

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

In the Matter of the Accusation Against:

Mark Stephen Wagner, M.D.

Physician's and Surgeon's
Certificate No. G 42267

Case No. 800-2017-030868

Respondent.

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 13, 2020.

IT IS SO ORDERED: October 14, 2020.

MEDICAL BOARD OF CALIFORNIA



Kristina D. Lawson, J.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
3 REBECCA L. SMITH
Deputy Attorney General
4 State Bar No. 179733
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, CA 90013
6 Telephone: (213) 269-6475
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 MARK STEPHEN WAGNER, M.D.
14 515 Cabrillo Park Drive, Suite 120
Santa Ana, California 92701-5016
15 Physician's and Surgeon's Certificate
16 No. G 42267,

17 Respondent.

Case No. 800-2017-030868

OAH No. 2020040153

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
20 entitled proceedings that the following matters are true:

21 **PARTIES**

22 1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of
23 California ("Board"). He brought this action solely in his official capacity and is represented in
24 this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith,
25 Deputy Attorney General.

26 2. Respondent Mark Stephen Wagner, M.D. ("Respondent") is represented in this
27 proceeding by attorney William A. Elliott, whose address is 13522 Newport Avenue, Suite 201,
28 Tustin, California 92780.

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

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

9 3. MEDICAL RECORD KEEPING COURSE. Within sixty (60) calendar days of the
10 effective date of this Decision, Respondent shall enroll in a course in medical record keeping
11 approved in advance by the Board or its designee. Respondent shall provide the approved course
12 provider with any information and documents that the approved course provider may deem
13 pertinent. Respondent shall participate in and successfully complete the classroom component of
14 the course not later than six (6) months after Respondent's initial enrollment. Respondent shall
15 successfully complete any other component of the course within one (1) year of enrollment. The
16 medical record keeping course shall be at Respondent's expense and shall be in addition to the
17 Continuing Medical Education ("CME") requirements for renewal of licensure.

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

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

26 4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar
27 days of the effective date of this Decision, Respondent shall enroll in a professionalism program,
28 that meets the requirements of Title 16, California Code of Regulations ("CCR") section 1358.1.

1 Respondent shall participate in and successfully complete that program. Respondent shall
2 provide any information and documents that the program may deem pertinent. Respondent shall
3 successfully complete the classroom component of the program not later than six (6) months after
4 Respondent's initial enrollment, and the longitudinal component of the program not later than the
5 time specified by the program, but no later than one (1) year after attending the classroom
6 component. The professionalism program shall be at Respondent's expense and shall be in
7 addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

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

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

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

25 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
26 and Accusation(s), and a proposed monitoring plan. Within fifteen (15) calendar days of receipt
27 of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a
28 signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands

1 the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor
2 disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan
3 with the signed statement for approval by the Board or its designee.

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

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

14 The monitor shall submit a quarterly written report to the Board or its designee which
15 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
16 are within the standards of practice of medicine, and whether Respondent is practicing medicine
17 safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure
18 that the monitor submits the quarterly written reports to the Board or its designee within ten (10)
19 calendar days after the end of the preceding quarter.

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

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1 In lieu of a monitor, Respondent may participate in a professional enhancement program
2 approved in advance by the Board or its designee that includes, at minimum, quarterly chart
3 review, semi-annual practice assessment, and semi-annual review of professional growth and
4 education. Respondent shall participate in the professional enhancement program at
5 Respondent's expense during the term of probation.

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

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

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

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

21 Respondent shall submit quarterly declarations not later than ten (10) calendar days after
22 the end of the preceding quarter.

23 9. GENERAL PROBATION REQUIREMENTS.

24 Compliance with Probation Unit

25 Respondent shall comply with the Board's probation unit.

26 Address Changes

27 Respondent shall, at all times, keep the Board informed of Respondent's business and
28 residence addresses, email address (if available), and telephone number. Changes of such

1 addresses shall be immediately communicated in writing to the Board or its designee. Under no
2 circumstances shall a post office box serve as an address of record, except as allowed by Business
3 and Professions Code section 2021, subdivision (b).

4 Place of Practice

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

8 License Renewal

9 Respondent shall maintain a current and renewed California physician's and surgeon's
10 license.

11 Travel or Residence Outside California

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

15 In the event Respondent should leave the State of California to reside or to practice,
16 Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the
17 dates of departure and return.

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

21 11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
22 its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting
23 more than thirty (30) calendar days and within fifteen (15) calendar days of Respondent's return
24 to practice. Non-practice is defined as any period of time Respondent is not practicing medicine
25 as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours
26 in a calendar month in direct patient care, clinical activity or teaching, or other activity as
27 approved by the Board. If Respondent resides in California and is considered to be in non-
28 practice, Respondent shall comply with all terms and conditions of probation. All time spent in

1 an intensive training program which has been approved by the Board or its designee shall not be
2 considered non-practice and does not relieve Respondent from complying with all the terms and
3 conditions of probation. Practicing medicine in another state of the United States or Federal
4 jurisdiction while on probation with the medical licensing authority of that state or jurisdiction
5 shall not be considered non-practice. A Board-ordered suspension of practice shall not be
6 considered as a period of non-practice.

7 In the event Respondent's period of non-practice while on probation exceeds eighteen (18)
8 calendar months, Respondent shall successfully complete the Federation of State Medical
9 Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence
10 assessment program that meets the criteria of Condition 18 of the current version of the Board's
11 "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the
12 practice of medicine.

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

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

15 Periods of non-practice for a Respondent residing outside of California will relieve
16 Respondent of the responsibility to comply with the probationary terms and conditions with the
17 exception of this condition and the following terms and conditions of probation: Obey All Laws;
18 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
19 Controlled Substances; and Biological Fluid Testing.

20 12. COMPLETION OF PROBATION. Respondent shall comply with all financial
21 obligations (e.g., restitution, probation costs) not later than one-hundred twenty (120) calendar
22 days prior to the completion of probation. Upon successful completion of probation,
23 Respondent's certificate shall be fully restored.

24 13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
25 of probation is a violation of probation. If Respondent violates probation in any respect, the
26 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
27 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke
28 Probation, or an Interim Suspension Order is filed against Respondent during probation, the

1 Board shall have continuing jurisdiction until the matter is final, and the period of probation shall
2 be extended until the matter is final.

3 14. LICENSE SURRENDER. Following the effective date of this Decision, if
4 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
5 the terms and conditions of probation, Respondent may request to surrender his or her license.
6 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
7 determining whether or not to grant the request, or to take any other action deemed appropriate
8 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
9 shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the
10 Board or its designee and Respondent shall no longer practice medicine. Respondent will no
11 longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical
12 license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

18 16. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
19 a new license or certification, or petition for reinstatement of a license, by any other health care
20 licensing action agency in the State of California, all of the charges and allegations contained in
21 Accusation No. 800-2017-030868 shall be deemed to be true, correct, and admitted by
22 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
23 restrict license.

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ACCEPTANCE

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

DATED: 7/30/20 
MARK STEPHEN WAGNER, M.D.
Respondent

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

DATED: 7/30/2020 
WILLIAM A. ELLIOTT
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/3/2020

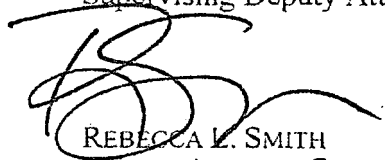
Respectfully submitted,
XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2017-030868

1 XAVIER BECERRA
Attorney General of California
2 JUDITH T. ALVARADO
Supervising Deputy Attorney General
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9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 800-2017-030868

13 MARK STEPHEN WAGNER, M.D.
515 Cabrillo Park Drive, Suite 120
14 Santa Ana, California, 92701-5016

A C C U S A T I O N

15 Physician's and Surgeon's Certificate
No. G 42267,

16 Respondent.
17

18 **PARTIES**

19 1. Christine J. Lally ("Complainant") brings this Accusation solely in her official
20 capacity as the Interim Executive Director of the Medical Board of California, Department of
21 Consumer Affairs ("Board").

22 2. On or about July 1, 1980, the Medical Board issued Physician's and Surgeon's
23 Certificate Number G 42267 to Mark Stephen Wagner, M.D. ("Respondent"). That license was
24 in full force and effect at all times relevant to the charges brought herein and will expire on April
25 30, 2022, unless renewed.

26 **JURISDICTION**

27 3. This Accusation is brought before the Board under the authority of the following
28 provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

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4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

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

(b) The administration and hearing of disciplinary actions.

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

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

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

(f) Approving undergraduate and graduate medical education programs.

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

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

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

5. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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1 (b) Any matter heard pursuant to subdivision (a), except for warning letters,
2 medical review or advisory conferences, professional competency examinations,
3 continuing education activities, and cost reimbursement associated therewith that are
4 agreed to with the board and successfully completed by the licensee, or other matters
5 made confidential or privileged by existing law, is deemed public, and shall be made
6 available to the public by the board pursuant to Section 803.1.

7
8 6. Section 2234 of the Code, states:

9
10 The board shall take action against any licensee who is charged with
11 unprofessional conduct. In addition to other provisions of this article, unprofessional
12 conduct includes, but is not limited to, the following:

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

15 (b) Gross negligence.

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

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

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

28 (d) Incompetence.

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

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

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

7. Section 2242 of the Code states:

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

1 unprofessional conduct. An appropriate prior examination does not require a
2 synchronous interaction between the patient and the licensee and can be achieved
3 through the use of telehealth, including, but not limited to, a self-screening tool or a
questionnaire, provided that the licensee complies with the appropriate standard of
care.

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

6 (1) The licensee was a designated physician and surgeon or podiatrist serving in
7 the absence of the patient's physician and surgeon or podiatrist, as the case may be,
8 and if the drugs were prescribed, dispensed, or furnished only as necessary to
9 maintain the patient until the return of his or her practitioner, but in any case no
longer than 72 hours.

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

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

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

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

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

21 8. Section 725 of the Code states:

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

26 (b) Any person who engages in repeated acts of clearly excessive prescribing or
27 administering of drugs or treatment is guilty of a misdemeanor and shall be punished
28 by a fine of not less than one hundred dollars (\$100) nor more than six hundred

1 dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than
2 180 days, or by both that fine and imprisonment.

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

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

8 9. Section 2266 of the Code, states:

9 The failure of a physician and surgeon to maintain adequate and accurate
10 records relating to the provision of services to their patients constitutes unprofessional
11 conduct.

12 CONTROLLED SUBSTANCES/DANGEROUS DRUGS

13 10. Code section 4021 states:

14 "Controlled substance" means any substance listed in Chapter 2 (commencing
15 with Section 11053) of Division 10 of the Health and Safety Code.

16 11. Code section 4022 provides:

17 "Dangerous drug" or "dangerous device" means any drug or device unsafe for
18 self-use in humans or animals, and includes the following:

19 (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing
20 without prescription," "Rx only," or words of similar import.

21 (b) Any device that bears the statement: "Caution: federal law restricts this
22 device to sale by or on the order of a _____," "Rx only," or words of similar
23 import, the blank to be filled in with the designation of the practitioner licensed to use
24 or order use of the device.

25 (c) Any other drug or device that by federal or state law can be lawfully
26 dispensed only on prescription or furnished pursuant to Section 4006.

27 FACTUAL ALLEGATIONS

28 12. Respondent is the owner and director of OC Comprehensive Care, an outpatient clinic
in Santa Ana. From November 9, 2011 through July 21, 2018, Patient 1¹ received care and
treatment from Respondent and his staff at OC Comprehensive Care for post-traumatic stress

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¹ For privacy purposes, the patient in this Accusation is referred to as Patient 1.

1 disorder ("PTSD") and panic disorder. Patient 1 developed a dependence upon benzodiazepines
2 during his care and treatment at Respondent's clinic.

3 13. Patient 1 initially presented to Respondent's clinic on November 11, 2011, at which
4 time he was seen by Dr. T.P. and diagnosed with PTSD and anxiety. Patient 1 received a medical
5 cannabis certificate.² Dr. T.P. prescribed 90 tablets of Xanax,³ 1 mg, with instructions to take
6 one tablet three times a day. Dr. T.P. next saw Patient 1 on December 7, 2011, at which time he
7 prescribed 120 tablets of Xanax, 1 mg, with instructions for Patient 1 to take one tablet three
8 times a day.

9 14. Respondent first saw Patient 1 on January 5, 2012, at which time Respondent noted
10 that Patient 1's chief complaints were anxiety, PTSD and panic disorder. Respondent
11 documented that Patient 1 reported having less frequent and less severe panic attacks with the
12 attacks occurring about two times a day rather than three times a day. On a "Physical Findings"
13 template, Respondent checked off that the patient's examination was within normal limits in all
14 respects. No other assessment was noted. Respondent's impression was PTSD and panic
15 disorder. Respondent prescribed 150 tablets of Xanax, 1 mg, with instructions for Patient 1 to
16 take five tablets daily, twice a day and one additional tablet as needed for breakthrough panic.
17 Respondent instructed the patient to return in one month.

18 15. Patient 1 returned to Respondent's clinic on February 4, 2012, at which time
19 Respondent noted that Patient 1's chief complaint was anxiety. Respondent documented that
20 Patient 1 reported that he experienced a couple panic attacks daily which would last about 15
21 minutes, that the medication was helpful and that he preferred taking two tablets three times a
22 day. Respondent prescribed 180 tablets of Xanax, 1 mg, with instructions for Patient 1 to take
23 two tablets three times a day.

24 ///

25 ² Patient 1 received medical cannabis certificates for the following time periods during his care
26 and treatment at Respondent's clinic: November 9, 2011 through November 8, 2012; January 11, 2014
27 through January 10, 2015; February 10, 2015 through February 9, 2016; and September 16, 2016 through
September 16, 2017.

28 ³ Xanax, the brand name for alprazolam, is a Schedule IV Controlled Substance and a dangerous
drug.

1 16. For the next 10 months, Patient 1 was seen monthly at Respondent's clinic by
2 Respondent or his staff. At each monthly visit, Patient 1 was prescribed 180 tablets of Xanax, 1
3 mg, with instructions to take two tablets three times a day. After the March 2, 2012 visit, PTSD
4 was dropped as a diagnosis, without explanation. Thereafter, the health care providers, including
5 Respondent noted an impression of "anxiety" and occasionally, the additional impression of
6 "panic disorder". Other than checking off boxes on a "Physical Findings/s" templates, no other
7 physical assessments or evaluations for that 10-month time period were charted. Patient history
8 taking was likewise limited to checking off boxes. Other than one notation by Respondent on
9 April 2, 2012, that he "re-advised patient regarding tolerance, dependence, and withdrawal
10 symptoms," there was no documentation of obtaining informed consent regarding the risks of
11 taking Xanax:⁴

12 17. On January 23, 2013, Patient 1 was seen at Respondent's clinic by staff physician, Dr.
13 A.P. At that time, Dr. A.P. noted that the patient's chief complaint was anxiety, that the anxiety
14 was stable as expected and that the patient had no side effects or new complaints. Dr. A.P. noted
15 that the patient had no panic attacks and that his anxiety was well controlled. Dr. A.P.'s
16 impression was anxiety. He prescribed 180 tablets of Xanax, 1 mg, with instructions for Patient 1
17 to take two tablets three times a day. In addition, he prescribed 30 tablets of Lexapro,⁵ 10 mg,
18 with instructions for Patient 1 to take once a day. There was no documentation setting forth the
19 reason for prescribing Lexapro and no documentation of any discussion of the risks and benefits
20 associated with taking Lexapro. Patient 1 was also instructed to return to the clinic in one month.

21 18. On February 22, 2013, Patient 1 was seen by Respondent at which time the patient
22 reported that the Lexapro was not effective and that Xanax works better. Respondent's
23 impression was anxiety/panic disorder. He prescribed 180 tablets of Xanax, 1 mg, two tablets to
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26 ⁴ Only on July 27, 2012 and August 29, 2012, Patient 1 executed a document entitled Controlled
27 Substance Informed Consent Form. These two forms do not document the risks associated with taking
28 controlled substances.

⁵ Lexapro is a selective serotonin reuptake inhibitor (SSRI). It is used as a treatment for major
depressive disorder.

1 be taken three times a day and 30 tablets of Lexapro, 10 mg, to be taken once a day. The patient
2 was instructed to return in a month.

3 19. For the remainder of 2013 through April 4, 2014, Patient 1 was seen monthly at
4 Respondent's clinic by Respondent or his staff for a chief complaint of anxiety. At each monthly
5 visit, Patient 1 was prescribed 180 tablets of Xanax, 1 mg, two tablets to be taken three times a
6 day and 30 tablets of Lexapro, 10 mg, to be taken once a day. For each visit, the physical
7 examination documentation consisted of checking off boxes on "Physical Finding/s" templates
8 and the health care provider's impression was always "anxiety" with the occasional additional
9 impression of panic disorder. There was no documentation of any discussions with Patient 1
10 regarding the risks of taking Xanax and Lexapro.

11 20. On May 2, 2014, Patient 1 was seen at Respondent's clinic by Dr. A.P. The patient's
12 chief complaint was anxiety follow-up. Dr. A.P. noted that the patient felt that his anxiety was
13 better controlled when he took 20 mg of Lexapro. On a "Physical Finding/s" template, Dr. A.P.
14 checked off that the examination was within normal limits in all respects. No other assessment
15 was noted. Dr. A.P.'s impression was anxiety. Dr. A.P. increased the patient's Lexapro to 30
16 tablets at 20 mg. Other than the patient's indication that his anxiety was better controlled when
17 he took 20 mg of Lexapro, no further reason or explanation for the increase in dose was noted.
18 Likewise, there was no documentation of any discussions with Patient 1 regarding the risks of
19 increasing the dosage. Dr. A.P. also prescribed 180 tablets of Xanax, 1 mg, to be taken three
20 times a day. The patient was instructed to return in 1 month.

21 21. Patient 1 returned to Respondent's clinic on May 31, 2014, and was again seen by Dr.
22 A.P. The patient's chief complaint was anxiety follow-up. Dr. A.P. noted that the 20 mg of
23 Lexapro was working well, the patient's anxiety was managed and he had no panic attacks. Dr.
24 A.P. checked off that the patient's physical examination was within normal limits in all respects.
25 No other assessment was noted other than a urine drug test positive for benzodiazepines. Dr.
26 A.P.'s impression was anxiety. He prescribed 30 tablets of Lexapro, 20 mg, and 180 tablets of
27 Xanax, 1 mg, to be taken three times a day. The patient was instructed to return in 1 month.

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1 22. On June 27, 2014, Patient 1 was seen by Respondent who noted the patient's chief
2 complaint was anxiety follow-up. He further noted that the patient was taking Lexapro 20 mg
3 and it was "working better." Respondent noted that the patient was not undergoing therapy,
4 counseling or group sessions. Respondent checked off that the patient's physical examination
5 was within normal limits. Respondent's impression was anxiety/panic disorder. He prescribed
6 30 tablets of Lexapro, 20 mg, with two refills, as well as 180 tablets of Xanax, 1 mg, to be taken
7 three times a day. In addition, Respondent noted that he recommended therapy. The patient was
8 instructed to return in 1 month.

9 23. For the remainder of 2014, Patient 1 continued to present on a monthly basis to
10 Respondent's clinic for medications for his "anxiety/panic disorder." On July 25, 2014,
11 Respondent added an additional diagnosis of depression. Other than when Patient 1 reported that
12 he lost his medications, his panic attacks were documented to be under control.⁶ During this
13 timeframe, Patient 1's medical records from the clinic reflected normal examinations, with
14 occasional urine drug testing reflecting that the patient was positive for benzodiazepines. On
15 September 15, 2014, Respondent noted that Patient 1's CURES report reflected that in addition to
16 the Xanax prescribed at Respondent's clinic, Patient 1 was receiving Valium.⁷ Respondent
17 further documented that the patient reported that Valium had "no effect." In addition to the
18 monthly prescriptions for Lexapro and Xanax, Respondent added a prescription for 30 tablets of
19 Valium 10 mg, one tablet to be taken at bedtime. The dose and dosage of these medications were
20 adjusted at various visits without documented explanation.

21 24. Patient 1 continued to present to Respondent's clinic on a monthly basis in 2015 for
22 treatment of his "anxiety/panic disorder." Every month, Patient 1 was noted to have had a normal
23 examination. Lexapro was discontinued in August 2015, at which time Respondent noted that the
24 patient was "not taking or acquiring Lexapro as prescribed." Every month, Patient 1 continued to

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26 ⁶ In September and October 2014, Patient 1 reported that he lost his medications and on both
occasions, Respondent gave him new prescriptions.

27 ⁷ Valium, the brand name for diazepam, is a Schedule IV Controlled Substance, a benzodiazepine,
28 and a dangerous drug.

1 be prescribed Xanax and Valium, with varying doses and dosages.⁸ Respondent recommended
2 grief counseling in August 2015. Respondent noted in October 2015 that grief counseling was to
3 be arranged and in November 2015, that the patient had not yet seen a therapist. Also of
4 significance, at the time of Patient 1's September 21, 2015 visit, Respondent noted that it would
5 be the patient's last visit of receiving 120 tablets each of Xanax and Valium and that the patient
6 must have a psychological support evaluation. Respondent further documented "[p]atient very
7 demanding and I suspect diversion."

8 25. Patient 1 continued to present to Respondent's clinic on a monthly basis in 2016 for
9 treatment of his "anxiety/panic disorder." In September and October 2016, Patient 1's visits were
10 by video conference and in December 2016, Patient 1's visit was by audio conference. The
11 examinations of Patient 1 were essentially documented to be "normal" with the exception of July
12 2016 at which time Respondent documented tenderness of the left 5th, 6th and 7th costochondral
13 junctions following an accident the patient had in his garage 2 weeks prior. Three urine drug
14 screens performed in 2016 reflected that the patient was positive for benzodiazepines and opioids.
15 The only visit that the positive opioid was discussed was on November 12, 2016, at which time
16 the patient reported that he had "left-over" Tylenol with Codeine⁹ from when he broke his
17 sternum and had taken it because he had an upper respiratory infection with cough that had since
18 resolved. In 2016, Patient 1 was prescribed 120 tablets of Xanax, 2 mg, and 120 tablets of
19 Valium, 10 mg. At the time of Patient 1's October 15, 2016 video conference, Respondent
20 documented that the patient claimed to have no problems at the pharmacy despite the high dose of
21 benzodiazepines. With respect to therapy, the patient reported that he was considering therapy in
22 February 2016. In March 2016, the patient reported that his girlfriend was better than a therapist
23 and in May 2016, the patient reported that he was seeing a church therapist. In June and August
24 2016, the patient reported that he benefited little from psychological therapy. In June 2016,

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26 ⁸ In August 2015, Patient 1 reported that he lost his medications and in response, Respondent gave
him a new prescription.

27 ⁹ Tylenol with Codeine, the brand name for acetaminophen and codeine, is a Schedule IV
28 Controlled Substance and a dangerous drug.

1 Patient 1 reported that he tried cannabis but that it was not helpful. Notwithstanding, his medical
2 cannabis certification was renewed for anxiety, panic disorder, headaches and low back pain.

3 26. On January 7, 2017, Patient 1 was seen by Respondent for anxiety follow-up.¹⁰ At
4 that time, Respondent noted that the patient's anxiety was well controlled with medication and
5 very difficult to wean. There was no indication when, if at all, an attempt to wean occurred. He
6 also noted that the patient reported that therapy was not effective in the past. Respondent
7 documented a normal examination. Respondent's impression was chronic and acute anxiety.
8 Respondent prescribed 120 tablets of Xanax, 2 mg, and 120 tablets of Valium, 10 mg. With
9 respect to his plan, Respondent noted that the patient has been on this therapy for "years" and in
10 the patient's own words, he was "functioning normal" and "productive."

11 27. Patient 1 was next seen by Respondent on February 4, 2017, with a chief complaint of
12 anxiety follow-up. Respondent noted that the patient claimed that he required "high dose"
13 therapy for persistent anxiety/panic. He further noted that the patient "pleads for meds at all
14 visits." Respondent documented a normal examination and noted that the patient's urine drug test
15 was positive for benzodiazepines, morphine¹¹ and THC.¹² Respondent's assessment was chronic
16 anxiety/panic disorder and benzodiazepine dependence. He instructed the patient to follow-up
17 with a psychiatrist or psychologist for evaluation. Respondent noted that he will gradually
18 decrease the patient's prescriptions starting with Xanax. Respondent further noted that the patient
19 returned about an hour after his visit with a bottle of Tylenol with Codeine prescribed by Kaiser
20 physician, Dr. B.N. on July 11, 2016, for a sternal fracture.

21 28. On February 7, 2017, Respondent noted in Patient 1's chart that he spoke with Kaiser
22 psychiatrist, Dr. B.B. who reported that Patient 1 presented to the Kaiser Baldwin Park
23 emergency room with thoughts of overdosing on Xanax/Valium. Dr. B.B. reported that Patient 1
24 was admitted voluntarily for detoxification and counseling.

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26 ¹⁰ This visit appears to be incorrectly dated in Patient 1's medical records as January 7, 2016.

27 ¹¹ Morphine is a Schedule II Controlled Substance and a dangerous drug.

28 ¹² THC (tetrahydrocannabinol) is a Schedule I Controlled Substance and is a dangerous drug.

1 29. On February 7, 2017, Patient 1 was admitted to Kaiser's psychiatric in-patient unit for
2 three days for depression and suicidal ideation. Thereafter, Patient 1 was referred to a Kaiser
3 multidisciplinary intensive outpatient substance abuse and detoxification program overseen by
4 Kaiser physician, Dr. M.K. A benzodiazepine dependence treatment plan was established for
5 Patient 1. He underwent a detoxification and agreed that he would remain benzodiazepine free
6 indefinitely and any emergence of anxiety would be treated with non-benzodiazepines.¹³ Over a
7 two-month period from February 7, 2017 to April 10, 2017, Patient 1 successfully completed
8 Valium and Xanax detoxification.

9 30. Patient 1 returned to Respondent's clinic on May 30, 2017, at which time he was seen
10 by Nurse Practitioner I.B. for anxiety follow-up. He was noted to have had a normal
11 examination. Nurse Practitioner's impression was anxiety. She prescribed 120 tablets of Xanax,
12 2 mg, and 120 tablets of Valium, 10 mg and noted that the patient stated that he has been taking
13 this medication for two years and denied medication side effects. Patient 1 was instructed to
14 return in 1 month. There was no reference to the patient's recent detoxification.

15 31. On June 24, 2017, Respondent documented that he had a videoconference with
16 Patient 1 at which time the patient reported that everything was okay. There was a further note
17 that the patient had "paid \$408.00 and charged twice for anxiety as per medical director." Again,
18 there was no reference to the patient's recent detoxification.

19 32. On July 22, 2017, Respondent documented that he had a videoconference with Patient
20 1 at which time the patient reported that he was stable as expected with medications and
21 worsened without medications. Respondent noted that the patient had chronic anxiety and panic
22 and that the patient admitted abuse and overuse of Valium and Xanax. Respondent documented
23 that the patient was "pleading" and reported that things were good as long as he was medicated.
24 Respondent advised Patient 1 to see a therapist or psychiatrist. He prescribed the patient 60

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27 ¹³ It was anticipated by Dr. M.K. that Patient 1 would likely experience reemergence of anxiety in
28 the process of being tapered off benzodiazepines (using long-acting clonazepam to taper Patient 1 off the
Valium and Xanax) and that if he experienced anxiety at a level requiring pharmacologic intervention,
non-benzodiazepines would be used.

1 tablets of Xanax, 2 mg, and 60 tablets of Valium, 10 mg. He noted that with the medication
2 reduction, the patient may need to follow-up in 2 weeks.

3 33. On August 19, 2017, Respondent documented that he had a videoconference with
4 Patient 1. The patient reported that he saw a therapist in July and would see a therapist in
5 Respondent's office on Tuesdays. The patient requested an increase to 90 tablets of Xanax and
6 Valium. Respondent prescribed 60 tablets of Xanax, 2 mg, and 60 tablets of Valium, 10 mg.

7 34. On September 16, 2017, Respondent documented that he had a videoconference with
8 Patient 1. The patient was noted to be stable as expected and improved. The patient reported that
9 he attended a therapy session. He requested a change in his medication with an increase in Xanax
10 tablets and reduction of Valium. Respondent agreed and prescribed 90 tablets of Xanax, 2 mg,
11 and 30 tablets of Valium, 10 mg. Respondent noted that the patient would be seen in person for
12 the following visit.

13 35. Patient 1 was seen by Respondent on October 14, 2017 at which time Respondent
14 noted that the patient was doing well and was less anxious with therapy sessions. Respondent
15 documented a normal examination and noted an impression of anxiety/panic disorder.
16 Respondent prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of Valium, 10 mg. Patient 1 was
17 instructed to return in one month.

18 36. Patient 1 continued to present to Respondent's clinic on a monthly basis for treatment
19 of his "anxiety/panic disorder" and was prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of
20 Valium, 10 mg from November 2017 through May 2018. It was noted that Patient 1 participated
21 in therapy at Respondent's clinic. Urine drug screen performed on November 11, 2017 and
22 March 3, 2018 were positive for benzodiazepines and opioids. Patient 1 reported taking left over
23 Tylenol with Codeine on both occasions. On March 21, 2018, Respondent noted that he
24 "discussed issues of patient safety with patient."

25 37. On June 28, 2018, Patient 1 was seen by Respondent in follow-up for anxiety. Patient
26 I reported that his chest felt like it was collapsing and his anxiety felt awful when he wakes up
27 but that it would be better within 10 minutes of taking Xanax 2 mg. The patient reported that he
28 also took Xanax at around 11:00 a.m. to 1:00 p.m. and around 5:00 p.m. to 6:00 p.m. and took

1 Valium at bedtime. Respondent documented that Patient 1 stated that he was not supplementing
2 with other drugs and he denied selling drugs in the past. Respondent also documented that
3 Patient 1 admitted to taking left over Tylenol with Codeine. Patient 1 reported that he stopped
4 attending group meetings because he moved. Respondent's impression was anxiety and panic
5 disorder. Respondent documented that Patient 1 inquired as to clonazepam/Klonopin¹⁴ after a
6 review on YouTube. Respondent prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of
7 clonazepam 1 mg. Patient 1 was instructed to follow-up in 1-2 weeks for a response to
8 clonazepam. Patient 1 was also instructed to participate in group therapy and was advised to
9 avoid narcotics, muscle relaxers and other sedating drugs.

10 38. A telephonic follow-up with Patient 1 took place on July 5, 2018, at which time the
11 patient stated that the clonazepam was more effective than Xanax. That same day, Patient 1 was
12 seen by Respondent for his anxiety/panic disorder. Respondent documented that the patient
13 stated that clonazepam 1 mg did not give the same effect as Valium 10 mg when substituted while
14 continuing Xanax 2 mg three times a day. He tried clonazepam 2 mg three times a day without
15 Valium and did well. He also reported that he was not in therapy but had seen a psychiatrist in
16 Norwalk two times in the past. Respondent encouraged the patient to participate in group therapy
17 and see the psychiatrist in Norwalk or find a new one if the psychiatrist in Norwalk is no longer
18 available. Respondent noted that he planned to contact the patient's prior psychiatrist to discuss
19 Patient 1's case. Respondent prescribed 90 tablets of clonazepam, 1 mg, and instructed the
20 patient to take one to two tablets, maximum, three times a day but to try to take only one tablet
21 three times a day.

22 39. Patient 1 was last seen by Respondent for anxiety follow-up on July 21, 2018. At that
23 time, Respondent documented that the patient reported taking two tablets of Xanax, 2 mg and 4
24 tablets of clonazepam, 1 mg, daily. The patient stated that he had no chest pain, palpitations,
25 shortness of breath, lightheadedness, syncope, psychosis, suicidal thoughts, headaches, nausea, or
26 vomiting and was not drinking alcohol. Respondent noted a normal examination and his

27 ¹⁴ Klonopin, the brand name for clonazepam, is a Schedule IV Controlled Substance, a
28 benzodiazepine, and a dangerous drug.

1 impression was anxiety and panic disorder. Respondent prescribed 60 tablets of Xanax, 2 mg,
2 and 120 tablets of clonazepam, 1 mg. He instructed the patient to return in a month and to bring
3 his medication bottles in for a pill count.

4 STANDARD OF CARE

5 40. When prescribing benzodiazepines, the standard of care requires that the physician
6 take a complete patient history, including the nature and extent of symptoms over time and
7 document the history in the patient's medical records.

8 41. When prescribing benzodiazepines, the standard of care requires that the physician
9 perform a mental status examination and document the findings of the mental status examination
10 in the patient's medical records. A mental status examination includes a description of the
11 patient's affect; speech pattern; thought organization; the presence or absence of symptoms of
12 depression; the presence or absence of psychotic symptoms; the presence or absence of cognitive
13 deficits; and the presence or absence of suicidal or homicidal ideation.

14 42. When a physician diagnoses a patient with a psychiatric diagnosis, such as PTSD or
15 panic disorder, the standard of care requires that there be a sufficient history to justify a diagnosis.
16 When a chronic psychiatric disorder is no longer a working diagnosis, the physician must
17 document the reasoning as to why the diagnosis has been dropped, especially when the same
18 pharmacologic treatment is continued. When amending a diagnosis and making a diagnosis of
19 depression, the standard of care requires that the physician take a detailed history to support the
20 diagnosis and document the findings in the patient's medical records.

21 43. When a physician provides care and treatment for diagnoses of PTSD, anxiety
22 disorder and panic disorder, the standard of care requires the physician perform a physical
23 examination and order of routine laboratory studies, including a complete blood count, chemical
24 pain and thyroid function tests.

25 44. When a physician prescribes medications to a patient, the standard of care requires
26 that the physician obtain informed consent and document the assessment of the indications,
27 benefits, risks alternatives (and offer of alternatives), adverse effects, effectiveness, and/or
28 precautions regarding safe prescribing of medications.

1 45. When prescribing benzodiazepines, the standard of care requires that the physician
2 obtain informed consent and document that informed consent was obtained. Informed consent for
3 benzodiazepines includes but is not limited to (1) the risk of dependence and tolerance; (2) the
4 risk of withdrawal, including the potential for worsening anxiety, panic attacks, life-threatening
5 seizures and delirium; (3) risk of sedation, including an increased risk for motor vehicle
6 accidents; (4) risk of cognitive impairment; (5) increased risk for falls; and (5) risk of respiratory
7 depression if combined with alcohol or opioids.

8 46. When prescribing benzodiazepines, the standard of care requires that the physician
9 attempt to stabilize the patient on a single benzodiazepine and document the rationale should the
10 physician prescribe two benzodiazepines to be used concurrently.

11 47. When the dose or dosage of benzodiazepines is changed, the standard of care requires
12 that the physician clearly document the rationale for the change in the patient's medical records.

13 48. When treating PTSD and/or panic disorder, the standard of care is to prescribe a trial
14 of an SSRI and try to keep treatment with benzodiazepines to a minimum. When the patient has a
15 positive response to an SSRI, the standard of care requires that the physician attempt to decrease
16 the dose of benzodiazepine to determine if the patient can be managed on a lower benzodiazepine
17 dose with the ultimate goal to taper the patient off benzodiazepines all together. When the trial of
18 an SSRI is complete, the standard of care requires that the physician document the reasoning for
19 continuing or discontinuing it.

20 49. When a physician suspects that a patient is abusing, is dependent on, and/or is
21 diverting drugs with a high abuse potential, the standard of care requires that the prescribing
22 physician refer the patient to a psychiatrist or substance abuse-treatment program for an
23 evaluation and treatment.

24 50. When a patient is in need of a psychiatric evaluation refuses to obtain one, the
25 standard of care requires that the physician treating the patient require that the psychiatric
26 evaluation be a condition of treatment rather than merely recommending one and accepting the
27 patient's refusal to undergo one.

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1 medication regimen. On July 25, 2014, Respondent, without explanation, noted an additional
2 diagnosis of depression; however, there was no change in the patient's medication regime and no
3 additional treatment recommendations made.

4 58. Respondent failed to perform complete and thorough physical examinations and
5 failed to order routine laboratory studies during Patient 1's care and treatment at Respondent's
6 clinic.

7 59. Respondent failed to obtain informed consent before prescribing Xanax, Valium and
8 Klonopin to Patient 1. Respondent's notation on April 2, 2012 that he "re-advised patient
9 regarding tolerance, dependence, and withdrawal symptoms" was insufficient to fully inform
10 Patient 1 of the risks associated with taking Xanax.

11 60. Respondent failed to attempt to stabilize Patient 1 on a single benzodiazepine and
12 inappropriately began prescribing two benzodiazepines concurrently without documenting the
13 rationale for prescribing two benzodiazepines concurrently.

14 61. Respondent inappropriately changed the doses and dosages of Patient 1's Xanax and
15 Valium during the course of Patient 1's care and treatment at Respondent's clinic without
16 documenting the rationale for the changes in Patient 1's medical records.

17 62. Respondent failed to obtain and document informed consent for the SSRI trial of
18 Lexapro prescribed to Patient 1 from January 23, 2013 through August 2015.

19 63. Respondent attempted an SSRI trial of Lexapro with Patient 1 from January 23, 2013
20 through August 2015 without any attempt to decrease and taper Patient 1's Xanax use. Other
21 than noting that Patient 1 was "not taking or acquiring Lexapro as prescribed," Respondent failed
22 to document the rationale for discontinuing Lexapro and prescribing two benzodiazepines, Xanax
23 and Valium. Further, there was no documentation as to why the trial of SSRI was not initiated
24 sooner than January 23, 2013.

25 64. Respondent failed to refer the patient to a psychiatrist or substance abuse treatment
26 program when he suspected that Patient 1 was diverting medications and when he suspected that
27 Patient 1 was dependent on the medications that Respondent was prescribing

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)**

3 72. Respondent is subject to disciplinary action under Code section 2242, subdivision (a),
4 in that he committed unprofessional conduct when he prescribed dangerous drugs to Patient 1
5 without an appropriate prior examination or medical indication therefor. Complainant refers to
6 and, by this reference, incorporates herein, paragraphs 12 through 69, above, as though fully set
7 forth herein.

8 73. Respondent's acts and/or omissions as set forth in paragraphs 12 through 69, above,
9 whether proven individually, jointly, or in any combination thereof, constitute unprofessional
10 conduct pursuant to section 2242, subdivision (a), of the Code. Therefore cause for discipline
11 exists.

12 **FOURTH CAUSE FOR DISCIPLINE**

13 **(Excessive Prescribing)**

14 74. Respondent is subject to disciplinary action under Code section 725, in that he
15 excessively prescribed dangerous drugs to Patient 1. Complainant refers to and, by this reference,
16 incorporates herein, paragraphs 12 through 69, above, as though fully set forth herein.

17 75. Respondent's acts and/or omissions as set forth in paragraphs 12 through 69, above,
18 whether proven individually, jointly, or in any combination thereof, constitute unprofessional
19 conduct pursuant to section 725. Therefore cause for discipline exists.

20 **FIFTH CAUSE FOR DISCIPLINE**

21 **(Failure to Maintain Accurate and Adequate Medical Records)**

22 76. Respondent is subject to disciplinary action under section 2266 of the Code for failing
23 to maintain adequate and accurate records relating to his care and treatment of Patient 1.
24 Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 42, 44
25 through 48, 53, 55 through 57, 59 through 63, and 68, above, as though fully set forth herein.

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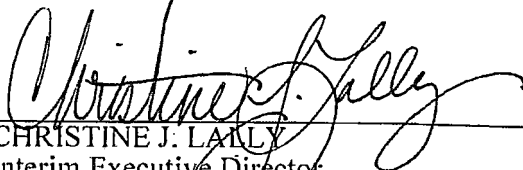
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 42267, issued to Mark Stephen Wagner, M.D.;
2. Revoking, suspending or denying approval of Mark Stephen Wagner, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Mark Stephen Wagner, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: MAR 13 2020


CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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