anxiety disorder. Of note, the diagnosis of anxiety was not listed on Respondent's notes for Patient 1, but was gleaned from consulting a neurologist's notes. The records were unclear if other safer therapy for anxiety disorder had been tried for the patient prior to initiating Alprazolam. There was no documentation that the patient had been evaluated by psychiatry to determine if the Alprazolam could be tapered off, or if an alternative could be used. There was no documentation that Nalaxone antidote therapy was recommended, in order to decrease the risk of accidental drug overdose and respiratory failure with the concurrent usage of narcotics and benzodiazepines.

13. Respondent took over the hydrocodone acetaminophen prescription for Patient 1, but there was no documentation regarding how the patient was risk stratified for opioid misuse. No clarification of previous treatment modality was carried out. No titration of doses was found in the available medical records. Functional goals and adverse events were not clearly delineated. No monitoring through PDMP (Prescription Drug Monitoring Programs) and urine toxicology was documented. Records also indicate that Respondent had been prescribing Didrex (a Schedule III controlled substance), for at least more than three months, to treat the patient's obesity and ADD. There was no clear indication for long-term use of this potentially dangerous and addictive medication to treat the patient's obesity and ADD.

14. Respondent's handwritten notes were also often illegible. There were not many details. Nonstandard abbreviations were often used which made the notes difficult to understand. The EMR notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of the patient. Conflicting information often co-existed in the same note. Identifying information including dates and patient names were sometimes missing. Physical findings were not always documented. Chief complaints were not often addressed in the

assessment and plan. Documentation for multiple visits were compiled onto one note, essentially rendering them impossible to interpret. Some notes were not signed or signed a few months late. These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

Patient 2

15. Patient 2 (or "patient") is a 60 year-old female with various maladies, including possible coronary artery disease, history of syncopal episodes, osteomyelitis, ulcers, COPD, hypertension, lupus, rheumatoid arthritis, chronic vertebral body compression fractures, hypoxia, anxiety, hypothryroidism, and history of hypotension.[3] Per the patient's record, she was characterized as "moderate" and "high" for opioid misuse.[4] Respondent concurrently prescribed benzodiazepines and opiates to treat this patient (including Oxycontin and Hydromorphone for the patient's pain and Clonazepam for her anxiety disorder).

16. Although Patient 2 was characterized as at moderate to high risk for opioid misuse, there was no discussion and evaluation of aberrant behavior, including refusal for physical exam or firing of consultants, which were documented on one occasion. No titration of doses were found in the available records. No medication reconciliations were provided. Functional goals and adverse events were not clearly delineated. No monitoring through PDMP and urine toxicology was documented. No records from the previous treating physicians were documented.

17. Respondent's notes were also often illegible. There were not many details. Nonstandard abbreviations were often used which made the notes difficult to understand. The EMR notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of the patient. Conflicting information often co-existed in the same note. Identifying information including dates and Patient 2's name was sometimes missing. Physical

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[3] Despite the patient having a long history of health problems, there was no documentation that Respondent adequately addressed all these problems in his preoperative consultation of the patient.

[4] The patient had a history of altered mental status/hypoxia of unclear etiology and syncopal events, which could have been the result of opioid usage or at least exacerbated by opioid usage. Despite the complexity of her case, including patient resistance and opioid misuse potential, there was no documentation that pain management was consulted.

findings were not always documented. Chief complaints were not often addressed in the assessment and plan. Documentation for multiple visits were compiled onto one note, essentially rendering them impossible to interpret. Medication reconciliation and labs were not provided.

18. There was no consideration of non-opiate or non-pharmacological therapies in the medical records. There was no documentation that the patient was referred to rheumatology for her joints. There was no documentation that Respondent considered specific treatments/medications for the patient's lupus and arthritis.[5] There was no documentation that Respondent referred the patient to psychiatry and pain management to assist with the patient's management of anxiety and pain. Given the high amount of narcotics and benzodiazepines that the patient was receiving, Naloxone antidote therapy should have been prescribed to the patient. These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

Patient 3

19. Patient 3 (or "patient") is a 58 year-old-female who treated with Respondent from about 2011 to 2016.[6] She had various maladies, including a history of fibromyalgia, ADD, insomnia, anxiety, hypothyroidism, hypertension, and chronic back pain.[7] Prior to treating with Respondent, Patient 3 had been prescribed Opana, a long-acting opioid. Apparently, Respondent attempted to wean the patient off of Opana with Hydrocodone, and eventually Methadone.[8]

20. Although Patient 3 was characterized, at one point, as high risk for opioid misuse, there was no documentation of discussion and evaluation of aberrant behavior. Functional goals and adverse events were not clearly delineated. No monitoring through PDMP and urine toxicology was documented.

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[5] It appears as though Respondent treated the patient's arthritis with opiate therapy. Chronic opiate therapy is not the recommended medical treatment for inflammatory arthritis.

[6] The records available for review on this patient are from 2013 to 2016.

[7] The records also included a letter from the patient thanking Respondent for converting her from Opana to Methadone.

[8] It was not clear from the chart if the patient had failed all other opioid medications before Methadone was initiated, and it was not clear how the tapering was done from the records. Also, no mention of EKG monitoring was made.

21. Respondent's notes were also often illegible. There were not many details. Nonstandard abbreviations were often used which made the notes difficult to understand. The notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of the patient. Conflicting information often co-existed in the clinic notes. Documentation for multiple visits were compiled onto one note, essentially rendering them impossible to interpret.

22. Respondent was also prescribing both narcotics (including Methadone and Norco) and Clonazepam for the patient's insomnia.[9] Patient 3 was prescribed multiple hypnotics during the same time frame. There was no documentation that Respondent tried to taper off at least one of these classes of medications to mitigate the risk of respiratory failure and/or overdose. There was no documentation that the patient was referred to pain management and/or psychiatry, and no documentation that Respondent considered possible diversion.

23. Respondent also prescribed Adderall for Patient 3 (for presumed ADHD), but there was no clear indication from the records for its use, and no documentation that there was a discussion and monitoring of the side effects of Adderall use. Moreover, Respondent failed to provide appropriate work up of his evaluation of dyspnea on exertion relating to this patient. These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

Patient 4

24. Patient 4 (or "patient") is a 61 year-old male who treated with Respondent from approximately 2010 to the present.[10] This patient had various medical conditions including hypertension, depression, anxiety, diabetes with neuropathy, MGUS, GERD, HCV/alcoholic cirrhosis, COPD, gout, chronic bilateral leg pain, history of noncompliance, and esophageal and peptic ulcers.

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[9] Respondent also prescribed Abilify to the patient for insomnia, which was not approved by the FDA to treat insomnia.

[10] Again, these are only approximate dates. The patient may have treated with Respondent prior to 2010.

25. Respondent prescribed Diazepam, Temazepam, and Lorazepam (later changed to Alprazolam) concurrently with Zolpidem and Zaleplon for the patient.[11] There was no mention of whether Patient 4 was a good candidate for these medications, in light of the patient's past alcohol and substance abuse history, noncompliance, and pulmonary functional status. No discussion over goal or duration of treatment was documented. No evaluation of adverse side effects was mentioned in the clinic notes. No monitoring of aberrant behavior was carried out, and no psychiatry consultation was documented.

26. The clinic notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of Patient 4. Not many details were present. Conflicting information often co-existed in the clinic notes. Multiple notes with slightly different content sometimes were present for the same visit. It was unclear if medication reconciliations were performed/addressed as the patient was noted to be on different classes of benzodiazepines as well as hypnotics. Multiple notes were not signed. These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

Patient 5

27. Patient 5 (or "patient") is a 61-year-old female with a history of renal transplant, obesity, hypothyroidism, and insomnia. She was seeing Respondent for her renal allograft function, weight loss, and other medical issues.

28. Respondent had been prescribing Phentermine for the patient more than the approved few weeks for weight loss. Patient 5 had no clear indication for long term use of this potentially dangerous and addictive medication. The patient was documented to have a good appetite, which means that Phentermine was not working and therefore should have been stopped. There was no clearly documented weight loss regimen in terms of caloric restriction, exercises, and behavioral modification.

29. Respondent's notes were also often illegible. There were not many details. Nonstandard abbreviations were often used which made the notes difficult to understand. The

[11] These are all dangerous drugs with serious side effects if used inappropriately.

notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of Patient 5. Conflicting information often co-existed in the same note. Relevant history and physical findings were not always documented. Chief complaints were not often addressed in the assessment and plan. It is unclear if medication reconciliation was carried out as the patient appears to be on the same classes of medications over and over again. Notes were often not signed.[12] These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

Patient 6

30. Patient 6 (or "patient") is a 58- year-old female with asthma, bipolar depression, history of breast cancer with mastectomy, fibromyalgia, TMJ disorder, headaches, possible sleep apnea, cervical radiculitis, cervical facet arthropathy, herniated discs, history of frequent falls, and history of dumping syndrome related to Cytotec. Patient 6 treated with Respondent for various medical concerns, including pain management.

31. Respondent's notes were again often illegible. There were not many details. Nonstandard abbreviations were often used which made the notes difficult to understand. The notes appeared to have been copied and pasted on several occasions and did not reflect the actual conditions of Patient 6. Conflicting information often co-existed in the clinic notes. Chief complaints were not often addressed in the assessment and plan. Documentation for multiple visits were compiled onto one note, essentially rendering them impossible to interpret. Patient identifying information and dates were often missing, making interpretation of the notes impossible. These acts and omissions in the treatment of the patient constituted an extreme departure from the standard of care.

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[12] As with the other patients mentioned herein, documentation was so poor that cross-covering physicians would have difficulty in assisting in the management of this patient.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – 5 Patients)

32. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care of Patients 1 through 4, and Patient 6, above. The circumstances are as follows:

33. The facts and circumstances in paragraphs 10 through 26, and 30 through 31, above, are incorporated by reference as if set forth in full herein.

34. Respondent also committed repeated negligent acts in his care of Patients 1 through 4, and Patient 6 above. The circumstances are as follows:

Patient 1

35. Respondent departed from the standard of care in evaluating and treating Patient 1's hypertension. Blood pressure readings on multiple visits were out of goal range for the patient. The patient was on at least two medications (Didrex and Maxalt) which can elevate blood pressure. However, there was no mention of possible alternatives for these to address this concern.

36. Respondent also failed to adequately evaluate and manage Patient 1's chronic pain via non-pharmacological or non-opiate options, and failed to adequately provide informed consent and pain care agreement to her. These acts and omissions in the treatment of Patient 1 constitute simple departures from the standard of care.

Patient 2

37. Respondent also committed simple departures from the standard of care by failing to adequately follow through on the informed consent and pain care agreement with Patient 2. It appears that Respondent did seek to address the goals of care in terms of informed consent and pain care agreement, but the execution or documentation was lacking.

Patient 3

38. Respondent also committed simple departures from the standard of care in failing to adequately follow through on the informed consent and pain care agreement with Patient 3. There was no documentation that there was a formal discussion between Respondent and the

patient regarding the benefit, risk, and alternatives of long-term opiate therapy, there was no pain care agreement signed by the patient, and no discussion regarding aberrant behavior and monitoring.

39. Respondent also committed simple departures from the standard of care in his use and monitoring of Testosterone for Patient 3, and in his evaluation of the patient's claim of decreased libido.

Patient 4

40. Respondent also committed simple departures from the standard of care in failing to provide appropriate components in his preoperative consultation for Patient 4.

Patient 6

41. Respondent also committed simple departures from the standard of care by failing to adequately follow through on the informed consent and pain care agreement with Patient 6, and by failing to provide appropriate initiation/continuation, titration, and monitoring of chronic opiate pain management for Patient 6.

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Exam/Indication- 6 Patients)

42. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed dangerous drugs to Patients 1 through 6 without an appropriate prior examination or medical indication therefor.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing- 6 Patients)

43. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patients 1 through 6.

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FIFTH CAUSE FOR DISCIPLINE

(Inadequate Records- 6 Patients)

44. By reason of the facts and allegations set forth in the First and Second Causes for Discipline above, Respondent is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patients 1 through 6.

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 72189, issued to Danny Faraz Farahmandian, M.D.;

2. Revoking, suspending or denying approval of Danny Faraz Farahmandian, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Danny Faraz Farahmandian, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: March 13, 2018

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

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