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

In the Matter of the Accusation Against: GUVEN UZUN, M.D. Physician's and Surgeon's Certificate No. A 72928 Respondent.	)	File No. 06-2007-181358

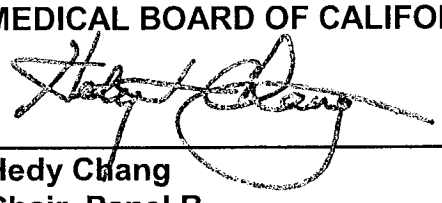
DECISION

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

This Decision shall become effective at 5:00 p.m. on April 22, 2011.

DATED March 24, 2011

MEDICAL BOARD OF CALIFORNIA



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

In the Matter of the Accusation Against: **GUVEN UZUN, M.D.** **P.O. Box 12843** **Marina Del Rey, California 90295** **Physician and Surgeon's Certificate No. A72928** Respondent.	Case No. 06-2007-181358 OAH No. 2010030350 **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. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Guven Uzun, M.D. (Respondent) is represented in this proceeding by attorney Thomas A. Mesereau, Jr. and Susan C. Yu, whose address is: Mesereau & Yu, LLP, 10390 Santa Monica Boulevard, Suite 220, Los Angeles, California 90025.

3. On or about August 24, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72928 to Guven Uzun, M.D. The Physician's and Surgeon's Certificate was in full force

and effect at all times relevant to the charges brought in Accusation No. 06-2007-181358 and will expire on March 31, 2012, unless renewed.

JURISDICTION

4. Accusation No. 06-2007-181358 was filed before the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 21, 2010. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 06-2007-181358 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 06-2007-181358. Respondent has also carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order and the effects it will have on his physician's and surgeon's certificate.

6. 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.

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

CULPABILITY

8. Respondent admits the truth of the charges and allegations alleged in Accusation No. 06-2007-181358 the following: First Cause for Discipline, paragraph 69 C and D; Second Cause for Discipline, paragraph 72 C, D, F, G, H, and I; Ninth Cause for Discipline, paragraph 105 B and C; Fourteenth Cause for Discipline, paragraph 125 A; and Fifteenth Cause for Discipline, paragraph 128 A, E, F, G and H, as charged and alleged in the Accusation. As to the remainder

of the allegations in the Accusation, Respondent agrees not to contest them for the purposes of this settlement.

Further, if Respondent ever petitions to modify or terminate any term or condition set forth herein, including but not limited to probation, or should the Board or any other regulatory agency in California or elsewhere hereinafter institute any other action against Respondent, including, but not limited to, an Accusation and/or Petition to Revoke Probation, the allegations and facts set forth in the Accusation shall be deemed admitted for all purposes.

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

CONTINGENCY

10. 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 Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his 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.

11. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. 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:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 72928 issued to Respondent Guven Uzun, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for eight (8) years on the following terms and conditions.

1. ACTUAL SUSPENSION As part of probation, respondent is suspended from the practice of medicine for six (6) months beginning the sixteenth (16th) day after the effective date of this decision.

2. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

3. 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, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

4. ETHICS COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics 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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical

education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall 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, which shall include 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, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

6. MONITORING – PRACTICE AND BILLING Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as practice and billing monitors, the names and qualifications of two or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are American Board of Medical Specialties (ABMS) certified. The monitors shall have no prior or current business or personal relationship with respondent, or other relationships that could reasonably be expected to compromise the ability of the monitors 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 monitors. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitors 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 monitors shall submit a signed statement that the monitors have 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 monitors disagrees with the proposed monitoring plan, the monitors 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 and billing shall be monitored by the approved monitors. Respondent shall make all records available for immediate inspection and copying on the premises by the monitors at all times during business hours, and shall retain the records for the entire term of probation.

The monitors 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 and billing, and whether respondent is practicing medicine safely, and billing appropriately.

It shall be the sole responsibility of respondent to ensure that the monitors 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(s) 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(s) 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.

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.

7. 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 Division or its designee within 15 calendar days.

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

8. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

9. 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.

10. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

11. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division 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).

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 Division, 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.

12. INTERVIEW WITH THE DIVISION, 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 Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

13. 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 Division 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 30 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 Division 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; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total 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.

14. 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 Division 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 30 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 Division 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.

15. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, 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.

16. 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 Division, 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, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. 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 Division 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 Division 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.

18. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Thomas A. Mesereau and Susan C. Yu. I fully understand the stipulation and the effects it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/26/11

GUVEN UZUN, M.D.
Respondent

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We have read and fully discussed with Respondent Guven Uzun, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. We approve its form and content.

DATED: 1/26/11

Thomas A. Mesereau, Jr.
Attorney for Respondent

Susan C. Yu
Attorney for Respondent

ENDORSEMENT

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

Dated: January 26, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 06-2007-181358

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

In the Matter of the Accusation Against: **GUVEN UZUN, M.D.** **P.O. Box 12843** **Marina Del Rey , California 90295** **Physician's and Surgeon's Certificate No. A 72928** Respondent.	Case No. 06-2007-181358 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 24, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 72928 to GUVEN UZUN, 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 March 31, 2012, unless renewed.

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 2234 of the Code states:

"The Division of Medical Quality[1] 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 [Chapter 5, the Medical Practice Act].

"(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."

5. Section 2261 of the Code states: "Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Bus. & Prof. Code § 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

6. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

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 810 of the Code states, in pertinent part:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) . . . .

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

"(b) . . . . (d)."

9. Section 725 of the Code states, in pertinent part:

"(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....

(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 ($600), or by imprisonment for a term of not less than 60 day nor more than 180 days, or by both that fine and imprisonment.

(c) . . . (d)."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patient C.C. [2])

10. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient C.C. The circumstances are as follows:

11. On or about June 3, 2004, patient C.C., a then 43-year-old female, presented to respondent with a history of chronic daily headaches, neck pain, and intermittent spasms radiating into her shoulders and occasional numbness in her hands. Respondent's diagnostic impression of the patient's condition was mild carpal tunnel syndrome[3], intractable migraine/rebound headaches, cervical radiculopathy[4] and cervical spasm.

12. On or about August 2, 2004, respondent saw the patient again. Respondent ordered that the patient undergo an upper extremity Electromyography[5] (EMG)/Nerve Conduction Velocity[6] (NCV) study to access her continuing complaints. Initially, patch electrodes[7] were utilized; however, the patient was unable to tolerate the electrical stimulation generated, and asked that it be stopped. The patch electrodes were removed and respondent then utilized

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[2] For privacy, the patients in the Accusation will be identified by their first and last initial. The full name will be disclosed to Respondent upon timely request for discovery pursuant to Government Code section 11507.6. In addition, all references to the care and treatment respondent rendered to the patients identified in the Accusation are from the certified records respondent produced to the Board, unless otherwise indicated.

[3] Carpal tunnel is a passageway in the wrist, created by bones and ligaments of the wrist, through which the median nerve (which runs through the wrist and into the hand) passes. Carpal tunnel syndrome is a disorder caused by compression at the wrist of the median nerve supplying the hand, causing pain and burning, or numbness and tingling paresthesias in the fingers and hand, sometimes extending to the elbow.

[4] Radiculopathy is a term for the disease of the nerve root. Sometimes referred to as a pinched nerve, it refers to compression of the nerve root – the part of a nerve between the vertebrae. This compression causes pain to be perceived in areas to which the nerve leads.

[5] Electromyography (commonly referred to as EMG) is a type of test in which a nerve's function is tested by stimulating a nerve with electricity, and then measuring the speed and strength of the corresponding muscle's response.

[6] Nerve conduction velocity test (commonly referred to as NCV) is a test that measures the time it takes a nerve impulse to travel a specific distance over the nerve after electronic stimulation.

[7] An electrode is a conductor or medium by which an electric current is conducted to or from any medium, such as a cell, body, solution, or apparatus. A needle electrode is a thin, cylindrical electrode with an outer shaft beveled to a sharp point, enclosing a wire or series of wires. A patch electrode is a tiny electrode with a blunt tip that is used in studies of membrane potentials.

monopolar disposable needle electrodes on various muscles to complete the test. Respondent summarized, interpreted and signed the report findings noting, inter alia, that "the bilateral median motor and sensory nerves revealed prolonged distal latency,[8] normal amplitude and decreased conduction velocity.[9] The bilateral median sensory nerves revealed prolonged distal latency, amplitude and decreased conduction velocity. The bilateral ulnar and median F-wave[10] latencies were normal." However, respondent's findings are not supported by a review of the actual data listed in the study.

13. On or about December 8, 2004, respondent saw the patient again and performed a cervical and thoracic facet joint[11] block injection. However, there was no Magnetic Resonance Imaging (MRI)[12] or Computed tomography (CT) scan[13] of the cervical or thoracic spine showing facet joint disease, nor had the patient been diagnosed with facet joint disease. In addition, respondent failed to utilize fluoroscopy[14] during the procedure.

14. On or about January 7, 2005, respondent saw the patient again who complained of

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[8] Distal latency (in electoneuromyography) is the interval between the stimulation of a compound muscle and the observed response. Normal nerve conduction velocity is above 40 m/sec in the lower extremities and above 50 m/sec in the upper extremities, but age, muscle disease, temperature, and other factors can influence the velocity.

[9] Conduction velocity is the speed with which an electrical impulse can be transmitted through excitable tissue.

[10] F-wave is a waveform recorded in electroneuromyographic and nerve conduction tests. It appears on supramaximal stimulation of a motor nerve and is caused by antidromic (relating to the propagation of an impulse along an axon in a direction that is the reverse of normal) transmission of a stimulus. The F wave is used in studies of motor nerve function in the arms and legs.

[11] The facet joint (or zygapophyseal) is a synovial joint (the most common and most moveable type of joints in the body) between the superior articular process of one (lower) vertebra and the inferior articular process of the adjacent (higher) vertebra. A facet joint block is both a test and a type of treatment. A local anesthetic medication is injected into the facet joint or the small nerve branches going to the facet joint. The physician watches on a fluoroscope as the needle is inserted to make sure it goes into the proper location. The medication numbs the area around the facet joint, and if the pain goes away, the physician can assume that the facet joint is contributing to the problem.

[12] Magnetic resonance imaging (commonly referred to as MRI) is a noninvasive method using nuclear magnetic resonance to render images of the inside of an object. It is primarily used in medical imaging to demonstrate pathological or other physiological alteration of living tissues.

[13] Computed tomography (originally known as computed axial tomography), commonly referred to as CAT or CT scan is a medical imaging method employing tomography (any of several techniques for making detailed x-rays of a plane section of a solid object, such as the body, while blurring out the images of the other planes) where digital geometry processing is used to generate a three-dimensional image of the internals of an object from a large series of two-dimensional x-ray images taken around a single axis of rotation.

[14] Fluoroscopy is an imaging (x-ray) technique commonly used by physicians that makes it possible to obtain real-time images of the internal structures of a patient. Fluoroscopy uses x-ray to produce real-time video images. After the x-rays pass through the patient, instead of using film, they are captured by a device called an image intensifier and converted into light. The light is then captured by a TV camera and displayed on a video monitor.

worsening back pain, among other things. Respondent diagnosed the patient with lumbar radiculopathy with acute lumbar spasm, and administered a lumbar facet joint injection. However, there was no MRI or CT scan of the lumbar spine showing that the patient suffered from facet joint disease, nor had the patient been diagnosed with this condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

15. Also on or about January 7, 2005, respondent claims he performed a needle EMG/NCV of the lower extremity, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

16. Concerning the January 7, 2005 patient visit, the Motion Picture Industry Pension & Health Plans (hereinafter referred to as MPI), patient C.C.'s insurance company, received copies of the patient's medical records, on or about May 9, 2006, in support of respondent's claim for payment. Respondent also produced certified records of the patient's medical records to the Board on or about April 9, 2008. In comparing the two sets of records it is apparent that the records have been altered, modified, fabricated, and created as follows, inter alia: the MPI lumbar injection record is on different paper, contains a different procedure description and narrative than the record produced to the Board; the signed EMG/NCV report sent to MPI contains a different chief complaint, different values for some of the nerves tested, and a different impression than the record produced to the Board. In addition, the EMG/NCV report produced to the Board contains additional handwritten entries that are not contained in the record received by MPI. These additional handwritten entries are not dated, initialed, signed, or explained. Further, respondent's signature is different on both records.

17. On or about February 12, 2005, respondent saw the patient again and complained of continuing neck and back pain. Respondent claims he performed another needle EMG/NCV of the upper and lower extremities, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the

electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

18. Concerning the February 12, 2005 patient visit, the EMG/NCV report received by MPI does not contain the additional handwritten entries under the impression portion of the report that are contained in the record produced to the Board. These additional handwritten entries are not dated, initialed, or explained.

19. Patient C.C. saw respondent again on or about March 18, 2005. Respondent performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

20. On or about May 27, 2005, respondent saw the patient again and claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

21. Concerning the May 27, 2005 patient visit, the signed EMG/NCV report received by MPI in support of respondent claim for payment reflects that the lower extremities were tested on this date. However, the EMG/NCV report produced to the Board reflects that the upper extremities were tested. In addition, the typewritten neurological follow up note produced to the Board also notes that an upper extremity EMG/NCV was conducted. This typewritten note was not sent to MPI. Further, the handwritten neurological attending note sent to MPI does not contain some of the additional handwritten entries in the records produced to the Board. These additional handwritten entries are not dated, initialed, signed, or explained.

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22. On or about August 13, 2005, respondent saw the patient again and performed an Electroencephalogram (EEG)[15] to further evaluate the patient's complaints. Respondent interpreted the results as abnormal, signed the report, and recorded in the follow up neurological note that the EEG was consistent only with mild slowing. However, this statement contradicts the findings.

23. Concerning the August 13, 2005 patient visit, the medical records received MPI from respondent, in or about February 2007, in support of his claim for payment are different from the records produced to the Board in April 2008. In the EEG report received by MPI the clinical impression is different and does not reflect the changes respondent made to the record produced to the Board. In addition, there are handwritten entries in the EEG report and the handwritten neurological consultation follow-up note produced to the Board which are not contained in the records received by MPI. These additional handwritten entries are not dated, initialed, signed, or explained.

24. On or about September 17, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

25. Also, on or about September 17, 2005, respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease. Nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

26. On or about October 19, 2005, patient C.C. saw respondent again. Respondent reports in the follow up neurological note that an EEG was completed and the results are "without significant changes." However, there is no evidence that an EEG was ever performed on this visit.

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[15] An Electroencephalogram (commonly referred to as EEG) is a record of the tiny electrical impulses produced by the brain's activity. By measuring the characteristic wave patterns, the EEG can help diagnose certain conditions of the brain.

27. On or about November 4, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

28. Regarding the November 4, 2005 patient visit, the signed EMG/NCV report sent to MPI notes additional information under the impression, and does not contain the additional handwritten entries that are in the record produced to the Board. These additional handwritten entries are not dated, initialed, signed, or explained.

29. On or about November 15, 2005, patient C.C. saw respondent again. Respondent ordered that the patient receive an infusion of Intravenous Immunoglobulin (IVIG)[16]. However, there was no indication in the EMG/NCV studies that the patient suffered from Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)[17]; nor had she been diagnosed with this condition.

30. On or about December 5, 2005, respondent saw the patient, and claims to have performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

31. Regarding the December 5, 2005 patient visit, MPI received medical records from respondent, on or about May 4, 2006, in support of his claim for payment which are different from the records produced to the Board in April 2008. The signed EMG/NCV report received by MPI does not contain the additional handwritten entries that are in the record produced to the

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[16] IVIG refers to intravenous immunoglobulin. Immunoglobulins (also known as antibodies) are proteins that are found in blood or other bodily fluids of vertebrates, and are used by the immune system to identify and neutralize foreign objects, such as bacteria and viruses.

[17] Chronic inflammatory demyelinating polyneuropathy (CIDP) is an acquired immunemediated inflammatory disorder of the peripheral nervous system. The pathologic hallmark of the disease is loss of the myelin sheath (the fatty covering that wraps around and protects nerve fibers) of the peripheral nerves. Polyneuropathy is a condition in which many peripheral nerves are afflicted with a disorder.

Board. These additional handwritten entries are not dated, initialed, or explained. In addition, respondent's signature is different in both records.

32. On or about December 27, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

33. Concerning the December 27, 2005 patient visit, the Neurological consultation note sent to MPI is completely blank with the exception of the patient's name and date. However, the record produced to the Board is on different letterhead, and has been filled out. In addition, the cervical facet joint injection procedure note sent to MPI states, inter alia, that the "patient complained of feeling lightheaded immediately following the procedure...." However, the record produced to the Board states that the patient had no complaints following the procedure. In addition, the report produced to the Board notes that the patient "also received kineret subQ injection without any complication." This information is not contained in the record sent to MPI.

34. Patient C.C. saw respondent again on or about January 19, 2006. Respondent claims that he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

35. Also, on or about January 19, 2006, respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

36. On or about February 7, 2006, respondent saw patient C.C. who denied experiencing

any palpitations, chest pains or loss of consciousness. Nevertheless, respondent ordered that the patient undergo a Transthoracic Echocardiogram[18] (ECHO), which was performed by a technician who reported the preliminary findings. However, the results were not interpreted by a cardiologist, consistent with the standard of practice. Respondent also ordered that the patient undergo a Transcarotid Duplex[19] study even though the patient did not display any risk factors for carotid artery disease or carotid artery dissection, and there was no clinical evidence of vascular pathology involving the anterior circulation.

37. The patient saw respondent again on or about February 24, 2006. Respondent claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

38. Concerning the February 24, 2006 patient visit, the signed EMG/NCV report received by MPI in support of respondent's claim for payment contains two additional sentences under the impression portion of the report that are not in the record produced to the Board. In addition, the EMG/NCV report and the neurological consultation follow-up note sent to MPI do not contain the additional handwritten entries reflected in the records produced to the Board. These additional handwritten entries are not dated, initialed, signed, nor explained. In addition, respondent's signature is different on both EMG/NCV reports.

39. On or about March 11, 2006, C. C. saw respondent again and denied experiencing any palpitations, chest pains, shortness of breath, or loss of consciousness. Nevertheless,

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[18] A Transthoracic (across or though the thoracic cavity or chest wall) Echocardiogram is a diagnostic test that uses ultrasound waves to create an image of the heart muscle and may show such abnormalities as poorly functioning heart valves or damage to the heart tissue from a past heart attack.

[19] A Transcarotid duplex study is a procedure that uses ultrasound to look for blood clots, plaque buildup, and other blood flow problems in the carotid arteries which are located in the neck and supply blood to the brain.

respondent ordered another ECHO even though this study had been performed a month earlier. However, there is no evidence that a cardiologist ever reviewed or interpreted the technician's preliminary findings, consistent with the standard of practice, and respondent did not refer the patient to a cardiologist for further evaluation. In addition, respondent reports, in the signed typewritten follow up neurological note that an "EEG was completed with no evidence of seizures." However, there is no evidence that an EEG was ever performed on this visit.

40. On or about March 26, 2006, respondent saw the patient again. Respondent claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

41. Regarding the March 26, 2006 patient visit, the facet joint injection procedure note sent to MPI describes the procedure as a "Cervical Facet Joint Injection." However, the record produced to the Board describes the procedure as a "Lumbar Facet Steroid Injection" and is on different letterhead. In addition, the EMG/NCV report sent to MPI lists a different chief complaint, and reports different values for some of the nerves tested in the study than are contained in the record produced to the Board.

42. On or about April 14, 2006, patient C.C. saw respondent again who ordered another EEG. Respondent interpreted the results as abnormal with diffuse slowing and localized spike-and-wave activity in the left hemisphere. However, the body of the report does not support respondent's interpretation as it does not mention that the activity was localized only to the left hemisphere.

43. On or about April 28, 2006, the patient saw respondent again and claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study

had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

44. Concerning the April 28, 2006 patient visit, MPI received medical records from respondent, on or about November 3, 2006, in support of his claim for payment which are different than the records produced to the Board in April 2008. The signed EMG/NCV report received by MPI reflects that a lower extremity study was performed. However, the records produced to the Board reflect that an upper extremity study was performed. In addition, the EMG/NCV report received by MPI contains a different chief complaint, a different impression, and is on different letterhead than the records produced to the Board. Further, the records received by MPI include a lumbar epidural injection record which was not produced to the Board, nor is this procedure referenced in the typewritten follow up neurological visit note signed by respondent.

45. On or about May 10, 2006, respondent saw the patient. Respondent performed another cervical and lumbar facet joint block injections without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

46. On or about May 25, 2006, patient C.C. saw respondent again and claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

47. Concerning the May 25, 2006 patient visit, MPI received medical records from respondent, on or about January 17, 2007, in support of his claim for payment which included a handwritten signed follow up neurological consultation note, dated 5/25/06, which was not produced to the Board in April 2008.

48. On or about May 26, 2006, respondent saw the patient and ordered that she undergo another EEG, as well as another Carotid duplex study despite no risk factors for carotid artery disease or carotid artery dissection, and no clinical evidence of vascular pathology involving the

anterior circulation. In addition, although the patient denied experiencing any palpitations, chest pains or loss of consciousness, respondent ordered that she undergo another ECHO. The ECHO was performed by a technician who reported the preliminary findings. However, the results were not interpreted by a cardiologist, consistent with the standard of practice, nor did respondent refer the patient to a cardiologist for a consultation or evaluation.

49. Concerning the May 26, 2006 patient visit, MPI received medical records from respondent, on or about November 3, 2006 and on or about January 17, 2007, in support of his claim for payment which are different from the records produced to the Board. The signed follow up neurological consultation note received by MPI is almost completely blank except for the patient's name, date of visit, and impression/plan portion of the record. However, the note produced to the Board has been filled out and does not include the same handwritten entries in the record received by MPI. In addition, the signed "Transcarotid Duplex" report received by MPI reports "irregular calcific plaquing" and that the "degree of stenosis is 20-30 percent in the internal carotid artery." However, these findings are not present in the "Carotid Duplex" report produced to the Board which reports "no clacific plaquing" and "no stenosis."

50. On or about June 19, 2006, the patient saw respondent again who claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also ordered that the patient receive another infusion of IVIG despite no clinical diagnosis nor any EMG/NCV or other neurophysiological findings indicating that the patient suffers from CIDP. Further, respondent performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

51. Concerning the June 19, 2006 patient visit, the signed EMG/NCV report sent to MPI does not contain all of the impressions noted in the record produced to the Board, contains a different summary of findings, and respondent's signature is different. An additional follow up

neurological consultation note was sent to MPI that was not produced to the Board. In addition, the IVIG record sent to MPI is on different letterhead, reflects different start and end times, temperatures, pulse and blood pressure readings, inter alia, than what is contained in the record produced to the Board.

52. On or about July 27, 2006, respondent saw the patient again. Respondent ordered that the patient undergo a fourth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study at this time.

53. Respondent saw patient C.C. again on or about October 18, 2006. Respondent claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

54. C.C. saw respondent again on or about November 7, 2006. However, it is unclear what the patient complained of as there are two separate records for this visit reflecting different complaints. Respondent ordered a third Carotid duplex study despite the patient having no risk factors for carotid artery disease or carotid artery dissection, and no clinical evidence of vascular pathology involving the anterior circulation. Respondent also ordered a fifth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study.

55. Concerning the November 7, 2006 patient visit, the "Transcarotid Duplex" report received by MPI, in or about February 2007, in support of respondent's claim for payment reports "irregular calcific plaquing" and that the "degree of stenosis is 20-30 percent in the internal carotid artery." However, these findings are not present in the Carotid Duplex" report sent to the Board which reports "no" or "regular calcific plaquing" and no "evidence of stenosis." In addition, the report sent to MPI lists a technician and date of birth which are not included in the record produced to the Board. Further, the handwritten follow up note received by MPI does not contain the additional handwritten impression, inter alia, which is in the record produced to the Board.

56. On or about December 5, 2006, respondent saw the patient again. Respondent

ordered the patient undergo a fourth Carotid duplex study. This study was not necessary and had been performed less than a month earlier with completely different findings[20]. Respondent also claims he performed another needle EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

57. On or about December 29, 2006, the patient saw respondent again who administered another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

58. On or about January 26, 2007, respondent saw the patient again and claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent administered another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

59. On or about February 8, 2007, patient C. C. saw respondent again who ordered the patient undergo a sixth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study at this time.

60. On or about February 16, 2007, respondent saw the patient again and ordered the patient undergo a seventh EEG even though this same study had been performed a week earlier, and there were no new physical findings or symptoms severe enough to warrant a repeat of this study at this time. In addition, respondent reports in the follow up neurological visit notes that an EMG/NCV of the upper extremities was "completed and showing worsening of cervical

[20] Interestingly, this study records the "irregular calcific plaquing" and the" 20-30 percent" degree of stenosis reported in the May 26, 2006 and November 7, 2006 studies sent to MPI.

Radiculopathy." However, there is no evidence that an EMG/NCV study was ever performed on this visit.

61. On or about February 23, 2007, a MRI of the patient's cervical spine was performed at ProHealth Advanced Imaging which revealed that all the facet joints were normal, and there was no evidence of canal stenosis or facet joint disease. Additionally, the patient underwent an MRI of the brain, with and without contrast, which was reported as normal.

62. On or about February 26, 2007, respondent saw the patient again for a follow-up visit. There is a conflict in the neurological findings as respondent notes that "sensation diminished to lateral aspects forearm and diminished in lower extremities" in the neurological examination. However, he also notes that "sensation was intact to touch and pinprick in upper and lower extremities," which is inconsistent. In addition, he ordered a fifth Carotid duplex, which was not necessary.

63. On or about February 28, 2007, C.C. saw respondent again who performed another cervical facet joint injection despite the MRI findings, five days earlier, showing no facet joint pathology. Respondent also claims that he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

64. On or about April 14, 2007, the patient saw respondent who performed another unnecessary cervical facet join. Respondent also ordered the ninth EEG, which was not necessary.

65. On or about April 24, 2007, respondent saw the patient again for a follow up visit. Respondent performed another unnecessary cervical facet join injection. Respondent also claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

66. Patient C. C. saw respondent again on or about May 2, 2007. Respondent ordered a

tenth EEG. However, this study was not necessary and had been performed less than a month earlier.

67. On or about May 11, 2007, the patient saw respondent again who performed another unnecessary cervical facet injection. Respondent also claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

68. On or about June 25, 2007, patient C.C. was last seen by respondent who performed another unnecessary cervical facet block injection. In addition, there is a discrepancy in the records as the cervical facet joint injection procedure note sent to MPI is on different letterhead, contains, inter alia, a different narrative and procedure description than the record produced to the Board.

69. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting gross negligence as follows:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred;

B. By fabricating the administration of and creating carotid duplex study reports which never occurred;

C. By prescribing facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

D. By failing to dispense and administer facet joint block injections utilizing fluoroscopy; and

E. By altering and modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient C.C.)

70. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and

treatment of patient C.C. The circumstances are as follows:

71. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

72. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated negligent acts:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred;

B. By fabricating the administration of and creating carotid duplex study reports which never occurred;

C. By prescribing facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

D. By failing to dispense and administer facet joint block injections utilizing fluoroscopy;

E. By altering and modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

F. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, nor transient ischemic attack;

G. By failing to interpret the electroencephalogram (EEG) studies properly;

H. By prescribing and administering Immunoglobulin (IVIG) without any clinical diagnosis, EMG/NCV or neurological findings showing that the patient suffered from chronic inflammatory demylinating polyneuropathy (CIDP); and

I. By failing to refer the patient to a cardiologist for evaluation and review of echocardiographic (ECHO) studies, and to pursue additional diagnostic testing to evaluate the patient's condition.

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THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing of Treatment and Use of Diagnostic Procedures)

(Patient C.C.)

73. Respondent is subject to disciplinary action under section Business and Professions Code section 725, subdivision (a), in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment and use of diagnostic procedures in his care and treatment of patient C.C. The circumstances are as follows:

74. Paragraphs 11 through 68, inclusive, above are incorporated herein by reference as if fully set forth.

75. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated acts of clearly excessive prescribing and administering drugs and treatment, and use of diagnostic procedures:

A. By prescribing, administering and utilizing repeated electromyography/nerve conduction velocity (EMG/NCV) studies with no new symptoms, findings or circumstances justifying the repeat study;

B. By prescribing, dispensing, and administering facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

C. By prescribing, administering, and utilizing repeated electroencephalogram (EEG) studies with no new symptoms, findings or circumstances justifying the repeat study;

D. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, nor transient ischemic attack;

E. By prescribing and utilizing repeated echocardiogram (ECHO) studies with no new symptoms, findings or circumstances justifying the repeat study; and

F. By prescribing, furnishing, dispensing, and administering infusions of Immunoglobulin (IVIG) without a diagnosis of chronic inflammatory demylinating polyneuropathy (CIDP).

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FOURTH CAUSE FOR DISCIPLINE

(Fraud – Patient C.C.)

76. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient C.C. The circumstances are as follows:

77. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

78. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting fraud:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By knowingly preparing, making and/or subscribing different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim; and

C. By knowingly subscribing carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient C.C.)

79. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient C.C. The circumstances are as follows:

80. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

81. Respondent committed acts in the care and treatment of patient C.C constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By knowingly preparing, making and/or subscribing different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

C. By knowingly subscribing carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim.

D. By prescribing, dispensing, and administering facet joint block injections when the diagnostic imaging showed no anatomic evidence of facet joint disease or canal stenosis;

E. By prescribing, administering, and utilizing repeated electroencephalogram (EEG) studies with no new symptoms, findings or circumstances justifying the repeat study;

F. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, nor transient ischemic attack;

G. By prescribing and utilizing repeated echocardiogram (ECHO) studies with no new symptoms, findings or circumstances justifying the repeat study; and

H. By prescribing, furnishing, dispensing, and administering infusions of Immunoglobulin (IVIG) without a diagnosis of chronic inflammatory demylinating poluyneuropathy.

SIXTH CAUSE FOR DISCIPLINE

(False Representations – Patient C.C.)

82. Respondent is subject to disciplinary action under Business and Professions Code

section 2261 in that he knowingly made or signed a document directly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient C.C. The circumstances are as follows

83. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

84. Respondent committed acts where he knowingly made and or signed documents directly related to the practice of medicine in the care and treatment of patient C.C which falsely represented the existence or nonexistence of facts constituting false representations:

A. By knowingly making and subscribing numerous needle EMG/NCV report studies, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly making and subscribing different facet joint injection block procedure notes, and falsely reporting the findings; and

C. By knowingly subscribing carotid duplex report studies for the same date reflecting markedly different findings.

SEVENTH CAUSE FOR DISCIPLINE

(Altering or Modifying Medical Records or Creating False Medical Records – Patient C.C.)

85. Respondent is subject to disciplinary action under Business and Professions Code section 2262, in that he altered or modified the medical record of any person, with fraudulent intent, or created any false medical record, with fraudulent intent, in his care and treatment of patient C.C. The circumstances are as follows:

86. Paragraphs 10 though 67, inclusive, above are incorporated herein by reference as if fully set forth.

87. Respondent altered and modified, and created false medical records, with fraudulent intent, in the care and treatment of patient C.C.:

A. By creating and subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By creating different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

C. By creating, altering or modifying carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim; and

D. By altering and or modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

EIGHT CAUSE FOR DISCIPLINE

(Gross Negligence – Patient M.E.)

88. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient M.E. The circumstances are as follows:

89. On or about March 6, 2006, patient M.E., a then 29-year-old female, presented to respondent with complaints of increased weakness, tingling and numbness in both legs and left arm. Physical examination revealed, among other things, proximal motor weakness in the lower and upper extremities, although there is a discrepancy between the handwritten and typewritten note regarding the severity of the weakness. Respondent claims he performed an EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. However, only patch electrodes were used during the study. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent's clinical impression was that the patient suffered from chronic inflammatory demylinating neuropathy[21]. However, there were insufficient findings to support this diagnosis. The patient's weight was not recorded on this visit.

90. On or about March 27, 2006, respondent saw patient M.E. again and did not record her weight. Respondent ordered that she be administered 42 grams of IVIG. Respondent did this

[21] Neuropathy is a functional disturbance or pathological change in the peripheral nervous system, sometimes limited to noninflammatory lesions as opposed to those of neuritis.

without knowing her weight which was necessary to determine the proper dosage. In addition, the entire dosage, which was administered in two hours, should have been administered daily in smaller dosages for a period of time for a number of series over a period of several weeks.

91. On or about April 3, 2006, respondent saw patient M.E. again and did not record her weight. He ordered that she be administered 42 grams of IVIG, which was administered over a three hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

92. On or about April 17, 2006, respondent saw patient M.E., and again did not record her weight. He ordered that she be administered an unknown dosage of IVIG over what appears to be a five-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

93. Respondent saw patient M.E. on or about May 1, 2006, and did not records her weight. He ordered that she be administered 42 grams of IVIG, which was administered in less than a three-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

94. On or about May 10, 2006, patient M.E. was seen by respondent and her weight was again not recorded. Respondent ordered that she be administered 50 grams of IVIG, which was administered over an unknown period of time as no end time is reflection in the record. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

95. On or about June 21, 2006, patient M.E. was again seen by respondent who again failed to record her weight. Respondent ordered that she be administered 62 grams of IVIG, which was administered over a two-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

96. On or about June 28, 2006, respondent saw patient M.E. again and failed to record her weight. Respondent ordered that she be administered another 62 grams of IVIG, which was administered over a five-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

97. Patient M.E. saw respondent on or about July 17, 2006, for an office visit. However, respondent billed the Motion Picture Industry Pension & Health Plans (hereinafter referred to as MPI), patient M.E.'s insurance company, for an office visit and needle EMG/NCV he claims he performed on this day. However, this study never occurred, and there are no medical records for this date.

98. On or about July 19, 2006, respondent claims he saw patient M.E. and performed another needle EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. In addition, respondent claims the patient was administered 36 grams of IVIG, over an unknown amount of time. However, this visit did not occur.

99. MPI received medical records from respondent, in or about 2007, in support of his claim for payment. Included in those records was an Immune Globulin IV Human Infusion (IVIG) record, and a two page patient visit note dated August 21, 2006, which was not produced to the Board on or about April 9, 2008. However, this visit never occurred. Respondent nevertheless billed MPI over $10,000.00 for this visit.

100. Respondent claims he saw patient M.E. for an office visit on or about September 11, 2006. However, this visit never occurred and there are no medical records for this date. Nevertheless respondent billed MPI for an office visit.

101. Respondent claims he saw patient M.E. for an office visit on or about October 17, 2006. However, this visit never occurred and there are no medical records for this date. Nevertheless respondent billed MPI for an office visit and various medical procedures which were never performed.

102. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting gross negligence by fabricating the administration of and creating a needle

electromyography/nerve conduction velocity (EMG/NCV) report for a study which never occurred.

NINTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient M.E.)

103. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient M.E. The circumstances are as follows:

104. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

105. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting repeated negligent acts:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred.

B. By diagnosing the patient with chronic inflammatory deymyelinating polyneuropathy without sufficient diagnostic or neurophysiological findings supporting such a diagnosis;

C. By prescribing, dispensing and administering Immunoglobulin (IVIG) without knowing and utilizing the patient's weight to determine the proper dosage, and dispensing and administering the infusions outside of the recommended schedule.

TENTH CAUSE FOR DISCIPLINE

(Fraud – Patient M.E.)

106. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient M.E. The circumstances are as follows:

107. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

108. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting fraud:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim; and

B. By knowingly preparing, making and/or subscribing IVIG records for services and treatment not rendered on August 21, 2006, with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim.

ELEVENTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient M.E.)

109. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient M.E. The circumstances are as follows:

110. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

111. Respondent committed acts in the care and treatment of patient M.E. constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim; and

B. By knowingly preparing, making and/or subscribing IVIG records for services and treatment not rendered on August 21, 2006, with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered with the intent to present, use, or to allow them to be presented or used in support of

any false or fraudulent claim.

TWELFTH CAUSE FOR DISCIPLINE

(False Representations – Patient M.E.)

112. Respondent is subject to disciplinary action under section Business and Professions Code section 2261 in that he knowingly made or signed a document directly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient M.E. The circumstances are as follows:

113. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

114. Respondent knowingly made and/or signed documents directly related to the practice of medicine in the care and treatment of patient M.E which falsely represented the existence or nonexistence of facts constituting false representations:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly preparing and/or making patient visit notes and IVIG records for services and treatment not rendered on August 21, 2006; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered.

THIRTEENTH CAUSE FOR DISCIPLINE

(Creating False Medical Records – Patient M.E.)

115. Respondent is subject to disciplinary action under section Business and Professions Code section 2262, in that he created false medical records, with fraudulent intent, in his care and treatment of patient M.E. The circumstances are as follows:

116. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

117. Respondent committed acts of fraudulently creating false medical records in the care and treatment of patient M.E.:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly preparing and/or making patient visit notes and IVIG records for services and treatment not rendered on August 21, 2006; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered.

FOURTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence – Patient C.P.)

118. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient C.P. The circumstances are as follows:

119. On or about September 7, 2006, patient C.P., a then seventy-five-year-old female, presented to respondent with complaints of nervousness, anxiety and neck pain radiating into her shoulders. An EMG/NCV of the patient's upper extremities was performed indicating the patient presents with numbness, tingling in the bilateral upper and lower extremities. However, the patient had no complains related to her lower extremities on this visit. Respondent summarized and interpreted the EMG/NCV findings and signed the report indicating, inter alia, that the "bilateral....tibial and peroneal motor nerves revealed prolonged distal latency," and the "bilateral H-reflexes were normal." However, the H-reflexes, and the tibial and peroneal nerves are not tested in an upper extremity study, as they are lower extremity nerves. Respondent also prescribed the patient Marinol[22] even though the patient was not anorexic, receiving chemotherapy nor having problems with nausea and vomiting.

120. On or about September 14, 2006, patient C.P. saw respondent for a follow-up visit. Although she had no complaints of dizziness or vertigo, and no symptoms consistent with anterior-circulation ischemic symptomatology, respondent nevertheless ordered that the patient

[22] Marinol is a trademark for the drug dronabinol, which is one of the major active substances in cannabis, used as an antiemetic for cancer chemotherapy to control nausea and vomiting and anorexia and weight loss.

undergo a Transcarotid duplex study for dizziness/vertigo. The study, performed by technician German Elenes, revealed "irregular calcific plaquing", but no evidence of stenosis. Respondent signed the report.

121. On or about September 25, 2006, respondent's office faxed patient C.P. a copy of her medical records. Included in the records was a signed EMG/NCV report, dated 9/7/2006, which describes the chief complaint as "numbness and tingling, neck pain radiating to the bilateral upper extremities and hands." However, this report is markedly different from the one produced to the Board on or about October 24, 2007, in that it contains different: chief complaints; findings; and impressions, inter alia. In addition, this report is also markedly different from the one faxed to the patient in December 2006 as further discussed below.

122. In addition, concerning the September 25, 2006 fax, the Transcarotid duplex report, dated 9/7/2006, notes the technician as German Elenes and revealed 20-30 percent degree of stenosis in the right and left Doppler findings, "an abnormal, low amplitude Doppler signal" in "the proximal and distal vertebral artery." However, this report is markedly different from the report faxed to the patient in December 2006, as further discussed below. Further, this report was not produced to the Board in October 2007.

123. On or about December 11, 2006, respondent's office faxed the patient an additional copy of her medical records. Included in the records was a signed EMG/NCV report, dated 9/7/2006, which reflects a different chief complaint than the report faxed to the patient in September 2006, and contains an additional impression that is not contained in the record produced to the Board.

124. In addition, concerning the December 11, 2006 fax, the Transcarotid duplex report, dated 9/14/2006, lists the technician as Annalee, and notes the correct patient date of birth. This report indicates that no stensosis or any abnormal calcific plaquing was revealed, and reports that "a normal Doppler signal" was "detected in the proximal and distal vertebral artery." However, this report is markedly different from the report faxed to the patient in September 2006 which contains different findings, descriptions, and technicians. In addition, this report was not included in the records produced to the Board in October 2007. However, the transcarotid duplex report

produced to the Board notes a different technician who reports "irregular calcific plaquing in the internal carotid" arteries.

125. Respondent committed acts and omissions in the care and treatment of patient C.P. constituting gross negligence as follows:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

FIFTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient C.P.)

126. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient C.P. The circumstances are as follows:

127. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

128. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated negligent acts:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

E. By failing to take an inadequate initial history and physical examination on the initial

patient visit;

F. By failing to formulate an adequate patient management plan;

G. By prescribing, administering and utilizing carotid ultrasounds despite no patient symptoms for cerebrovascular disease; and

H. By prescribing Marinol when there was no indication that the patient was anorexic or had nausea or vomiting.

SIXTEENTH CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing of Treatment and Use of Diagnostic Procedures)

(Patient C.P.)

129. Respondent is subject to disciplinary action under Business and Professions Code section 725, subdivision (a), in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment and use of diagnostic procedures in his care and treatment of patient C.P. The circumstances are as follows:

130. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

131. Respondent committed acts in the care and treatment of patient C.P. constituting repeated acts of clearly excessive use of diagnostic procedures by ordering the patient undergo carotid duplex studies with no patient symptoms for cerebravascular disease.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Fraud – Patient C.P.)

132. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient C.P. The circumstances are as follows:

133. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

134. Respondent committed acts and omissions in the care and treatment of patient C.P. constituting fraud:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient C.P.)

135. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient C.P. The circumstances are as follows:

136. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

137. Respondent committed acts in the care and treatment of patient C.P. constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By fabricating and creating carotid duplex study reports with different findings;

B. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

C. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

NINETEENTH CAUSE FOR DISCIPLINE

(False Representations – Patient C.P.)

138. Respondent is subject to disciplinary action under Business and Professions Code section 2261 in that he knowingly made or signed a document directly related to the practice of

medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient C.P. The circumstances are as follows:

139. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

140. Respondent knowingly made and signed documents directly related to the practice of medicine in the care and treatment of patient C.P which falsely represented the existence or nonexistence of facts constituting false representations:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

TWENTIETH CAUSE FOR DISCIPLINE

(Altering or Modifying Medical Records or Creating False Medical Records – Patient C.P.)

141. Respondent is subject to disciplinary action under Business and Professions Code section 2262, in that he altered or modified the medical record of any person, with fraudulent intent, or created any false medical record, with fraudulent intent, in his care and treatment of patient C.P. The circumstances are as follows:

142. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

143. Respondent altered and modified, and created false medical records, with fraudulent intent, in the care and treatment of patient C.P.:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity

(EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records – All Patients)

144. Respondent is subject to disciplinary action under section Business and Professions Code section 2261 in that he failed to maintain adequate and accurate medical records in his care and treatment of patients C.C., M.E. and C.P. The circumstances are as follows:

145. Paragraphs 11 through 68, 89 through 101, and 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

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 72928, issued to respondent, GUVEN UZUN, M.D.

Revoking, suspending or denying approval of respondent's authority to supervise physician assistants, pursuant to section 3527 of the Code;

2. Ordering respondent to pay the Medical Board of California the reasonable costs of probation monitoring, if placed on probation; and

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

DATED: January 21, 2010

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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