BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Brian Patrick Keller, D.P.M.	)	**Case No. 500-2013-000007**
Doctor of Podiatric Medicine License No. E 4185	)	
Respondent	)	

DECISION

The attached Accusation is hereby adopted as the Decision and Order of Board of Podiatric Medicine, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 2, 2017.

IT IS SO ORDERED May 3, 2017.

BOARD OF PODIATRIC MEDICINE

By: _____
Michael A. Zapf, D.P.M., President

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BRIAN PATRICK KELLER, D.P.M.** 841 Sterling Parkway, #130 Lincoln, CA 95648 Podiatrist License No. E 4185, Respondent.	Case No. 500-2013-000007 OAH: Case No. 2016100126 **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. Brian Naslund ("Complainant") is the Executive Officer of the Board of Podiatric Medicine ("Board"). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

2. Respondent Brian Patrick Keller, D.P.M. ("Respondent") is represented in this proceeding by attorney Mark R. Gibson, whose address is:

/ / /

Mark Gibson
Bradley, Curley, Barrabee, & Kowalski, P.C.
1100 Larkspur Landing Circle, Suite 200
Larkspur, CA 94939

3. On or about December 17, 1998, the Board issued Podiatrist License No. E 4185 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 500-2013-000007, and will expire on September 30, 2018, unless renewed.

JURISDICTION

4. Accusation No. 500-2013-000007 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 26, 2016. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 500-2013-000007 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 500-2013-000007. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 500-2013-000007, if proven at a hearing, constitute cause for imposing discipline upon his Podiatrist License.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in the Accusation No. 500-2013-000007, and that he has thereby subject his Podiatrist License No. E 4185 to disciplinary action.

11. Respondent agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if he ever petitions for early termination and/or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 500-2013-000007, shall be deemed true, correct, and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California.

CONTINGENCY

13. This stipulation shall be subject to approval by the Board of Podiatric Medicine. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Podiatric Medicine 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.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Podiatrist License No. E 4185 issued to Respondent Brian Patrick Keller, D.P.M. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION Respondent shall not order, prescribe, dispense, administer and/or possess any controlled substances listed in Schedule II and III of the Act as defined by the California Uniform Controlled Substances Act. Respondent shall not order, prescribe, dispense, administer and/or possess any controlled substances classified as a benzodiazepine medication as listed in Schedule IV of the Act as defined by the California Uniform Controlled Substances Act.

Respondent shall be able to order, prescribe, dispense, administer, and/or possess non-benzodiazepine controlled substances as listed in Schedule IV and all controlled substances as listed in Schedule V of the Act as defined by the California Uniform Controlled Substances Act so long as he follows all requirements set forth in term number two of this Stipulated Settlement and Disciplinary Order.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered or possessed by respondent during probation showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnosis for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger in chronological order. All

records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

Respondent understands and agrees that the Board will use California's Prescription Drug Monitoring Program, commonly known as the Controlled Substance Utilization and Review and Evaluation System or CURES 2.0, to verify the prescriptions provided and recorded by Respondent.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises is a violation of probation.

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

Respondent shall perform 40 hours of additional educational program(s) and/or course(s) for the first two years of probation. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition. Beginning in the third year of probation and continuing through the fifth year of probation, this requirement will be reduced to 20 hours of additional educational program(s) and/or course(s). After the third year Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

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4. PRESCRIBING PRACTICES COURSE Within 60 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 Board 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 Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

5. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Board 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 Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

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

6. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to 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 Board 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 Board 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 podiatric medicine. The Program shall also evaluate, assess, and provide recommendations regarding Respondent's continued prescription of controlled substances. 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 Board 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.

7. MONITORING - PRACTICE/BILLING Within 30 days of the effective date of this Decision, the entire practice shall be monitored, including, but not limited to the following: medical records, charting, pre and postoperative evaluations, all surgical procedures and billing records.

The Board shall immediately, within the exercise of reasonable discretion, appoint a doctor of podiatric medicine from its panel of medical consultants or panel of expert reviewers as the

monitor.

The monitor shall provide quarterly reports to the Board or its designee which include an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of podiatric medicine or billing, or both, and whether respondent is practicing podiatric medicine safely.

The Board or its designee shall determine the frequency and practice areas to be monitored. Such monitoring shall be required during the entire period of probation. The Board or its designee may at its sole discretion also require prior approval by the monitor of any medical or surgical procedures engaged in by the respondent. The respondent shall pay all costs of such monitoring and shall otherwise comply with all requirements of his or her contract with the monitor, a copy of which is attached as "Appendix A - Agreement to Monitor Practice and/or Billing." If the monitor terminates the contract, or is no longer available, the Board or its designee shall appoint a new monitor immediately. Respondent shall not practice at any time during the probation until the respondent provides a copy of the contract with the current monitor to the probation investigator and such contract is approved by the Board.

Respondent shall provide access to the practice monitor of respondent's patient records and such monitor shall be permitted to make direct contact with any patients treated or cared for by respondent and to discuss any matters related to respondent's care and treatment of those patients. Respondent shall obtain any necessary patient releases to enable the monitor to review records and to make direct contact with patients. Respondent shall execute a release authorizing the monitor to provide to the Board or its designee any relevant information. If the practice monitor deems it necessary to directly contact any patient, and thus require the disclosure of such patient's identity, respondent shall notify the patient that the patient's identity has been requested pursuant to the Decision. This notification shall be signed and dated by each patient prior to the commencement or continuation of any examination or treatment of each patient by respondent and a copy of such notification shall be maintained in each patient's file. The notifications signed by respondent's patients shall be subject to inspection and copying by the Board or its designee at any time during the period of probation that respondent is required to comply with this condition.

The practice monitor will sign a confidentiality agreement requiring him or her to keep all patient information regarding respondent's patients in complete confidence, except as otherwise required by the Board or its 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.

Following the initial three in-person practice monitor reviews with the Respondent and where no practice or billing issues have been discovered, the practice monitor, with the agreement of the Board, may choose to conduct alternating reviews on an electronic basis, foregoing the need to meet face-to-face at every review. The Respondent and the practice monitor shall still meet face-to-face for the next review that follows an electronic review.

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

8. 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 podiatric 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.

9. PHYSICIAN ASSISTANTS Prior to receiving assistance from a physician assistant, respondent must notify the supervising physician of the terms and conditions of his/her probation.

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

11. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. PROBATION COMPLIANCE UNIT Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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

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

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

14. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in section 2472 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has

been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions, with the exception of this condition, and the following terms and conditions of probation: Obey All Law; 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 totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing podiatric 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.

15. FAILURE TO PRACTICE PODIATRIC MEDICINE - CALIFORNIA RESIDENT In the event the respondent resides in the State of California and for any reason respondent stops practicing podiatric medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California as defined in this condition will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in section 2472 of the Business and Professions Code.

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

Respondent's license shall be automatically cancelled if respondent resides in California

and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code section 2472.

16. 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 will be fully restored. Probation will not terminate and will continue in a tolled status until Respondent meets all financial obligations.

17. VIOLATION OF PROBATION If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, the period of probation shall be extended until the matter is final, and no petition for modification of penalty shall be considered while there is an accusation or petition to revoke probation pending against respondent.

18. COST RECOVERY Within 90 calendar days from the effective date of the Decision or other period agreed to by the Board or its designee, respondent shall reimburse the Board the amount of $**9,500.00** for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent of his/her obligation to reimburse the Board for its costs.

19. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice podiatric 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 podiatric medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

20. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Board of Podiatric Medicine and delivered to the Board or its designee within 60 days after the start of the new fiscal year. Failure to pay costs within 30 calendar days of this date is a violation of probation.

21. NOTICE TO EMPLOYEES Respondent shall, upon or before the effective date of this Decision, post or circulate a notice which actually recites the offenses for which respondent has been disciplined and the terms and conditions of probation to all employees involved in his/her practice. Within fifteen (15) days of the effective date of this Decision, respondent shall cause his/her employees to report to the Board in writing, acknowledging the employees have read the Accusation and Decision in the case and understand respondent's terms and conditions of probation.

22. CHANGES OF EMPLOYMENT Respondent shall notify the Board in writing, through the assigned probation officer, of any and all changes of employment, location, and address within thirty (30) days of such change.

23. COMPLIANCE WITH REQUIRED CONTINUING MEDICAL EDUCATION Respondent shall submit satisfactory proof biennially to the Board of compliance with the requirement to complete fifty hours of approved continuing medical education, and meet continuing competence requirements for re-licensure during each two (2) year renewal period.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Mark R. Gibson. I understand the stipulation and the effect it will have on my Podiatrist License. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Podiatric Medicine.

DATED: 3/14/2017

BRIAN PATRICK KELLER, D.P.M.
Respondent

I have read and fully discussed with Respondent Brian Patrick Keller, D.P.M. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 3-14-17

MARK R. GIBSON
Attorney for Respondent

ENDORSEMENT

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

Dated: 3-15-17

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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APPENDIX A
Agreement to Monitor Practice and/or Billing

AGREEMENT TO MONITOR PRACTICE AND/OR BILLING

Introduction

The role of the practice and/or billing monitor (Monitor) is to ensure, to the extent possible, that the Probationer will conduct his/her practice with safety to the public and in a competent manner. The Monitor is responsible for reporting to the Board of Podiatric Medicine (Board) any identified problems or deficiencies in the quality of the Probationer's patient care, billing practices, medical record keeping, and/or professional conduct. The Monitor also fulfills the role of an educator and advisor to the Probationer, with the goal of assisting the Probationer to improve clinical skills and gain insight into practices that led to disciplinary action, so that learning and rehabilitation will occur. In order to provide this type of objective oversight, the Monitor must not have any prior or current business, personal, or other relationship with the Probationer that could reasonably be expected to compromise the ability of the Monitor to render fair and unbiased reports to the Board.

The Board's Expectations

Prior to agreeing to monitor the probationer's practice, you must carefully review the Accusation (which explains the reasons for the disciplinary action against the probationer) and the Decision (which explains the terms and conditions of the probationer's probation). You should also meet the probationer at his/her practice location, so that you will have a clear understanding of the nature of the practice that you will be responsible for monitoring. If you accept the Monitor role, you will be expected to visit the probationer's practice location regularly, randomly select and review the probationer's charts, and report your findings to the Board (in writing) once each quarter, or as otherwise required by the Decision. These requirements are detailed in the Monitoring Plan, with which you must abide. If you disagree with the Monitoring Plan, you may submit a revised plan, however, *the revisions must be approved by the Investigator who is assigned to enforce the Decision.* Once the Monitoring Plan is signed by all parties, there can be no deviations from the agreement. If you are no longer able or willing to monitor the probationer, you must immediately notify the assigned Investigator.

AGREEMENT

I, _____, D.P.M., "Monitor", hereby agree to monitor the medical and/or billing practice of _____, D.P.M., "Probationer."

I have received and have read a copy of the Accusation and Decision regarding the Probationer.

- I clearly understand the role of a Monitor and what is expected of me.
- I have no prior or current business, personal or other relationship with the Probationer that could reasonably be expected to compromise my ability to render fair and unbiased reports to the Board.
- I understand that the Probationer is responsible for all costs associated with the monitoring of his/her practice, and that the Board does not set these costs. I am not being compensated for my services by any form of bartering arrangement with the Probationer.
- I have reviewed the Monitoring Plan and (check one):

	Agree to monitor the Probationer as specified in the Plan.
	I am submitting a revised Monitoring Plan for approval by the assigned Investigator. I understand that the Investigator may reject my proposed revisions, in which case I may either decline to monitor the Probationer's practice, or submit a new proposed Monitoring Plan that is acceptable to the assigned Investigator.

I agree to regularly submit written reports to the assigned Investigator regarding my review of the Probationer's practice. The due dates and required content of these reports is detailed in the Monitoring Plan.

If I am no longer able or willing to continue to monitor the Probationer's practice, I agree to immediately notify the assigned Investigator.

Executed on_____, **20**_____,

at _____ _____, **California**.
(City) (County)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
Monitor (Print Name) Signature

I have no prior or current business, personal or other relationship with (*insert Monitor's name*) that could reasonably be expected to compromise (*insert Monitor's name*) ability to render fair and unbiased reports to the Board. I have agreed to compensate the monitor at the rate of $_____ per hour for all work performed in executing the duties of monitor.

Executed on_____, **20**_____,

at _____ _____, **California**.
(City) (County)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
Probationer (Print Name) Signature

Exhibit A

Accusation No. 500-2013-000007

KAMALA D. HARRIS
Attorney General of California
VLADIMIR SHALKEVICH
Acting Supervising Deputy Attorney General
JOHN S. GATSCHET
Deputy Attorney General
State Bar No. 244388
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-5230
Facsimile: (916) 327-2247
Attorneys for Complainant

BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BRIAN PATRICK KELLER, D.P.M.** 841 Sterling Parkway, #130 Lincoln, CA 95648 Podiatrist License No. E 4185 Respondent.	Case No. 500-2013-000007 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kathleen Cooper, J.D. ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Podiatric Medicine, Department of Consumer Affairs ("Board").

2. On or about December 17, 1998, the Board of Podiatric Medicine issued Podiatrist License Number E 4185 to Brian Patrick Keller, D.P.M. ("Respondent"). The Podiatrist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2016, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2222 of the Code states as follows:

"The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

"The California Board of Podiatric Medicine may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in this chapter."

5. Section 2234 of the Code states, in pertinent part:

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

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

"(b) Gross negligence.

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"(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.

"..."

6. Section 2242 of the Code states, in pertinent part:

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

"..."

7. Section 2266 of the Code states, in pertinent part:

"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."

COST RECOVERY

8. Section 2497.5 of the Code states, in pertinent part:

"(a) The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

"(b) The costs to be assessed shall be fixed by the administrative law judge and shall not be increased by the board unless the board does not adopt a proposed decision and in making its own

decision finds grounds for increasing the costs to be assessed, not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

"(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

"(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

"(e)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

"(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for those unpaid costs.

"(f) All costs recovered under this section shall be deposited in the Board of Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct."

DRUGS

9. This Accusation concerns controlled substances prescribed to various patients by Respondent, a licensed Doctor of Podiatric Medicine, as more fully described below:

10. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).[1] Hydrocodone with acetaminophen is a dangerous drug

[1] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163.

pursuant to California Business and Professions Code section 4022 and is a Schedule III controlled substance pursuant to California Health and Safety Code section 11056(e).

11. Hydromorphone hydrochloride – Generic name for the drug Dilaudid. Hydromorphone hydrochloride is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone is a long-acting medication used to treat severe pain. Hydromorphone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

12. Diazepam – Generic name for the drug Valium. Diazepam is a long acting benzodiazepine used to treat anxiety. Benzodiazepines are a class of psychoactive drugs whose core chemical structure is the fusion of a benzene ring and a diazepine ring. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Diazepam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

13. Codeine Phosphate -- Codeine Phosphate is an opioid analgesic drug used to treat mild to moderate pain. The drug can be combined with acetaminophen. Codeine Phosphate is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Codeine Phosphate is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

14. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short acting benzodiazepine used to treat anxiety. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

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15. Oxycodone – Generic name for the drug Oxycontin. Oxycodone is a long acting opioid analgesic used to treat moderate to severe pain. It has a high danger of abuse and can lead to addiction. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

16. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent long acting opioid analgesic. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent that morphine and hundreds of more times more potent than heroin.[2] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

17. Oxycodone with Acetaminophen – Generic name for Percocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence in the treatment of patients K.S., Z.S., W.R., M.R., P.D., and D.P. The circumstances are as follows:

Patient K.S.

19. On May 2, 2012, Respondent began providing care to Patient K.S.[3] at his clinic located in Lincoln, California. K.S. had experienced an injury while at work. Respondent

[2] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html
[3] All witnesses will be identified in discovery.

documented a handwritten physical examination of K.S. and noted that he stepped off a ladder wrong. The patient noted that he was currently taking Advil. The findings and impressions are illegible in the records. Respondent prescribed 90 pills of Norco, 7.5/325 mg., with 3 refills. There was no documentation in the medical records to support why this prescription was necessary to treat K.S.

20. On May 14, 2012, Respondent noted that he saw Patient K.S. for a pre-operative appointment in a handwritten history and physical. He documented that the K.S. was taking Norco for pain. It was noted that K.S. was suffering from a fractured bone. Many of the entries in the chart are illegible. There is no description of the type of pain that K.S. was experiencing or whether the prescription for Norco provided on May 2, 2012, was helping to alleviate his pain. Respondent prescribed 90 pills of Vicodin, 5/500 mg. with 2 refills. There was no documentation in the medical records to support why this prescription was necessary to treat K.S., especially considering a short-acting prescription of Norco had been written by Respondent just twelve days earlier.

21. On June 12, 2012, Respondent performed surgery on Patient K.S. to repair a fracture. Fluoroscopy was performed. Also on that day, Respondent approved three additional refills of the original May 2, 2012, prescription for 90 pills Norco, 7.5/325 mg. by fax to a pharmacy. The pharmacy noted that K.S. had previously filled a 90 pill Norco prescription on May 2, 2012, and a 90 pill Norco prescription on May 27, 2012, and filled a 90 pill Vicodin prescription on May 14, 2012. While Respondent had wrote the prescriptions for K.S. to take 4 pills a day at a rate of 120 pills a month, K.S. had already filled 270 pills in the month of May 2012. The fax sheet to the pharmacy was added to the K.S.'s medical file but no note was made regarding why K.S. was now on two different short-acting narcotic medications. Also there was no documentation as to whether it was appropriate for K.S. to be taking more pills than he was prescribed. At the subject interview on November 18, 2015, Respondent acknowledged, "the reason why this patient, uh, uh, continued to take his narcotic analgesic, um, sometime more than the way I prescribed it, but just – just to, uh – to obtain appropriate level of pain management." Respondent did not clearly document that he spoke with the patient regarding his overuse of medication.

22. On June 15, 2012, Respondent saw Patient K.S. in clinic. The progress note is illegible and fails to provide any information related to the purpose of the visit and the status of Patient K.S.'s current pain level. It fails to explain how Patient K.S. was responding to previous pain medication prescriptions. Respondent provided Patient K.S. with a prescription for 120 pills Dilaudid 2 mg. and 30 pills Valium 10 mg. There is no documentation contained in the record to explain why the new prescriptions were necessary. There is no documentation contained in the record that informed consent was obtained for the titration of new pain medication. There is no documentation contained in the record that sets forth a treatment plan. There is no documentation contained in the record explaining how the new medications were titrated. There is no documentation in the record that indicates whether Respondent considered or instructed Patient K.S. to discontinue using Vicodin and/or Norco.

23. On June 22, 2012, June 25, 2012, and July 2, 2012, Patient K.S. was seen in clinic by Respondent. The visits were documented on one single sheer of paper that was titled Progress Notes. The records are illegible. Respondent did not document Patient K.S.'s pain levels, did not describe if the pain medications were effective, and did not explain why he had previously titrated new medications.

24. On June 3, 2012, Patient K.S. filled a prescription for 90 pills of Vicodin 5/500 mg. On June 13, 2012, Patient K.S. filled a prescription for 90 pills of Norco 7.5/325 mg. On June 16, 2012, Patient K.S. filled a prescription for 90 pills of Vicodin 5/500 mg. On June 18, 2012, Patient K.S. filled a prescription for 40 pills of Acetaminophen and Codeine Phosphate 30/300 mg. On June 28, 2012, Patient filled a prescription for 40 pills of Acetaminophen and Codeine Phosphate 30/300 mg. All of the June 2012 prescriptions and refills were prescribed by Respondent and were dispensed by two separate pharmacies to K.S. Assuming Patient K.S. was taking all of the medications prescribed in June 2012, Patient K.S. potentially could have been taking 4,775 mg. of Acetaminophen per day. Respondent failed to document whether he was concerned with Patient K.S. having renal and hepatic toxicity. Respondent failed to order and/or document whether he ordered liver function tests and/or refer Patient K.S. to a pain management specialist.

25. Respondent's treatment of K.S. as described above represents a separate and distinct extreme departure from the standard of care in that during each visit alleged above Respondent failed to obtain and/or document the patient's informed consent for pain management; failed to elicit and/or document the patient's response to prescribed medications; failed to elicit and/or document the patient's objective and subjective pain at clinic visits; failed to create and/or document a plan for pain medication; failed to explain and/or document the reasons for titrating new medications; failed to consider and/or document whether or not the patient was at risk for renal and hepatic toxicity; and failed to discuss with and/or document whether it was appropriate for the patient to be taking more medication than was directed by Respondent.

Patient Z.S.

26. Respondent saw Patient Z.S. at the office of another Doctor of Podiatric Medicine located in Sacramento, California. Respondent saw patients part-time at that office. At the November 18, 2013, subject interview Respondent stated that Patient Z.S. suffered from rheumatoid arthritis, had a swollen ankle, and had inflamed joints. It is unclear when Respondent first began treating Patient Z.S. The Respondent provided no medical records to the Board and stated that the medical records had been lost and/or destroyed.[4] Throughout his care of Patient Z.S., the Respondent failed to document and/or provide documentation to the Board of why he was prescribing controlled medications, failed to document and/or provide documentation whether he reviewed the benefits and risks of providing treatment with Z.S., failed to document and/or provide documentation that Z.S. was responding to treatment and failed to keep any records that could be made available to subsequent treating providers.

27. On April 8, 2011, Respondent prescribed 90 pills of Norco 10/325 mg to Z.S. with one refill. On May 6, 2011, Respondent approved a prescription of 60 pills of Norco 10/325 mg. to Z.S. On May 16, 2011, Z.S. requested a refill of 60 pills of Norco 10/325 mg. The pharmacist noted that Z.S. was taking more medication that he was prescribed and that he was taking two tablets every six hours rather than one tablet every six hours. Respondent did not agree to fill the

[4] The Board pieced together the care of Patient Z.S. by reviewing pharmacy records.

prescription on May 16, 2011 based on the pharmacist's notation. Respondent did not document and/or provide documentation that Z.S. was counseled about taking more medication than he was prescribed in the medical records. On June 2, 2011, Respondent refilled Z.S.'s prescription for 60 Norco 10/325 mg. On July 28, 2011, Respondent increased Z.S.'s prescription to 90 pills of Norco 10/325 mg. The Respondent failed to document and/or provide documentation on why he increased Patient Z.S.'s prescription. On September 29, 2011, Respondent prescribed 90 pills of Norco 10/325 mg. to Z.S. with two refills.

28. On December 21, 2011, Respondent prescribed 90 pills of Norco 10/325 mg. to Z.S. and authorized two refills. Patient was to take one tablet every six hours as needed for pain and the prescription was to last for 22 days. On January 5, 2012, Respondent allowed a six day early refill of 90 pills of Norco 10/325 for patient Z.S. The pharmacy noted that the patient had been doubling his medication and taking more than Respondent prescribed. Respondent did not document and/or provide documentation that he reviewed, analyzed or discussed with Patient Z.S. that he was taking more medication that he had been prescribed.

29. On March 2, 2012, Respondent prescribed 90 pills of Norco 10/325 mg. to Z.S. and authorized two refills. Patient Z.S. refilled the medication on March 23, 2012. On May 7, 2012, Respondent prescribed 90 pills of Norco 10/325 mg to Z.S. and authorized three refills. The prescription was supposed to last until May 29, 2012. On May 24, 2012, Respondent allowed a five day early refill of 90 pills of Norco 10/325 for patient Z.S. The pharmacy noted that the patient had been in severe pain and requested an early refill. Respondent did not document and/or provide documentation that he reviewed, analyzed or discussed with Patient Z.S. that he was taking more medication that he had been prescribed. On June 13, 2012, Patient Z.S. filled a 90 pills of Norco 10/325 mg. refill from Respondent.

30. On March 25, 2013, Respondent prescribed 90 pills of Norco 10/325 mg. to Z.S. It is unclear why Respondent prescribed these drugs after not prescribing to Patient Z.S. for 9 months. On April 23, 2013, Respondent prescribed 90 pills of Norco 10/325 mg. to Z.S. with one refill. Patient Z.S. refilled the medication on May 20, 2013. Finally, on October 30, 2013, Respondent prescribed 60 pills of Norco 10/325 mg. to Z.S. It is unclear why Respondent prescribed these

drugs after not prescribing to Patient Z.S. for 5 months. Respondent did not document and/or provide documentation supporting any of the prescriptions from 2013 and failed to document why he was treating Patient Z.S., why the medications were necessary to treat Patient Z.S., and failed to document his management of Patient Z.S.'s pain.[5]

31. Respondent's treatment of Z.S. as described above represents a separate and distinct extreme departure from the standard of care in that during each visit alleged above Respondent failed to obtain and/or document the patient's informed consent for pain management; failed to elicit and/or document the patient's response to prescribed medications; failed to elicit and/or document the patient's objective and subjective pain at clinic visits; failed to create and/or document the plan for pain medication; failed to explain and/or document the reasons for increasing medications; failed to consider and/or document whether or not the patient was at risk for renal and hepatic toxicity; and failed to discuss with and/or document whether it was appropriate for the patient to be taking more medication then was directed by Respondent.

Patient W.R.

32. On June 2, 2008, Respondent began providing care to Patient W.R. Respondent already treated W.R.'s wife, M.R. and they often came to appointments together. Patient W.R. suffered from nucleated plantar lesions, and had a mild drop-foot from a history of back problems. Patient W.R. also suffered from neuropathy and restless legs under the same circumstances as his wife. Patient W.R. had previously been on low-dose alprazolam and asked Respondent to "replace it" in 2010 when he began seeing a new primary care physician who would not prescribe alprazolam. At his subject interview on November 18, 2015, Respondent stated, "I felt it appropriate to, uh, to treat him with this medication. As he had taken on a new primary doctor, the doctor, uh, and – and these folks seem to have a little bit of a language barrier. Um, there's a little bit of communication barrier. I believe they felt much more comfortable with me as they had been under my care for many years."

[5] Patient Z.S. died of acute methadone toxicity on November 25, 2013. A number of other providers were providing multiple controlled substances to Patient Z.S. The toxicology screen did not show the presence of Norco.

33. On August 23, 2010, Respondent wrote Patient W.R. a prescription for 90 pills of .25 mg Alprazolam with three refills. Respondent would provide an additional 12 prescriptions with three refills for 90 pills of .25 mg Alprazolam between December 23, 2010, and January 16, 2015. The progress note on August 23, 2010, states as follows, "Rx Alprazolam 0.25 mg 8hs." There are four illegible words and the number 11307 with a circle and an L in the middle. In the margin it is as follows, "Rx Alprazolam restless legs. Sleep difficulty. Cannot Sleep. > 4 hours/night." Respondent's documentation does not contain any medical records supporting Patient W.R.'s complaint. Respondent did not perform and/or document an appropriate history and physical exam, did not develop and/or document a treatment plan, and did not consider and/or document a follow-up protocol. In reviewing the 33 notes documented between August 23, 2010, and March 18, 2015, Respondent only mentions the patient's progress on Alprazolam on one occasion, April 4, 2012, by noting, "Rx Alprazolam helps sleep helps calm restless legs." While Respondent's chart includes refills and prescriptions for Alprazolam, there is no documentation that Respondent ever communicated with Patient W.R.'s primary care physician regarding medications, no documentation regarding the patient's response to the medication, no documentation that Respondent reviewed alternatives to medication, and no documentation that Respondent sought to refer the patient out for further consultation with other specialists.

34. Respondent's treatment of Patient W.R. as described above represents a separate and extreme departure from the standard of care by engaging in the long-term prescribing of alprazolam and failing to perform and/or document an appropriate history and physical exam, failing to develop and/or document a treatment plan, failing to consider and/or document a follow-up protocol, failing to engage in and/or document communication with W.R.'s primary care physicians, failing to adequately document the patient's response to the medications, failing to consider and/or document that he reviewed alternatives to medication, and failing to consider and/or document making medical referrals to other specialists.

Patient M.R.

35. On November 17, 2006, Respondent began providing treatment to Patient M.R., the wife of Patient W.R. Patient M.R. was seen for diabetic foot care and suffered from diabetes and

hypertension. Patient M.R. was on blood pressure medication, cholesterol, insulin, and thyroid medication. Patient M.R. also had a complaint of neurological disorders in her feet and legs which she described as restless legs. According to Respondent's subject interview, prior to 2010, Patient M.R. received alprazolam from her primary care physician.

36. On June 21, 2010, Respondent prescribed 60 pills of alprazolam .5 mg. with three refills to Patient M.R. for a 30 day supply. On December 28, 2010, Respondent began prescribing 120 pills of alprazolam .5 mg. for a 60 day supply. Between December 28, 2010, and February 28, 2015, Patient M.R. either filled a prescription or refill of 120 pills of alprazolam .5 mg from Respondent on 25 occasions. Between June 21, 2010 and February 28, 2015, Patient M.R. received 3240 pills of alprazolam. In Respondent's subject interview he stated that, "she (M.R.) –she's entirely restless, uh, and complaining of allodynia of her feet, pins and needles feelings. And stated she did so much better with low-dose Alprazolam. Asked if I could prescribe it for her. And -- I did."

37. The Respondent documented a progress note on June 21, 2010, as follows, "Rx Alpro DMFC." There is no other information despite the fact that Respondent was starting Patient M.R. on a .5 mg, two times a day, alprazolam prescription. At Respondent's subject interview he stated that DMFC stands for diabetes mellitus foot care. Respondent did not document Patient W.R.'s complaint necessitating the prescription of alprazolam, did not obtain and/or document informed consent, did not perform and/or document an appropriate history and physical exam, did not develop and/or document a treatment plan, did not develop and/or document a follow-up protocol, did not document whether he discussed with the patient the use of the medication, and did not consider and/or document whether he reviewed alternatives to medication with Patient M.R.

38. Following the prescription of alprazolam, Respondent saw Patient M.R. on August 23, 2010, October 25, 2010, December 27, 2010, February 28, 2011, May 2, 2011, July 6, 2011, September 7, 2011, and November 9, 2011. On August 23, 2010, he documented as follows, "IDDM c/o" followed by four illegible words. On the margin of the August 23, 2010 note was "FSBS = 120-160." At the subject interview, Respondent stated IDDM stands for "insulin-

dependent diabetes mellitus." On October 25, 2010, he documented as follows, "IDDM, ocx of nails, D+G x 10" and initialed the note. On December 27, 2010, he documented as follows, "IDDM, ocx of nails, Rx Alprozolam # 120, 0.5 mg, 2 refill" and initialed the noted. On February 28, 2011, he documented as follows, "IDDM." On May 2, 2011, he documented as follows, "IDDM ocx of na" and initialed the note. On July 6, 2011, he documented as follows, "DMFC." On September 7, 2011, he documented as follows, "DMFC." On November 9, 2011, he documented as follows, "IDDM" and then follows that with six illegible words. At his subject interview, Respondent admitted that it would be difficult for a subsequent treating medical provider to determine how M.R. was doing between October 25, 2010, and November 9th, 2011. During that time, Patient M.R. received four refills of 120 pills of alprazolam. Respondent did not document whether Respondent evaluated the patient's response to medication, whether the patient was benefiting from the medication, whether he sought additional consultation or whether there were any subsequent findings related to the prescribing of alprazolam.

39. Between November 9, 2011, and February 28, 2015, there were an additional 25 notes where Respondent failed to document whether the continued prescriptions of alprazolam were effective, failed to document if he sought outside consultation, failed to document whether there were alternative treatments, and failed to document whether he re-evaluated if the prescriptions were appropriate.

40. Respondent's treatment of Patient M.R. as described above represents a separate and extreme departure from the standard of care by engaging in the long-term prescribing of alprazolam and failing to perform and/or document an appropriate history and physical exam, failing to develop and/or document a treatment plan, failing to develop and/or document a follow-up protocol, failing to engage in and/or document communication with M.R.'s primary care physicians, failing to adequately document the patient's response to the medications, failing to consider and/or document that he reviewed alternatives to medication, and failing to consider and/or document that he considered making medical referrals to other specialists.

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Patient P.D.

41. On October 18, 2006, Patient P.D. was referred to Respondent's practice for a consultation involving a complaint of tarsal tunnel syndrome by her physiatrist. On October 27, 2006, Respondent noted that Patient P.D. suffers from severe heel pain and that she walked on the side of her foot. On October 25, 2006, a neurologist determined that she did not suffer from tarsal tunnel syndrome. Respondent began providing services to relieve Patient P.D.'s pain. On September 26, 2008, the Respondent began providing Norco to P.D. The Board received and reviewed records from January 13, 2010 to March 11, 2015.

42. On January 13, 2010, February 7, 2010, March 3, 2010, March 23, 2010, April 16, 2010, May 7, 2010, May 27, 2010, June 18, 2010, July 7, 2010, July 27, 2010, August 18, 2010, September 7, 2010, September 29, 2010, October 24, 2010, November 18, 2010, December 11, 2010, and December 30, 2010, Patient P.D. either filled or refilled a prescription for 120 pills of Norco 10/325 mg written by Respondent. The Respondent's prescription was for Patient P.D. to take one tablet orally every 4 to 6 hours as needed for pain. The prescription was for a one month supply. In total, Patient P.D. received a total of 2,040 Norco pills in 2010.

43. On July 12, 2010, Respondent documented one note in Patient P.D.'s medical records. The note consists of five illegible words and the words, "3 months." Respondent also included the 2010 prescriptions and refills in Patient P.D.'s medical chart. However, there is no other information contained in Patient P.D.'s medical chart for the entire year of 2010.

44. On January 3, 2011, February 16, 2011, March 5, 2011, March 30, 2011, April 17, 2011, May 9, 2011, June 3, 2011, June 30, 2011, July 26, 2011, August 23, 2011, September 24, 2011, September 30, 2011, October 30, 2011, November 28, 2011, and December 26, 2011, Patient P.D. either filled or refilled a prescription for 120 pills of Norco 10/325 mg written by Respondent. The Respondent's prescription was for Patient P.D. to take one tablet orally every 4 to 6 hours as needed for pain. The prescription was for a one month supply. In total, Patient P.D. received a total of 1,800 Norco pills in 2011.

45. On June 3, 2011, Respondent copied a prescription into Patient P.D.'s medical chart and wrote, "called in for patient." On October 3, 2011, Respondent wrote the date in Patient

P.D.'s medical chart but did not document anything in the patient's chart for that day. Respondent also included the 2011 prescriptions and refills in Patient P.D.'s medical chart. However, there is no other information contained in Patient P.D.'s medical chart for the entire year of 2011.

46. When asked at the subject interview on November 18, 2015, whether there were other notes for 2010, for the Board to review, Respondent stated, "Yeah, Doctor, I'm – I'm going through the – the billing, and it does appear there's a single entry for 2010; July 12th." When asked for records that showed findings and documentation, Respondent stated, "This was an ongoing condition."

47. Respondent's 2010 treatment of Patient P.D. as described above represents a separate and extreme departure from the standard of care by engaging in the long-term prescribing of Norco without creating and/or documenting a long term treatment plan, without either conducting and/or documenting any clinical evaluation, without either conducting and/or documenting a periodic review of the patient's response to medications, without either reviewing and/or documenting alternatives to short-acting narcotics, without either reviewing and/or documenting that Patient P.D. had obtained early refills of her medication on May 27, 2010, July 27, 2010, September 29, 2010, and December 30, 2010, and failing to consult and/or document consultation with a pain management expert.

48. Respondent's 2011 treatment of Patient P.D. as described above represents a separate and extreme departure from the standard of care by engaging in the long-term prescribing of Norco without creating and/or documenting a long term treatment plan, without either conducting and/or documenting any clinical evaluation, without either conducting and/or documenting a periodic review of the patient's response to medications, without either reviewing and/or documenting alternatives to short-acting narcotics, without either reviewing and/or documenting that Patient P.D. had obtained an early refill of her medication on September 30, 2011, and failing to consult and/or document consultation with a pain management expert.

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Patient D.P.

49. On October 30, 2006, Respondent first began providing care to Patient D.P. after he was referred by his primary care physician for heel pain. On his entry form under past illness, Patient D.P. he stated that had pain and that, "Darvocet not strong enough." Patient D.P mentioned he had used Norco/Vicodin in the past. Over the next few years, Respondent treated Patient D.P.'s foot issues when he was referred by his primary care physician. Respondent also began providing pain management care to Patient D.P. For example on June 13, 2007, July 1, 2007, July 23, 2007, and August 16, 2007, Respondent prescribed 90 pills of Norco 7.5/325 mg. to D.P. This continued into 2008. On January 16, 2009, Respondent performed a drainage of a right heel deep abscess on Patient D.P.

50. On June 22, 2009, Respondent prescribed 120 pills Norco 7.5/325 mg. to Patient D.P. The Respondent documented that Patient D.P. continued to suffer from chronic foot and ankle pain. Respondent also documented that the patient walks 15 hours a day, and that he helps take care of the pain with 4 to 8 Norco 7.5/325 mg. a day. The original June 22, 2009, prescription was refilled on July 20, 2009, and August 25, 2009. On September 18, 2009, Respondent noted in Patient D.P.'s medical chart that D.P. suffers from chronic pain and has heel pain. Respondent wrote prescriptions for 120 pills of Oxycontin 20 mg. to be taken every twelve hours and 10 units of 50 mcg/hr Fentanyl. In Patient D.P.'s medical record is a telephone receptionist note dated September 19, 2009, for Respondent from Walgreens pharmacy stating to Respondent that he can't prescribe two long-acting medications at the same time and that the patient can't request refills on the medications. There is no notation in the Patient D.P.'s medical chart that Respondent considered the fact that he had prescribed two long-acting narcotic medications. Based on a review of the September 18, 2009, chart note Respondent failed to either conduct and/or document a physical exam and history prior to titrating new medications, failed to either develop and/or document a treatment plan prior to titrating new medications, failed to either obtain and/or document informed consent prior to titrating new medications, and failed to either consult and/or document a consultation to a new pain management provider when titrating long acting medications.

51. On October 9, 2009, Respondent documented a "pain medication evaluation" in Patient D.P.'s chart. Respondent documented that the patient was sleeping well on oxycodone and using Norco once a day. Respondent prescribed 60 pills of 20 mg. Oxycodone and 120 pills of Norco 7/5/325 mg. On October 30, 2009, there is a note in the patient's medical chart that Raley's Pharmacy in Natomas called in to report that Patient D.P. tried to refill a 120 pill Norco prescription. Raley's Pharmacy stated that they had found two prescriptions from two separate providers for 120 pills of Norco that had been recently prescribed. Raley's Pharmacy refused to issue an early refill. Respondent did not follow up and/or document following up with the Pharmacy or Patient D.P. about the early refill or investigate the dual prescriptions.

52. On November 9, 2009, Respondent documented a visit with Patient D.P. Respondent documented that Patient D.P. wanted a refill of Oxycontin. Respondent documented that he made Patient D.P. elect either Oxycontin or Norco but that he would not prescribe both. Patient D.P. preferred Oxycontin. Respondent documented that he called the pharmacy. He documented that Patient D.P. had refills for Norco. He documented a question mark next to Oxycontin. Respondent failed to explain and/or document why he was forcing his patient to choose between a short acting and long acting opioid medication in Patient D.P.'s medical record.

53. On December 18, 2009, Respondent documented a visit with Patient D.P. for heel pain. Respondent documented that the patient has, "chronic pain, narcotic tolerance/addict, 6 pills/day. Respondent then prescribed 180 pills of Norco 10/325 mg with 3 refills. Despite increasing the Norco prescription, and discontinuing the Oxycontin prescription, Respondent failed to perform and/or document a periodic review, develop and/or document a treatment plan, and failed to explain and/or document why he continued to prescribe medications to Patient D.P. whom he had documented as either having a narcotic tolerance or being an addict.

54. On or about November 3, 2009, Blue Cross/Blue Shield Insurance of Texas sent Respondent a letter regarding Patient D.P.'s prescriptions. The letter noted that between July 6, 2009, and September 21, 2009, Patient D.P. had received 13 prescriptions from at least five separate medical providers. Respondent had prescribed 8 of the prescriptions. The prescriptions had been filled at least at 4 different pharmacies. In total, the letter documented Patient D.P.

having filled 10 doses of fentanyl, 20 pills of Norco 5/325 mg., 630 pills of Norco 7.5/325 mg., 270 pills of Norco 10/325 mg., 40 pills of Percocet 10/325 mg, and 120 pills of Oyxcontin 20 mg. Assuming that Patient D.P. took these medications over a 90 day period, he would have been consuming just under 3500 mg. of Acetaminophen a day. Despite the Blue Cross/Blue Shield letter, Respondent failed to act on and/or document acting on this letter to determine if Patient D.P. was abusing medications, consider whether D.P. was approaching an unsafe amount of Acetaminophen and risking hepatic and renal toxicity, and to consider referring Patient D.P. to a pain management specialist.

55. Respondent continued to prescribed Norco to Patient D.P. in 2010. Respondent noted Patient D.P. failed to show for appointments on July 30, 2010, and September 8, 2010 in his office. Despite Patient D.P. failing to show in office, on September 22, 2010, Respondent prescribed 180 Norco 10/325 mg. tablets to Patient D.P. and provided 3 refills. Respondent failed to reevaluate and/or document whether he should continue prescribing narcotic pain medication to a Patient D.P. who was failing to make office appointments. Respondent also continued to prescribe narcotic pain medication without verifying Patient D.P.'s current state of health. The last medical visit in Respondent's office with Patient D.P. before the September 22, 2010, prescription was on documented as having occurred on June 4, 2010.

56. Respondent either prescribed or refilled Patient D.P.'s Norco prescription for 180 pills of Norco 10/325 mg. on October 18, 2010, November 15, 2010, December 15, 2010, January 4, 2011, February 14, 2011, March 11, 2011, April 20, 2011, May 17, 2011, June 14, 2011, and July 15, 2011. Despite prescribing 1800 pills of Norco 10/325 mg. to Patient D.P. between October 18, 2010, and July 15, 2011, Respondent's only documentation indicated that on January 26, 2011, Patient D.P. "failed confirmed appointment" and that on April 25, 2011, Respondent wrote the date without putting any information in Patient D.P.'s chart. Respondent failed to conduct and/or document periodic review of Patient D.P.'s pain management, failed to review and/or document why Patient D.P. was missing visits, and continued to phone in prescriptions and refills for D.P without seeing Patient D.P. at his office.

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57. On July 27, 2011, Respondent documented seeing Patient D.P. in office for chronic pain. Respondent documented that Patient D.P. was taking 12 Norco 10/325 mg. a day and noted that Patient D.P. was "taking too many." Respondent began prescribing 90 pills of 80 mg. Oxycontin. On August 22, 2011, Respondent saw Patient D.P. in office and prescribed an additional 90 pills of 80 mg. Oxycontin. On August 26, 2011, Respondent received a prescription notification from the pharmacy for 90 pills of 80 mg. Oxycontin under the name of D.P.'s wife. On August 31, 2011, Respondent noted that the prescription was a forgery and documented that he terminated care on September 7, 2011. Respondent noted that Patient D.P. stole Respondent's prescription pad, forged Respondent's signature and wrote in his wife's name. Respondent failed to contact law enforcement and report that Patient D.P. had stolen his prescription pad and forged his signature.

58. Respondent's treatment of Patient D.P. as described above represents a separate and extreme departure from the standard of care by engaging in the long-term prescribing of opioid pain medication without creating and/or documenting a long term treatment plan, without either conducting and/or documenting appropriate clinical evaluations, without either conducting and/or documenting a periodic review of the patient's response to medications, without either reviewing and/or documenting that Patient D.P. had early refills of his medication, without either reviewing and/or documenting that Patient D.P. was receiving medications from multiple sources, without ever consulting and/or documenting consultation with a pain management expert, and without terminating prescriptions and refills for Patient D.P. despite D.P. failing to make multiple clinical visits.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

59. Respondent's license is subject to disciplinary action under section 2234, subdivision (c) in that he committed repeated negligent acts during the treatment of patients T.K., The circumstances are as follows:

60. Complainant realleges paragraphs 18 through 58, and those paragraphs are incorporated by reference as if fully set forth herein.

61. On or about June 19, 2011, Respondent prescribed 90 pills of Norco, 7.5/325 mg., with one refill to patient T.K. T.K. filled her prescriptions on June 19, 2011, and August 1, 2011, at a Safeway Pharmacy. T.K. is Respondent's ex-wife. On November 18, 2015, at Respondent's interview with the Board, in response to a question asking why he had prescribed Norco to T.K., Respondent stated that he, "believe(d) she had some short-term gout attack or tendon issues as I recall." Respondent stated he examined her. When asked if there was a medical chart for T.K., Respondent stated, "Uh, I would like to think there is. There should be." To this date, Respondent has not provided a medical chart to the Board detailing the care and treatment provided to T.K.

62. During Respondent's treatment of W.R., Respondent between 2008 and 2015, Respondent repeatedly drafted illegible progress notes and used abbreviations that are not medically acceptable. For example, on November 9, 2011, Respondent appears to have documented the number 11307 and he drew two circles with a dot in the middle of the right circle. There were two other illegible numbers listed and the Respondent then signed the note. On February 1, 2012, Respondent appears to have written the word, "for" with two lines to the right of the word and the number 11307. In reviewing billing records it appears he billed under CPT[6] code 11307, "shaving of epidermal or dermal lesion" and "lesion diameter 1.1 to 2.0 cm" on both visits. The medical record does not provide any information for a subsequent treating provider to determine what was done. In addition to these two specific notes, there are repeated entries that fail to accurately describe procedures that were performed, describe the management of the patient and/or provide any information about the patient.

63. On February 13, 2013, when documenting Patient W.R.'s treatment visit Respondent drew two circles with a dot inside the right circle. He wrote 11308 next to the two circles and signed his initials. Respondent then billed under CPT code 11308, "shaving of epidermal or

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[6] CPT is an acronym for Current Procedural Terminology. CPT codes are published by the American Medical Association, and the fourth edition is the most current. The purpose of the coding system is to provide uniform language that accurately describes medical, surgical, and diagnostic services. There are approximately 7,800 CPT codes ranging from 00100 through 99499.

dermal lesion" and "lesion diameter more than 2.0 cm." Respondent made similar entries on October 10, 2012, December 12, 2012, and April 17, 2013. Respondent failed to document any information that would support the use of CPT code 11308, failed to provide any information that would describe the procedure that was performed, and failed to describe any information that would be helpful in the management of the patient.

64. The CPT Code 99213 is used to describe a medical visit where a patient is presenting with a problem of low to moderate severity. The encounter requires two out of three of the following: (1) Expanded Problem Focused History; (2) Expanded Problem Focused Exam; (3) Low complexity Medical Decision-Making. It is the middle coding for established patients between the five separate codes. On March 3, 2014, Respondent billed under CPT code 99213 for a visit with Patient W.R. In his note documenting the care provided to Patient W.R. he wrote a series of illegible abbreviations and the numbers "2" and "4". He then signed the note.

65. On January 14, 2015, Respondent documented a visit with Patient M.R. as follows, "In abr 250.60 11727 11072." Respondent then billed Patient M.R.'s insurance for CPT codes 11042 and 11721. CPT code 11042 is used for debridement of ulcer subcutaneous tissue and CPT code 11721 is used for is nail debridement more than six. There is no documentation contained in the record from January 14, 2015, to support the billing of either of these codes, no documentation to tell a subsequent treating provider what had been performed, and no documentation in the record to show management of Patient M.R.'s health issues on that date. In addition to this entry, Respondent repeatedly billed under CPT code 11042, wound debridement, without providing adequate documentation in support of his billing.

66. On July 9, 2014, Respondent documented the visit as follows, drew two lines next to "@ T1 ocx @dm 11730 TA 11721" and signed the note. Respondent then billed Patient M.R.'s insurance for CPT codes 11730 and 11721. CPT Code 11730 is a used for partial nail avulsion and CPT code 11721 is used for is nail debridement more than six. There is no documentation contained in the record from July 9, 2014, to support the billing of either of these codes, no documentation to tell a subsequent treating provider what had been performed, and no documentation in the record to show management of Patient M.R.'s health issues on that date. In

addition to this entry, Respondent repeatedly billed under CPT code 11730, without providing adequate documentation in support of his billing.

67. In addition to the conduct more fully described above in paragraphs 40 through 47, between January 1, 2012, and March 11, 2015, Respondent continued to provide Norco prescriptions to Patient P.D. The Respondent continued to fail to either conduct and/or document whether he had performed appropriate clinical evaluation, performed appropriate periodic review, and performed a review of alternatives. Respondent continued to keep Patient P.D. on Norco, a short acting narcotic, rather than titrate new long-acting narcotics and failed to refer her to a pain management specialist.

68. Respondent's actions represent negligent acts for the following reasons:

1. Respondent's failure to document why he was prescribing controlled substances to Patient T.K. represents a departure from the standard of care;

2. Respondent's prescription for controlled substances to a close family member, T.K., and/or without documenting a good faith examination represents a departure from the standard of care;

3. Respondent's failure to obtain and/or document patient K.S.'s informed consent for pain management represents a departure from the standard of care;

4. Respondent's failure to elicit and/or document patient K.S.'s response to prescribed medications, failure to elicit and/or document the patient's objective and subjective pain at clinic visits, and failure to create and/or document the plan for pain medication represents a departure from the standard of care;

5. Respondent's failure to explain and/or document the reasons for titrating new medications with K.S., failure to document whether or not the patient was at risk for renal and hepatic toxicity, and failure to discuss with and/or document whether it was appropriate for the patient to be taking more medication that was prescribed represents a departure from the standard of care;

6. Respondent failure to obtain and/or document patient Z.S.'s informed consent for pain management represents a departure from the standard of care;

7. Respondent's failure to document patient Z.S.'s response to prescribed medications, failure to document the patient's objective and subjective pain at clinic visits, and failure to create and/or document a plan for pain medication represents a departure from the standard of care;

8. Respondent's failure to explain and/or document the reasons for titrating new medications with Z.S., failure to document whether or not the patient was at risk for renal and hepatic toxicity, and failure to discuss with and/or document whether it was appropriate for the patient to be taking more medication that was prescribed represents a departure from the standard of care;

9. Respondent's repeated failure to document the management of patient W.R.'s complaints, failure to use acceptable medical abbreviations, and repeated failure to provide information represents a departure from the standard of care;

10. Respondent's repeated failure to document why he was using CPT code 11308 when treating patient W.R, failure to adequately document the management of the patient on the days that he billed under CPT code 11308, and repeated failure to provide information represents a departure from the standard of care;

11. Respondent's failure to support his use of the CPT code 99213 and provide document adequate and accurate information regarding what patient W.R. was suffering from represents a departure from the standard of care;

12. Respondent's long-term prescribing of alprazolam to Patients W.R. and M.R. as more fully described in paragraphs 31 through 33 and 34 through 39 above represents a departure from the standard of care;

13. Respondent's repeated billing of CPT Codes 11042 and 11730 while providing care to Patient M.R. without providing any documentation to support the billing represents a departure from the standard of care;

14. Respondent's continued pain management treatment of Patient P.D. in 2010 as more fully described in paragraphs 41 through 48 above represents a departure from the standard of care;

15. Respondent's continued pain management treatment of Patient P.D. in 2011 as more fully described above in paragraphs 41 through 48 above represents a departure from the standard of care;

16. Respondent's continued pain treatment of Patient P.D. between January 1, 2012, and March 11, 2015, represents a departure from the standard of care;

17. Respondent's continued pain management of Patient D.P. as more full described above in paragraphs 48 through 57 above represents a depature from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

69. Respondent's license is subject to disciplinary action under section 2234, subdivision (d), in that he demonstrated a significant lack of knowledge in his care and treatment of multiple patients. The circumstances are as follows:

70. Complainant realleges paragraphs 18 through 58 and those paragraphs are incorporated by reference as if fully set forth herein.

71. Respondent's treatment of Patient K.S., by failing to document the dosages and types of medications prescribed, by failing to understand the interactions of the dosages and the types of medications that he prescribed, and the lack of even basic charting demonstrates both a lack of knowledge in the provision of basic medical care and a lack of knowledge in how to safely provide pain management care.

72. Respondent's treatment of Patient W.R., by failing to understand the need to provide a clear indication for treatment, by failing to perform an appropriate history and physical exam on the patient, by failing to have a clear follow-up protocol with the patient, and by failing to document the patients response to continued medication demonstrates a lack of knowledge on how to safely provide controlled medication.

73. Respondent's treatment of Patient M.R., by failing to understand the need to provide a clear indication for treatment, by failing to perform an appropriate history and physical exam on the patient, by failing to have a clear follow-up protocol with the patient, and by failing to

document the patients response to continued medication demonstrates a lack of knowledge on how to safely provide controlled medication.

74. Respondent's treatment of Patient P.D., by failing to document clinical evaluation, failing to indicate a history and physical, failing to document the patient's response to medications, failing to schedule a review of the patient's progress, failing to obtain informed consent, failing to explore why she needed early refills, and failing to obtain a pain management consultation demonstrates a lack of knowledge on how to safely provide controlled medication.

75. Respondent's treatment of Patient D.P., by failing to document a clinical evaluation, failing to heed potential warning signs like early refills, multiple pain management providers, multiple prescriptions in a short period of time, and missed appointments, failing to perform periodic review, failing to provide a pain management referral when confronted by the fact that the patient was taking 12 Norco a day despite a prescription for 6-8 a day, and by failing to report Patient D.P. to law enforcement for stealing prescription pads and forging Respondent's name demonstrates a lack of knowledge on how to safely provide controlled medication.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

76. Respondent's license is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records. The circumstances are as follows:

77. Complainant realleges paragraphs 18 through 75 and those paragraphs are incorporated by reference as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without a Good Faith Exam and Medical Indication)

78. Respondent's license is subject to disciplinary action under section 2242 in that he repeatedly prescribed Xanax to Patients M.R. and W.R. over a number of years despite never conducting a good faith examination and despite the patients never having a medical indication that required the repeated dosing of Xanax.

79. Complainant realleges paragraphs 18 through 77 and those paragraphs are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Podiatrist License Number E 4185, issued to Brian Patrick Keller, D.P.M.

2. Ordering Brian Patrick Keller, D.P.M. to pay the Board of Podiatric Medicine the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2497.5;

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

DATED: August 26, 2016

Kathleen Cooper

KATHLEEN COOPER, J.D.
Interim Executive Officer
Board of Podiatric Medicine
Department of Consumer Affairs
State of California
Complainant

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