

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

In the Matter of the Accusation
Against:

Michael Warren Nielsen, M.D.

Physician's and Surgeon's
Certificate No. A 79412

Respondent.

Case No.: 800-2017-037990

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 January 7, 2022.

IT IS SO ORDERED: December 8, 2021.

MEDICAL BOARD OF CALIFORNIA



Richard E. Thorp, M.D., Chair
Panel B

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2 ALEXANDRA M. ALVAREZ
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9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against:

14 **MICHAEL WARREN NIELSEN, M.D.**
15 **5872 La Jolla Corona Drive**
La Jolla, CA 92037-7446

16 **Physician's and Surgeon's Certificate**
17 **No. A 79412,**

18 Respondent.

Case No. 800-2017-037990

OAH No. 2020120687

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

22 **PARTIES**

23 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
24 California (Board). He brought this action solely in his official capacity and is represented in this
25 matter by Rob Bonta, Attorney General of the State of California, by Rosemary F. Luzon, Deputy
26 Attorney General.

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1 **CULPABILITY**

2 9. Respondent does not contest that, at an administrative hearing, Complainant could
3 establish a *prima facie* case with respect to the charges and allegations contained in Accusation
4 No. 800-2017-037990, and Respondent hereby gives up his right to contest those charges.
5 Respondent further agrees that he has thereby subjected his Physician's and Surgeon's Certificate
6 No. A 79412 to disciplinary action.

7 10. Respondent agrees that if he ever petitions for early termination or modification of
8 probation, or if an accusation and/or petition to revoke probation is filed against him before the
9 Board, all of the charges and allegations contained in Accusation No. 800-2017-037990 shall be
10 deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or
11 any other licensing proceeding involving Respondent in the State of California.

12 11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 79412 is
13 subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth
14 in the Disciplinary Order below.

15 **CONTINGENCY**

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

26 13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
27 be an integrated writing representing the complete, final, and exclusive embodiment of the
28 agreements of the parties in the above-entitled matter.

1 practices course shall be at Respondent's expense and shall be in addition to the Continuing
2 Medical Education (CME) requirements for renewal of licensure.

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

8 Respondent shall submit a certification of successful completion to the Board or its
9 designee not later than 15 calendar days after successfully completing the course, or not later than
10 15 calendar days after the effective date of the Decision, whichever is later.

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

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

25 Respondent shall submit a certification of successful completion to the Board or its
26 designee not later than 15 calendar days after successfully completing the course, or not later than
27 15 calendar days after the effective date of the Decision, whichever is later.

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1 4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
2 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
3 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
4 Respondent shall participate in and successfully complete that program. Respondent shall
5 provide any information and documents that the program may deem pertinent. Respondent shall
6 successfully complete the classroom component of the program not later than six (6) months after
7 Respondent's initial enrollment, and the longitudinal component of the program not later than the
8 time specified by the program, but no later than one (1) year after attending the classroom
9 component. The professionalism program shall be at Respondent's expense and shall be in
10 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

24 The program shall consist of a comprehensive assessment of Respondent's physical and
25 mental health and the six general domains of clinical competence as defined by the Accreditation
26 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to
27 Respondent's current or intended area of practice. The program shall take into account data
28 obtained from the pre-assessment, self-report forms and interview, and the Decision(s),

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

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

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

15 If Respondent fails to enroll, participate in, or successfully complete the clinical
16 competence assessment program within the designated time period, Respondent shall receive a
17 notification from the Board or its designee to cease the practice of medicine within three (3)
18 calendar days after being so notified. The Respondent shall not resume the practice of medicine
19 until enrollment or participation in the outstanding portions of the clinical competence assessment
20 program have been completed. If the Respondent did not successfully complete the clinical
21 competence assessment program, the Respondent shall not resume the practice of medicine until a
22 final decision has been rendered on the accusation and/or a petition to revoke probation. The
23 cessation of practice shall not apply to the reduction of the probationary time period.

24 6. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this
25 Decision, Respondent shall submit to the Board or its designee for prior approval as a practice
26 monitor, the name and qualifications of one or more licensed physicians and surgeons whose
27 licenses are valid and in good standing, and who are preferably American Board of Medical
28 Specialties (ABMS) certified. A monitor shall have no prior or current business or personal

1 relationship with Respondent, or other relationship that could reasonably be expected to
2 compromise the ability of the monitor to render fair and unbiased reports to the Board, including
3 but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree
4 to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

21 The monitor(s) shall submit a quarterly written report to the Board or its designee which
22 includes an evaluation of Respondent's performance, indicating whether Respondent's practices
23 are within the standards of practice of medicine, and whether Respondent is practicing medicine
24 safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the
25 quarterly written reports to the Board or its designee within 10 calendar days after the end of the
26 preceding quarter.

27 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
28 such resignation or unavailability, submit to the Board or its designee, for prior approval, the

1 name and qualifications of a replacement monitor who will be assuming that responsibility within
2 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
3 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
4 notification from the Board or its designee to cease the practice of medicine within three (3)
5 calendar days after being so notified. Respondent shall cease the practice of medicine until a
6 replacement monitor is approved and assumes monitoring responsibility.

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

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

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

21 8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
22 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
23 advanced practice nurses.

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

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

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

6 11. GENERAL PROBATION REQUIREMENTS.

7 Compliance with Probation Unit

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

9 Address Changes

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

15 Place of Practice

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

19 License Renewal

20 Respondent shall maintain a current and renewed California physician's and surgeon's
21 license.

22 Travel or Residence Outside California

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

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

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

4 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
5 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
6 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
7 defined as any period of time Respondent is not practicing medicine as defined in Business and
8 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
9 patient care, clinical activity or teaching, or other activity as approved by the Board. If
10 Respondent resides in California and is considered to be in non-practice, Respondent shall
11 comply with all terms and conditions of probation. All time spent in an intensive training
12 program which has been approved by the Board or its designee shall not be considered non-
13 practice and does not relieve Respondent from complying with all the terms and conditions of
14 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
15 on probation with the medical licensing authority of that state or jurisdiction shall not be
16 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
17 period of non-practice.

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

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

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

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

6 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
7 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
8 completion of probation. Upon successful completion of probation, Respondent's certificate shall
9 be fully restored.

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

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

27 17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
28 with probation monitoring each and every year of probation, as designated by the Board, which

1 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
2 California and delivered to the Board or its designee no later than January 31 of each calendar
3 year.

4 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for
5 a new license or certification, or petition for reinstatement of a license, by any other health care
6 licensing action agency in the State of California, all of the charges and allegations contained in
7 Accusation No. 800-2017-037990 shall be deemed to be true, correct, and admitted by
8 Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or
9 restrict license.

10 ACCEPTANCE

11 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
12 discussed it with my attorney, David Rosenberg, Esq. I understand the stipulation and the effect
13 it will have on my Physician's and Surgeon's Certificate No. A 79412. I enter into this Stipulated
14 Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be
15 bound by the Decision and Order of the Medical Board of California.

16
17 DATED: 8-20-2021 
18 MICHAEL WARREN NIELSEN, M.D.
19 Respondent

20 I have read and fully discussed with Respondent Michael Warren Nielsen, M.D., the terms
21 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary
22 Order. I approve its form and content.

23
24 DATED: 9/3/21 
25 DAVID ROSENBERG, ESQ.
26 Attorney for Respondent

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ENDORSEMENT

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

DATED: 9/3/21

Respectfully submitted,
ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General



ROSEMARY F. LUZON
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-037990

1 XAVIER BECERRA
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10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
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13 In the Matter of the Accusation Against:

Case No. 800-2017-037990

14 **Michael Warren Nielsen, M.D.**
15 **5872 La Jolla Corona Drive**
La Jolla, CA 92037-7446

A C C U S A T I O N

16 **Physician's and Surgeon's Certificate**
17 **No. A 79412,**

18 Respondent.

19
20 **PARTIES**

21 1. William Prasifka (Complainant) brings this Accusation solely in his official capacity
22 as the Executive Director of the Medical Board of California, Department of Consumer Affairs
23 (Board).

24 2. On or about June 7, 2002, the Medical Board issued Physician's and Surgeon's
25 Certificate No. A 79412 to Michael Warren Nielsen, M.D. (Respondent). The Physician's and
26 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
27 herein and will expire on April 30, 2022, unless renewed.

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JURISDICTION

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

5 4. Section 2220 of the Code states:

6 Except as otherwise provided by law, the board may take action against all
7 persons guilty of violating this chapter. . .

8 5. Section 2227 of the Code states:

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

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

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

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

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

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

24 6. Section 2234 of the Code states:

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

28 (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.

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

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

9 ...
10 7. Section 2266 of the Code states:

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

14 8. Unprofessional conduct under section 2234 of the Code is conduct which breaches
15 the rules or ethical code of the medical profession, or conduct which is unbecoming a member in
16 good standing of the medical profession, and which demonstrates an unfitness to practice
17 medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

18 FIRST CAUSE FOR DISCIPLINE

19 (Repeated Negligent Acts)

20 9. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79412 to
21 disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of
22 the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B,
23 and C, as more particularly alleged hereinafter:¹

24 Patient A

25 10. On or about April 29, 2015, Patient A commenced treatment with Respondent as a
26 new patient. Patient A expressed interest in testosterone² replacement therapy to improve his
27 energy, libido, activity, mood, focus, and back pain management. In addition, Patient A stated
28 that he was considering changing primary care physicians. Patient A's medical history included

¹ References to "Patient A," "Patient B," and "Patient C" herein are used to protect patient
privacy.

² Testosterone is a Schedule III controlled substance pursuant to Health and Safety Code
section 11056, subdivision (f), and a dangerous drug pursuant to Business and Professions Code
section 4022.

1 chronic low back pain, hypertension, attention deficit hyperactivity disorder (ADHD), and
2 insomnia. Patient A's medications included Percocet,³ Valium,⁴ Xanax,⁵ Adderall,⁶ and Ambien.
3 During this visit, Patient A provided Respondent with a copy of a lab report dated October 9,
4 2013, when Patient A was under the care of another physician. The lab report showed a low total
5 testosterone level of 288 ng/dL.⁷ Respondent diagnosed Patient A with clinical hypogonadism.
6 Respondent did not perform any testicular or prostate examination during the visit. Respondent
7 did not order additional lab testing to confirm the low level of testosterone shown on the October
8 9, 2013, lab report. Respondent discussed testosterone replacement therapy and the potential side
9 effects with Patient A, and Patient A signed the informed consent form. Respondent prescribed
10 testosterone 200 mg/mL intramuscular (IM) injections to Patient A, to be administered on a
11 weekly basis for 90 days. Respondent noted that he would "check [the] labs in 4-5 months."

12 11. On or about July 8, 2015, Patient A had a visit with Respondent to follow up on his
13 testosterone therapy and transfer his primary care to Respondent. Respondent noted that Patient
14 A was "doing well" with his testosterone therapy. Respondent continued Patient A on his
15 regimen of testosterone 200 mg/mL weekly, and recommended that labs be performed. During
16 the visit, Patient A also reported that he was experiencing worsening back pain and was taking up
17 to six pills of Percocet 10 mg per day. Respondent noted that Patient A managed the pain
18 "moderately well so far" with at-home physical therapy, opiate medications, and benzodiazepines
19 as needed for muscle spasms. Respondent reviewed an MRI report of Patient A's lumbar spine
20 dated January 15, 2014, and documented the pertinent findings of lumbar disc herniation,

21 ³ Percocet (oxycodone and acetaminophen) is a Schedule II controlled substance pursuant
22 to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to
Business and Professions Code section 4022.

23 ⁴ Valium (diazepam) is a Schedule IV controlled substance pursuant to Health and Safety
24 Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
Code section 4022.

25 ⁵ Xanax (alprazolam) is a Schedule IV controlled substance pursuant to Health and Safety
26 Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions
Code section 4022.

27 ⁶ Adderall (dextroamphetamine and amphetamine) is a Schedule II controlled substance
pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug
pursuant to Business and Professions Code section 4022.

28 ⁷ The normal reference range for total (or serum) testosterone levels is 348-1197 ng/dL.

1 radiculopathy, and spinal canal stenosis. Respondent performed a thorough musculoskeletal
2 examination and recommended physical therapy. In addition, Respondent recommended that he
3 continue his pain management with opiates and benzodiazepines as needed, since they allowed
4 Patient A to perform daily life activities and to work. Respondent started Patient A on Percocet 5
5 mg tablets (#40) in order to assess the effectiveness of a lower dose. Respondent also discussed
6 concerns about combining opiates and benzodiazepines with Patient A.

7 12. On or about July 17, 2015, Respondent placed an order for labs for Patient A. The
8 results showed an excessively high serum testosterone level of 1457 ng/dL. The results also
9 showed an abnormally high LDL cholesterol level of 146 mg/dL,⁸ as well as increasing
10 erythrocytosis.⁹ Respondent did not see Patient A again until on or about October 12, 2015, and
11 he did not make any changes to Patient A's testosterone therapy in the interim.

12 13. On or about October 12, 2015, Patient A had a follow-up visit with Respondent.
13 Respondent noted that Patient A was "doing well" with his testosterone therapy, had no
14 complaints, and reported improvements in his energy and libido. In addition, Respondent noted
15 that the July 17, 2015, lab results showed a "marked increase in testosterone levels." Respondent
16 reviewed the results with Patient A. Respondent continued Patient A on his regimen of
17 testosterone 200 mg/mL weekly, and noted that labs should be repeated in "6 -12 months."
18 Regarding Patient A's back pain, Respondent noted that Patient A was still unable to do most
19 physical activities due to his back pain and required Percocet 10 mg, as much as six times a day,
20 to manage the pain. Patient A reported trying Percocet 5 mg, but ended up having to take two
21 pills at a time. He also reported using Xanax for muscle spasms with good relief, mostly at night
22 at a frequency of less than one pill per day. Respondent noted that Patient A's back pain was not
23 significantly worsening and he did not exhibit any red flags. He also noted that Patient A's use of
24 Percocet 10 mg several times a day was necessary for him to work and perform daily life
25 activities, that he had been on this dose for years without problems, and had no history of abuse,
26

27 ⁸ The normal reference range for LDL cholesterol levels is 0-99 ng/dL.

28 ⁹ Erythrocytosis refers to the increased production of red blood cells (erythrocytes).

1 addiction, or alcohol use. Respondent recommended that Patient A continue to manage his back
2 pain with heat, NSAIDs, and physical therapy. Respondent continued Patient A on Percocet
3 (#60) and increased the dosage from 5 mg to 10 mg. He noted that Patient A still had Xanax at
4 home, and he discussed the side effects of using opiates and benzodiazepines together with
5 Patient A.

6 14. On or about December 2, 2015, Patient A had a follow-up visit with Respondent.
7 Patient A reported continued improvements in his “well being,” sex drive, and energy.
8 Respondent noted that Patient A was “doing well” with his testosterone therapy and continued
9 him on his regimen of testosterone 200 mg/mL weekly. Patient A also reported that Xanax was
10 not lasting long enough and that he was awoken by muscle spasms on some nights. Patient A
11 described his back pain as getting “mildly worse,” which he attributed to his increased activity
12 level, but he otherwise reported no change in the character or quality of the pain. Respondent
13 continued Patient A on Percocet 10 mg, and discussed addiction and alcohol avoidance with him.
14 In addition, Respondent substituted Xanax with Valium 10 mg, due to its longer duration of
15 therapy for muscle spasm relief, which he discussed with Patient A. He also prescribed Ambien
16 12.5 mg to Patient A.

17 15. On or about January 29, 2016, Patient A saw Respondent to refill his Adderall
18 medication. Patient A showed Respondent an old prescription bottle and informed him that he
19 had been taking Adderall for “many years . . . off and on,” which his prior physician prescribed.
20 Patient A also stated that while he had taken other medications in the past, Adderall worked best
21 for him and had no significant side effects. Patient A asked Respondent to refill his Adderall
22 since Patient A only wanted to see him for all of his medical issues. Respondent prescribed
23 Adderall 20 mg, twice a day, to Patient A.

24 16. On or about February 10, 2016, Respondent placed an order for labs for Patient A.
25 The results continued to show erythrocytosis with elevated hematocrit, an increased total
26 cholesterol level of 238 mg/dL,¹⁰ including a high LDL cholesterol level of 115 mg/dL, and an

27 ¹⁰ The normal reference range for total cholesterol levels is 100-199 mg/dL.
28

1 increased free testosterone level of 39.7 pg/mL.¹¹ Respondent continued Patient A on his
2 regimen of testosterone 200 mg/mL weekly.

3 17. On or about March 24, 2016, April 15, 2016, and May 17, 2016, respectively, Patient
4 A saw Respondent. During the March 24, 2016, and May 17, 2016 visits, Respondent
5 recommended that Patient A go to a pain clinic for epidural spinal injections, but Patient A
6 declined. During these visits, Respondent continued Patient A on Percocet and Valium, along
7 with physical therapy. Respondent also continued Patient A on Adderall. During the April 15,
8 2016, visit, Respondent discussed trying a short-acting benzodiazepine again with Patient A, and
9 he prescribed Xanax to Patient A. On or about May 17, 2016, Respondent noted that Patient A
10 was using Valium and Xanax for muscle spasms, but not at the same time.

11 18. On or about June 15, 2016, Patient A saw Respondent to refill his pain medications
12 and Adderall. Respondent noted that Patient A had been on testosterone therapy for
13 approximately one year and was "doing well." Patient A reported that his pain was controlled
14 with Percocet, but felt it was not as effective and had to take two pills at once sometimes.
15 Respondent noted that he checked the CURES database and confirmed that no additional
16 controlled medications were being prescribed to Patient A. Respondent prescribed Percocet 10
17 mg to Patient A, but increased the number of pills from #60 to #75. Respondent also prescribed
18 Adderall to Patient A and renewed his testosterone prescription. Respondent noted that he placed
19 an order for labs and reminded Patient A to get them done.

20 19. On or about July 15, 2016, Respondent placed an order for labs for Patient A. The
21 results continued to show a high total testosterone level of 1575 ng/dL and a high total cholesterol
22 level of 246 mg/dL, including a high LDL cholesterol level of 119 mg/dL. The results also
23 showed a new finding of abnormal liver function test, with a high aspartate aminotransferase
24 (AST) level of 195 IU/L.¹² Respondent continued Patient A on his regimen of testosterone 200
25 mg/mL weekly.

26
27 ¹¹ The normal reference range for free testosterone levels is 8.7-25.1 pg/mL.

28 ¹² The AST test is a blood test that checks for liver damage. The normal reference range
for AST levels is 0-40 IU/L.

1 20. On or about July 19, 2016, Patient A saw Respondent to refill his pain medications.
2 Respondent noted that he reviewed the July 17, 2016, lab results with Patient A. Respondent did
3 not document anything else regarding the lab results, including the abnormal findings.

4 21. Between on or about August 12, 2016, and December 6, 2016, Patient A saw
5 Respondent on approximately four occasions. Patient A reported that his back pain was not
6 improving and he had to take up to three Percocet pills a day on many days, but still had to miss
7 work one day every two weeks due to pain. Respondent told Patient A that he should use a
8 benzodiazepine as a muscle relaxer to decrease his pain, instead of increasing his Percocet use,
9 and that he should not take both medications at the same time. Respondent continued Patient A
10 on Percocet 10 mg, but increased the number of pills from #75 to #90. He also continued Patient
11 A on Valium, Xanax, Adderall, and testosterone.

12 22. In or about 2017, Patient A saw Respondent on a monthly basis to refill his
13 medications. On or about January 11, 2017, Patient A reported that he was taking three to four
14 Percocet pills a day for pain and asked Respondent to increase the quantity of pills prescribed.
15 Respondent told Patient A to first try more regular use of heat and his benzodiazepine
16 medications before increasing his opiate medication.

17 23. On or about February 22, 2017, Respondent increased Patient A's Percocet 10 mg
18 pills from #90 to #120. On or about April 6, 2017, Respondent again recommended that Patient
19 A go to a pain clinic for epidural spinal injections. Respondent also discussed alternative pain
20 medications such as tramadol with Patient A, but Patient A was not receptive. As of this visit,
21 Patient A was taking Percocet 10 mg (#90). In addition, Patient A reported that Adderall was
22 working well for him and, although he was not taking it every day as per Respondent's
23 suggestion, he preferred to take it more consistently. Respondent encouraged Patient A to
24 decrease his Adderall use. Respondent prescribed Adderall to Patient A, but lessened the dosage.

25 24. On or about June 29, 2017, Patient A continued to report worsening back pain,
26 causing him to take four to five Percocet pills a day, use all of his Valium, and try acupuncture
27 treatment without change. He inquired about taking both Valium and Xanax in the same day, for
28 short acting relief during the day and long acting relief at night. He also asked Respondent to

1 increase his Percocet dosage to six pills per day. Respondent encouraged Patient A to continue
2 with acupuncture and consider alternative pain relief therapy such as transcutaneous electrical
3 nerve stimulation (TENS), which Patient A declined. Respondent increased Patient A's Percocet
4 10 mg pills from #90 to #120, advising him that four pills a day was the most he was comfortable
5 prescribing to him. He also prescribed Valium, Xanax, and Adderall to Patient A. He discussed
6 addiction and side effect risks with Patient A and cautioned him against using Valium and Xanax
7 at the same time.

8 25. For the remainder of 2017, Respondent continued Patient A on Percocet 10 mg,
9 ranging from #90 to #120 pills, as well as Valium and Xanax. He also continued Patient A on
10 Adderall and testosterone, at his same regimen of 200 mg/mL weekly.

11 26. During the entirety of 2017, no labs were ordered or performed to monitor Patient A's
12 testosterone therapy. In addition, between on or about January 29, 2016, and November 24, 2017,
13 Respondent did not document Patient A's vital signs, including his blood pressure, history of
14 present illness, or physical examination, with the exception of one visit, which took place on or
15 about July 26, 2017.

16 27. On or about January 18, 2018, Patient A saw Respondent and reported elevated blood
17 pressure during home monitoring. Respondent did not take Patient A's blood pressure during this
18 visit. Respondent's diagnosis was mild hypertension and prescribed amlodipine 2.5 mg to Patient
19 A. Patient A subsequently saw Respondent during near monthly visits, but Respondent did not
20 take Patient A's blood pressure until on or about August 8, 2018.

21 28. On or about August 28, 2018, Respondent placed an order for labs for Patient A. The
22 results showed a high free testosterone level of 30.4 pg/dL, a high AST level of 107 IU/L, and a
23 high total cholesterol level of 344 mg/dL, with a high LDL cholesterol level of 281 mg/dL.
24 Respondent did not document any assessment or discussion of the August 28, 2018, lab results in
25 any subsequent visits with Patient A in 2018.

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1 29. Between on or about January 18, 2018, and December 27, 2018, Respondent
2 continued Patient A on Percocet 10 mg (#120), Valium, Xanax, and Adderall. He also continued
3 Patient A on his regimen of testosterone 200 mg/mL weekly. During this timeframe, Respondent
4 did not document any vital signs, history of present illness, or physical examination of Patient A,
5 except on the August 8, 2018 visit.

6 30. During Respondent's care and treatment of Patient A, between on or about April 29,
7 2015, and December 27, 2018, Respondent did not require Patient A to sign a pain management
8 contract, did not order any urine toxicology testing, and did not perform any testicular or prostate
9 examination of Patient A. In addition, Respondent's chart for Patient A did not include a signed
10 copy of Patient A's HIPAA authorization form.

11 31. Respondent committed repeated negligent acts in his care and treatment of Patient A,
12 which included, but were not limited to the following:

13 A. Respondent improperly managed Patient A's testosterone replacement
14 therapy by failing to clinically address the potential side effects of testosterone
15 replacement therapy exhibited by Patient A, including abnormally high liver function
16 tests and high cholesterol; and by failing to reduce Patient A's testosterone dosage
17 despite abnormally high testosterone levels.

18 B. Respondent prescribed Adderall to Patient A on a chronic basis without
19 confirming Patient A's ADHD diagnosis.

20 C. Respondent improperly managed Patient A's hypertension by failing to
21 obtain regular blood pressure readings during Patient A's visits; and by failing to
22 reduce, or consider reducing, Patient A's testosterone and Adderall dosages in
23 response to Patient A's hypertension.

24 D. Respondent failed to recognize, evaluate, and address Patient A's
25 abnormal liver function tests.

26 E. Respondent improperly managed Patient A's hyperlipidemia by failing to
27 recognize, evaluate, and address Patient A's high cholesterol levels; by failing to
28 reduce, or consider reducing, Patient A's testosterone dosage in response to Patient

1 A's hyperlipidemia; and by failing to start, or consider starting, Patient A on anti-
2 cholesterol therapy.

3 F. Respondent improperly managed Patient A's chronic opiate therapy by
4 failing to properly assess addiction risks prior to prescribing Percocet to Patient A; by
5 failing to establish a multi-faceted pain management plan; by failing to have a pain
6 management contract; and by failing to order any urine toxicology testing.

7 G. Respondent improperly prescribed benzodiazepines to Patient A by
8 prescribing Valium and Xanax to Patient A simultaneously.

9 H. Respondent improperly prescribed opiates to Patient A by prescribing
10 Percocet to Patient A concurrently with a benzodiazepine.

11 I. Respondent failed to maintain adequate and accurate records regarding
12 his care and treatment of Patient A by failing to regularly document Patient A's
13 history of present illness, physical examinations, and vital signs, including Patient A's
14 blood pressure levels; and by failing to maintain a signed copy of Patient A's HIPAA
15 authorization form.

16 **Patient B**

17 32. On or about February 24, 2016, Patient B commenced treatment with Respondent for
18 possible testosterone replacement therapy. Patient B complained of fatigue, decreased libido, and
19 weight gain, and his health goals were weight loss, increased muscle mass and strength, and
20 increased libido. Patient B told Respondent that he had done a previous lab test, which showed
21 below normal total and free testosterone levels. Respondent documented that the lab results were
22 notable for a total testosterone level of less than "300," a free testosterone level of less than "8,"
23 and an estradiol level of "30." The lab report was not included in Patient B's chart. Respondent
24 did not document any additional information from the lab report, including the laboratory name,
25 the test date, or other findings such as prostate-specific antigen (PSA),¹³ liver function, or
26 cholesterol values. Respondent diagnosed Patient B with clinical hypogonadism. Patient B
27

28 ¹³ The PSA test is a blood test used primarily to screen for prostate cancer.

1 declined a testicular and prostate examination during the visit. Respondent did not order
2 additional lab testing to confirm Patient B's low testosterone levels. Respondent also did not
3 order baseline lab testing to obtain complete blood count (CBC), PSA, lipid, and liver function
4 values. Respondent discussed testosterone therapy with Patient B and its potential side effects,
5 and Patient B signed the informed consent form. Respondent prescribed testosterone 200 mg/mL
6 intramuscular (IM) injections to Patient B, to be administered once a week for 90 days.
7 Respondent noted that he would "check [the] labs in 4-5 months."

8 33. On or about August 24, 2016, Patient B saw Respondent to follow up on his
9 testosterone therapy. Patient B reported small improvements in his libido, energy, muscle mass,
10 and morning erections. He also reported mild testicular shrinkage. No physical examination was
11 done during this visit, including a testicular or prostate examination. Respondent reviewed the
12 results of lab testing performed two days earlier, on or about August 22, 2016. The results
13 showed normal total and free testosterone levels of 657 ng/dL and 15 pg/mL, respectively, as well
14 as normal hemoglobin. PSA, liver panel, and cholesterol panel testing were not performed.
15 Respondent noted that Patient B's testosterone levels had improved from pre-treatment levels,
16 and Patient B expressed interest in increasing his testosterone dosage. Respondent continued
17 Patient B on testosterone and increased his weekly testosterone dosage from 200 mg/mL to 240
18 mg/mL.

19 34. Respondent did not have a follow-up visit with Patient B until approximately one
20 year later, on or about August 26, 2017. Respondent's chart did not include any notes reflecting
21 any physical examinations of Patient B, lab testing, or any other contact with Patient B in the
22 interim.

23 35. On or about August 26, 2017, Patient B was scheduled to see Respondent to follow
24 up on his testosterone therapy, but Patient B was unable to make the office visit in person.
25 Respondent conducted the follow-up visit by phone. Patient B reported that he was happy with
26 his treatment and had no complaints. Respondent noted that there were no new labs for him to
27 review and he encouraged Patient B to get follow-up labs done. Respondent also noted that he
28 "reassured [Patient B] that treatment is based on symptom values versus lab results" and he "will

1 continue [the] treatment protocol despite no new labs[.]” Respondent continued Patient B on his
2 regimen of testosterone 240 mg/mL weekly and told Patient B to have a follow-up visit with the
3 clinic in “one year.”

4 36. Between on or about July 25, 2017, and April 24, 2018, Patient B filled
5 approximately four prescriptions of testosterone, which Respondent prescribed. With the
6 exception of the August 26, 2017, encounter, Respondent did not have any follow-up visits with
7 Patient B during this timeframe, and his chart did not include any notes reflecting any physical
8 examinations of Patient B, lab testing, or any other contact with Patient B. In addition,
9 Respondent’s chart for Patient B did not include a signed copy of Patient B’s HIPAA
10 authorization form.

11 37. Respondent committed repeated negligent acts in his care and treatment of Patient B,
12 which included, but were not limited to the following:

13 A. Respondent improperly managed Patient B’s testosterone replacement
14 therapy by failing to monitor treatment through office visits, physical examinations,
15 and lab testing; and by increasing Patient B’s testosterone weekly dosage beginning
16 on or about August 24, 2016, despite normal testosterone levels.

17 B. Respondent failed to maintain adequate and accurate records regarding
18 his care and treatment of Patient B by failing to document relevant lab values during
19 the initial February 24, 2016, visit; by failing to have regular follow-up labs; and by
20 failing to maintain a signed copy of Patient B’s HIPAA authorization form.

21 **Patient C**

22 38. Between on or about November 7, 2016, and November 17, 2017, Patient C filled
23 approximately 10 prescriptions of testosterone, which Respondent prescribed. For the
24 prescriptions filled on or about November 7, 2016, December 17, 2016, January 24, 2017, March
25 1, 2017, April 11, 2017, June 7, 2017, and August 2, 2017, respectively, the prescribed dosage
26 was 100 mg. For the prescriptions filled on or about August 28, 2017, October 12, 2017, and
27 November 17, 2017, respectively, the prescribed dosage increased to 200 mg.

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(General Unprofessional Conduct)**

3 42. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79412 to
4 disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct
5 which breaches the rules or ethical code of the medical profession, or conduct which is
6 unbecoming to a member in good standing of the medical profession, and which demonstrates an
7 unfitness to practice medicine, as more particularly alleged in paragraphs 10 through 41, above,
8 which are hereby incorporated by reference and realleged as if fully set forth herein.

9 **PRAYER**

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

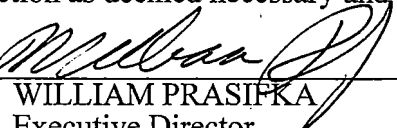
12 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 79412, issued
13 to Respondent Michael Warren Nielsen, M.D.;

14 2. Revoking, suspending or denying approval of Respondent Michael Warren Nielsen,
15 M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and
16 advanced practice nurses;

17 3. Ordering Respondent Michael Warren Nielsen, M.D., if placed on probation, to pay
18 the Board the costs of probation monitoring; and

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

20 DATED: OCT 19 2020

21 
22 WILLIAM PRASIFKA
23 Executive Director
24 Medical Board of California
25 Department of Consumer Affairs
26 State of California
27 Complainant

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