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

In the Matter of the First Amended Accusation Against: Ali Mokhlesi, M.D. Physician's & Surgeon's Certificate No. C 51972 Respondent.	Case No. 800-2019-055815

DECISION

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

This Decision shall become effective at 5:00 p.m. on May 29, 2023.

IT IS SO ORDERED: April 28, 2023.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **ALI MOKHLESI, M.D.** 11795 Education Street # 100 Auburn, CA 95602 Physician's and Surgeon's Certificate No. C 51972 Respondent.	Case No. 800-2019-055815 OAH No. 2021020285 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Reji Varghese ("Complainant") is the Deputy Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by John S. Gatschet, Deputy Attorney General.

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2. Respondent Ali Mokhlesi, M.D. ("Respondent") is represented in this proceeding by attorney Nicole D. Hendrickson, whose address is:

LaFollette, Johnson, DeHaas, Fesler & Ames, PC
655 University Avenue, Suite 119
Sacramento, CA 95825

3. On or about June 8, 2005, the Board issued Physician's and Surgeon's Certificate No. C 51972 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-055815, and will expire on November 30, 2024, unless renewed.

JURISDICTION

4. First Amended Accusation No. 800-2019-055815 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on March 1, 2022. Respondent timely filed his Notice of Defense contesting both the Accusation and the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2019-055815 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2019-055815. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2019-055815, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a *prima facie* basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

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

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14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT the Physician's and Surgeon's Certificate No. C 51972 issued to Respondent Ali Mokhlesi, M.D. shall be and is hereby publically reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with First Amended Accusation No. 800-2019-055815, is as follows:

"On or between November 19, 2013, and May 2019, while treating Patients 1, 2, 3, and 4, you failed to meet the standard of care for the proper prescription of controlled substances as more fully described in First Amended Accusation No. 800-2019-055815."

B. PRESCRIBING PRACTICES COURSE

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. On or about April 26-28, 2021, Respondent attended and completed the U.C. San

Diego PACE programs' "Physician Prescribing Course."

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later. Respondent may submit the certificate of completion from the April 26-28, 2021, "Physician Prescribing Course" to satisfy this term.

C. **MEDICAL RECORD KEEPING COURSE**

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

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. On or about April 29-30, 2021, Respondent attended and completed the U.C. San Diego PACE programs' Medical Record Keeping Course.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later. Respondent may submit the certificate of completion from the April 29-30, 2021, "Medical Record Keeping Course" to satisfy this term.

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D. PROFESSIONALISM PROGRAM (ETHICS COURSE)

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

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision. On or about January 7, 2023, Respondent enrolled to take the Western Institute of Legal Medicine, Inc.'s "Medical Ethics and Professionalism Course" scheduled to take place January 22-23, 2023.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later. Upon successful completion of the January 22-23, 2023, "Medical Ethics and Professionalism Course," Respondent may submit the certificate from that course to satisfy this condition.

E. CLINICAL COMPETENCE ASSESSMENT PROGRAM

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than one (1) year after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension

of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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

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

F. INVESTIGATION/ENFORCEMENT COST RECOVERY

Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation, as applicable, in the amount of **$15,000.00** (fifteen thousand dollars). Costs shall be due and payable to the Medical Board of California.

Payment must be made in full within ninety (90) days of the effective date of the Order. The filing of bankruptcy by Respondent shall not relieve Respondent of the responsibility to repay investigation and enforcement costs, including expert review costs. This condition shall be

monitored by the Probation Department.

G. FAILURE TO COMPLY

If Respondent fails to enroll, participate in, or successfully complete the educational program or course, described in conditions B, C, D, and E, within the designated time period set forth in each condition, Respondent shall receive and comply with a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the educational program(s) or course(s) has been completed as required by the express language of the Decision and Order. In addition, failure to successfully complete the education program(s) or course(s) outlined above shall also constitute general unprofessional conduct and is grounds for further immediate disciplinary action.

If Respondent fails to reimburse the Board as described in condition F, within the designated time period, Respondent shall receive and comply with a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until the full payment of the investigative and enforcement costs have been paid to the Board. In addition, failure to successfully reimburse the Board as outlined above shall also constitute general unprofessional conduct and is grounds for further immediate disciplinary action.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Nicole D. Hendrickson. 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: 1/12/23

ALI MOKHLESI, M.D.
Respondent

I have read and fully discussed with Respondent Ali Mokhlesi, 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: 01/13/2023

NICOLE D. HENDRICKSON
Attorney for Respondent

ENDORSEMENT

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

DATED: January 13, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2019-055815

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Attorneys for Complainant

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

In the Matter of the First Amended Accusation Against: **Ali Mokhlesi, M.D.** **11795 Education Street, Suite #100** **Auburn, CA 95602** Physician's and Surgeon's Certificate No. C 51972, Respondent.	Case No. 800-2019-055815 **FIRST AMENDED ACCUSATION**

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

2. On or about June 8, 2005, the Board issued Physician's and Surgeon's Certificate Number C 51972 to Ali Mokhlesi, M.D. ("Respondent"). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2022, unless renewed.

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JURISDICTION

3. On November 17, 2020, the Board properly filed an Accusation in Case No. 800-2019-055815 and served that Accusation on Respondent's address of record with the Board. The First Amended Accusation contains the same allegations and causes for discipline that were alleged in the Accusation filed on November 17, 2020.

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

5. Section 2227 of the Code provides, in pertinent part, that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2228.1 of the Code, states in pertinent part:

> (a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:
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> (1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:
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> ...
>
> (D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.
>
> (2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre1 or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

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

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

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

(b) Gross negligence.

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

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

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

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COST RECOVERY

8. Section 125.3[1] of the Code, states in pertinent part:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

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[1] Effective January 1, 2022. As amended by 2021 Cal.Legs.Serv.Ch. 649 (S.B. 806)(WEST), the Board will be seeking costs of investigation and enforcement incurred after January 1, 2022, to comply with the legislature's intent that investigative and enforcement costs be imposed in Medical Board disciplinary matters. The Board's amendment of the Accusation to add Bus. & Prof. Code section 125.3 does not involve the statute of limitations pursuant to Bus. & Prof. Code section 2230.5. The underlying allegations upon which the Board will make findings related to whether the Respondent committed unprofessional conduct were filed before the expiration of the statute of limitations. The collection of costs for the investigation and prosecution of the disciplinary matter is instead related to the imposition of discipline. The amendment to add Bus. & Prof. Code 125.3 is in line with the express legislative intent of the California legislature in Senate Bill 806.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

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

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

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

DEFINITIONS

9. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for the treatment of long-term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of more times more potent than heroin.[2] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (c).

10. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Hydrocodone with acetaminophen is a

[2] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12.[3] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

11. Oxycodone – Generic name for Roxicodone and Oxecta. Oxycodone has a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short-acting opioid analgesic used to treat moderate to severe pain. Oxycodone can also come in a long-acting formulation known as Oxycontin-ER. This formulation allows for extended release of the medication. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022, and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055 subdivision (b).

12. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Zolpidem tartrate – Generic name for Ambien. Zolpidem tartrate is a sedative and hypnotic used for short-term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Morphine sulfate – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system

[3] Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e).

(CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Temazepam – Generic name for the drug Restoril. Temazepam is a used on a short-term basis to treat insomnia. Temazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14 subdivision (c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

Patient 1

17. Patient 1[4] first began seeing the Respondent in 2006[5] after the Respondent joined the medical practice where she was an existing patient. Patient 1 suffered from severe chronic pain, which she described as being caused by constant back pain and joint pains. A CT scan conducted in 2003 indicated that Patient 1 had severe spinal stenosis. Patient 1 had prior diagnoses of myalgia, myositis, and fibromyalgia. Patient 1 also had a history of depression and was on antidepressant medication. According to the Respondent, Patient 1 was already receiving prescriptions of high dose opioids at the time that he took over her care. Patient 1 was relatively immobile and required 24 hour care by her children.

[4] All witnesses have been identified by numerical characters in order to protect confidentiality. All witnesses will be fully identified in discovery.

[5] Conduct occurring before November 19, 2013, is for historical context only and does not serve as an independent basis for discipline.

18. On or about December 2013, the Respondent prescribed a monthly prescription of 180 tablets of 10-325 mg hydrocodone with acetaminophen and 60 tablets of 100 mg morphine sulfate to Patient 1. That prescription continued on a monthly basis until August 2018. In addition, Patient 1 received Lyrica, a Schedule V controlled substance, from October 2012 until February 2018 on a regular basis. As prescribed, the Respondent's prescriptions to Patient 1 between December 2013 and August 2018 had a Morphine Equivalent Dose of 260 MED.[6] A review of a CURES[7] report on Patient 1 indicates that the Respondent began to taper down Patient 1's opioid prescriptions starting in August 2018. For example, in May 2019, the Respondent prescribed a monthly prescription of 60 tablets of 60 mg. morphine sulfate, 60 tablets of 15 mg. morphine sulfate, and 120 tablets of 10-325 mg. hydrocodone with acetaminophen to Patient 1. As prescribed, the Respondent's prescription to Patient 1 in May 2019 had a MED of 190.

19. Between December 2013 and May 2019, the Respondent failed to provide a clear treatment plan and assessment for the conditions necessitating the continued prescribing of controlled substances. For example, the Respondent failed to document that Patient 1 had "severe spinal stenosis" in the medical chart despite it being previously evidenced in a 2003 scan. Respondent originally documented that he prescribed MS Contin for myalgia and myositis but over time began associating the prescription with a lumbar fracture, knee pain, history of a recurrent vertebral fracture and mid-line pain. The Respondent failed to document why he changed the treatment plan for MS Contin to treat those conditions. During an interview with the Board, the Respondent stated that Patient 1 appeared to suffer from Fibromyalgia but he failed to adequately document Fibromyalgia in his treatment notes and never fully addressed Fibromyalgia in Patient 1's medical record.

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[6] Morphine Equivalent Dose ("MED"), is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. The California Medical Board Guidelines issued in November 2014 stated that any physicians should proceed cautiously (yellow flag warning) once an MED reaches 80 mg per day. http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf at page 17.

[7] Controlled Substance Utilization Review and Evaluation System (CURES) is a database maintained by the California Department of Justice, which tracks all controlled drug prescriptions that are dispensed in the State of California.

20. Between December 2013 and May 2019, the Respondent failed to examine the source of why Patient 1 suffered from a neurogenic bladder and whether her medications were causing urinary retention. The Respondent failed to discuss the fact that Patient 1's bedridden status may have contributed to her compression fracture due to osteopenia, nor did he discuss osteopenia in his treatment notes. The Respondent failed to use pain scales or urine toxicology screens as part of a treatment plan and periodic review of Patient 1's controlled substances despite prescribing high dose opioids to Patient 1. Between December 2013 and May 2019, the respondent failed to document that he could not provide urine toxicology screens through Patient 1's medical provider group. The Respondent failed to document on-going objective testing as part of a treatment plan and instead his periodic review of Patient 1's pain conditions relied heavily on Patient 1 and Patient 1's family's subjective report of pain.

21. On or about September 3, 2014, and February 13, 2017, Patient 1 entered into and signed a pain management agreement with the Respondent. The pain management agreement included information that stated pain medications can cause side effects including making the person sleepy and slow down reflexes, that alcohol can make pain medication side effects worse, and that pain medications with narcotics can be addictive. In July 2014, Patient 1's family members requested Ativan for Patient 1 because Patient 1 was suffering from withdrawal symptoms following a bowel cleanse. On or about July 25, 2014, the Respondent documented that Ativan was unnecessary as the absorption issues would resolve and that, "with all the medications (Patient 1) was taking, we do not want to sedate her brain further, as she may stop breathing." On or about February 13, 2015, the Respondent documented an e-mail exchange with an individual regarding Patient 1's care where he noted that he could not increase Patient 1's medications because, the "medications are making her respiratory drive to be shut down." The Respondent also documented that he believed Patient 1 had sleep apnea, that small amounts of movement cause her to be out of breath, and that he feared stronger pain medications, could "stop her breathing drive." The Respondent also documented that he mentioned "intense scrutiny" from the DEA on prescriptions. On or about August 30, 2017, the Respondent documented that he discussed with Patient 1 that her pain medication levels were already on the high side.

22. Between December 2013 and May 2019, the Respondent repeatedly documented that Patient 1 suffered from side effects consistent with her medication regimen. These documented side effects included constipation, somnolence, and inactivity progressing to bedridden status with decubitus ulcers, urinary retention with a Foley catheter, falls, and forgetfulness. Between December 2013 and May 2019, the Respondent failed to document whether he discussed these side effects and how they may directly relate to the controlled substances that he was prescribing to either the patient or a designated caregiver as part of providing a fully informed consent.

23. Between December 2013 and May 2019, the Respondent failed to adequately refer and/or document referring Patient 1 for specialty consultations for Patient 1. The Respondent documented that Patient 1 was seen by orthopedics for consultations on a few occasions but there is no other mention of any other referrals until Patient 1's family requested a referral to pain management on or about May 6, 2019. During an interview with the Board, the Respondent stated prior to 2017, there was only one specialist in Patient 1's health network for a pain management referral but there is no documentation that Patient 1 was referred to that one specialist, nor an explanation in the records that Respondent had no options available to provide a pain management referral. Between December 2013 and May 2019, the Respondent failed to refer and/or document referring Patient 1 for psychiatric consultation, a rheumatology consultation, and/or a physical medicine consultation. While the Respondent stated in his interview with the Board that a psychiatric consultation was difficult to arrange for his patients, the Respondent failed to document this fact in Patient 1's medical chart.

Patient 2

24. Patient 2 began seeing the Respondent in May 2008 after her previous medical provider left the practice. The Respondent initially saw her for follow-up related to treatment for diabetes, depression, back pain, insomnia and psoriasis. Patient 2 was noted to have constant back pain caused by fibromyalgia, that her pain increased when she walked, and that she had a difficult time walking. Patient 2 also had a history of thoracic outlet syndrome and had previously had surgery eight years earlier for that condition. In 2009, the Respondent referred Patient 2 to a pain management specialist in the area for interventional pain management. While

the pain management specialist determined Patient 2 was not a good candidate for pain management, the pain management specialist's office took over Patient 2's chronic pain management and that office prescribed those medications between 2009 and 2014. The pain management specialist closed their office in 2014 and Patient 2 returned to Respondent's primary care practice for continued pain management treatment.

25. On or about January 2015, the Respondent prescribed a monthly prescription of 270 10 mg. methadone tablets and a two-month prescription of 60 tablets of 10 mg. diazepam to Patient 2. The methadone and diazepam prescriptions continued on a monthly basis until June 2016. The MED of these prescriptions was 1080 MED[8] while in combination with a benzodiazepine. The Respondent suddenly discontinued Patient 2's diazepam prescription in June 2016. The Respondent continued Patient 2's methadone prescription until October 2016. On or about November 2016 through September 2019 the Respondent slowly tapered down Patient 2's methadone prescription. By September 2019, the Respondent was prescribing a monthly prescription of 120 tablets of 10 mg. methadone tablets to Patient 2. In comparison to the prescription in January 2015, the prescription in September 2019 had an MED of 320.

26. Between December 2013 and May 2019, the Respondent failed to create and/or document creating a clear treatment plan for Patient 2's chronic pain medication. Between December 2013 and May 2019, the Respondent failed to perform and/or document performing a clear and consistent assessment of Patient 2's progress on controlled substances. For example, during an interview with the Board, the Respondent stated he managed Patient 2's fibromyalgia but he failed to sufficiently document the care and treatment of fibromyalgia in Patient 2's medical chart. The Respondent documented multiple diagnoses for Patient 2 between December 2013 and May 2019, including depression, diabetic neuropathy, thoracic neuritis, low back pain, low back pain syndrome, back pain, chronic low back pain, insomnia, thoracic outlet syndrome, lumbago, and lumbar stenosis with neurogenic claudication. However, the Respondent failed to properly detail these diagnoses in Patient 2's medical chart. For example, on or about October

[8] The MED was calculated using the following on-line tool. http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

11, 2016, the Respondent documented that Patient 2 suffered from sciatica but he failed to properly document a review of systems and/or document a physical examination that supported his diagnosis of sciatica.

27. Between December 2013 and May 2019, the Respondent repeatedly failed to provide clear clinical objectives in relation to Patient 2's chronic pain management. For example, the Respondent documented that the goal in March 20, 2019, was to decrease Patient 2's methadone prescriptions to an amount covered by insurance, not whether that decrease was clinically optimal for the patient. Between December 2013 and May 2019, the Respondent failed to sufficiently use pain scales and urine toxicology screens as part of a comprehensive plan to perform periodic review of Patient 2's progress on chronic pain management. In addition, the Respondent failed to document why pain scales and urine toxicology screens were not used in Patient 2's chart despite her high dosing of methadone. Finally, between December 2013 and May 2019, Respondent's periodic review of Patient 2's progress on chronic pain management relied on Patient 2's subjective reports of pain rather than on objective clinical findings.

28. Between December 2013 and May 2019, the Respondent failed to properly create and/or document creating a clear and delineated treatment plan for the tapering of Patient 2's medications. For example, prior to tapering Patient 2's methadone prescription, the Respondent prescribed the medication to be taken five times per day with no breakthrough pain medicine option despite methadone having a relatively long half-life for absorption. The Respondent often listed in the medical chart that Patient 2 should take 1 to 2 tablets of methadone every 6 to 8 hours "prn[9]". In addition, Respondent continued Patient 2's methadone prescription while tapering down her prescription based on a subjective review of how much methadone she seemed to need by examining how much she was using. On or about April 1, 2016, a nurse verbally instructed Patient 2 to decrease her Valium prescription to 1 tablet daily and referenced instructions from a March 24, 2016, set of instructions regarding Patient 2 beginning to take Cymbalta. On or about June 10, 2016, the Respondent provided one last 30-day supply of 60 tablets of 10 mg. Valium.

[9] P.R.N., medical abbreviation meaning "when necessary" from the Latin phrase "pro re nata."

There was no other documentation contained in the medical record regarding the discontinuation of Valium in Patient 2's chart.

29. On or about January 2, 2015, April 26, 2017, and October 22, 2019, Patient 2 entered into and signed a pain management agreement. The pain management agreement included information that stated pain medications can cause side effects including making the person sleepy and slow down reflexes, that alcohol can make pain medication side effects worse, and that pain medications with narcotics can be addictive. Between December 2013 and May 2019, the Respondent documented a number of side effects from Patient 2's medication regimen including constipation, somnolence, falls, balance issues, memory issues, and confusion. However, Respondent failed to fully counsel and/or document fully counseling Patient 2 that these side effects may be related to her medications in Patient 2's medical chart.

30. Between December 2013 and May 2019, the Respondent failed to properly refer and/or document referring Patient 2 for specialist services. While there is mention of orthopedics, neurology, and physical therapy, there is little evidence that the Respondent made sufficient referrals for Patient 2 to be seen by a pain management specialist and a psychiatric specialist. For example, on March 20, 2018, there is a letter in Patient 2's chart, which stated she had been referred to a pain management specialist. On April 11, 2018, there is a message from Patient 2 that the pain management specialist did not manage methadone and that she needed a refill of her medications, including methadone. The Respondent failed to incorporate any of this information into his progress notes, and he failed to document whether Patient 2 actually saw the pain management specialist and whether or not other interventions or efforts at referral to pain management were made. On February 5, 2019, the Respondent documented that they had been working "overtime for pain management" but there is no specific information detailed in the patient's chart regarding progress on the referral. In addition, there is no documentation in the chart from December 2013 to May 2019 that Patient 2 was referred to psychiatry. On March 22, 2016, the Respondent instructed Patient 2 to abruptly stop taking high dose Zoloft that placed Patient 2 at increased risk. Despite evidence contained in many of the progress notes between December 2013 and May 2019, which documented that Patient 2's depression was not well

controlled, with high PHQ[10]-9 scores, even including suicidal ideation, the Respondent failed to refer her for a psychiatric consultation.

Patient 3

31. The Respondent began seeing Patient 3 in August 2011. Patient 3 had a history of moderate to severe lumbar disease, stenosis, bad knee arthritis, and advanced knee osteoarthritis. Patient 3 enjoyed being physically active and pain medication allowed him to continue daily activities. Patient 3 also had a surgical history that included bi-lateral knee replacement. Patient 3 began receiving Ambien in 2009, testosterone in 2010, and fentanyl in 2007. Patient 3 originally received a 50 mcg patch of fentanyl and that dose was increased in November 2010 to a 75 mcg patch of fentanyl. After taking over Patient 3's care, the Respondent tried a series of short-acting controlled substances for breakthrough pain including Vicodin, Norco, and oxycodone. In 2010, Patient 3 had an MRI done which showed radiologic evidence of degenerative disease in Patient 3's back.

32. On or about January 2014, the Respondent prescribed 15 patches of 100 mcg/1 hour fentanyl and 180 tablets of 20 mg. oxycodone to Patient 3. If taken over 30 days, the MED of these prescriptions was 420. In addition, the Respondent's prescribing of 15 patches was out of the normal prescribing pattern for fentanyl patches because the patches are designed to last three days and a typical prescription for 30 days would be ten patches. According to the Respondent, Patient 3 complained that on the third day of patch use, the patches were not effective and Patient 3 would replace the patches after two days of use. In reviewing Patient 3 CURES report, the Respondent prescribed 15 patches of 100 mcg/1 hour fentanyl and 180 tablets of 20 mg. oxycodone every one to two months to Patient 3 until August 2017. The Respondent then transitioned Patient 3 from oxycodone to 90 tablets of 10-325 mg hydrocodone with acetaminophen while keeping him on fentanyl. The Respondent kept Patient 3 on 15 patches of 100 mcg/1 hour fentanyl and 90 tablets of 10-325 mg hydrocodone with acetaminophen through October 2019. The MED of this fentanyl and hydrocodone with acetaminophen prescription, if taken over a 30-day period, was 270.

[10] PHQ-9 refers to the major depressive disorder (MDD) module of the fill PHQ.

33. In addition to prescribing fentanyl, oxycodone, and hydrocodone with acetaminophen to Patient, between December 2013 and May 2019, the Respondent also prescribed 90 tablets of 10 mg. Ambien on six occasions, 20 tablets of 10 mg. diazepam on six occasions, 30 tablets of 10 mg. Ambien on occasion, and 40 tablets of 10 mg. diazepam on two occasions. The Respondent also continued Patient 3 on testosterone throughout the time-period between December 2013 and May 2019. In reviewing the CURES report, between August 2016 and December 2016, the Respondent prescribed a daily dose of one 100 mcg/1 hour fentanyl patches, six tablets of 20 mg. oxycodone, one tablet of 10 mg. Ambien and two tablets of 10 mg. diazepam on multiple occasions.

34. Between December 2013 and May 2019, the Respondent failed to adequately perform and/or document performing physical examinations in relation to Patient 3's pain complaints. For example, the Respondent documented that Patient 3 suffered from neuropathy but failed to document a physical examination nor work-up document for the condition. On May 23, 2017, the Respondent documented that Patient 3 had a complaint of foot numbness and the Respondent ordered an MRI. The Respondent failed to document performing a physical examination of Patient 3 related to the complaint of foot numbness. On August 7, 2017, the Respondent documented that Patient 3 had a new problem involving "PAD[11]" with reports of hand and feet turning white with burning and numbness. Once again the Respondent failed to document performing a physical examination of Patient 3 other than marking that the extremities had "no edama." Finally, on March 7, 2018, the Respondent diagnosed Patient 3 with fibromyalgia but failed to document a relevant physical examination.

35. Between December 2013 and May 2019, the Respondent failed to sufficiently use pain scales and urine toxicology screens as part of a comprehensive plan to perform periodic review of Patient 3's progress on chronic pain management. In addition, the Respondent failed to document why pain scales and urine toxicology screens were not used in Patient 3's chart despite Respondent prescribing high doses of fentanyl and oxycodone. Finally, between December 2013

[11] PAD may refer to peripheral arterial disease which may also be known as peripheral vascular disease (PVD).

and May 2019, Respondent's periodic review of Patient 3's progress on chronic pain management relied on Patient 3's subjective report of pain rather than objective clinical findings.

36. On November 24, 2014, May 23, 2017, July 2, 2018, and July 9, 2019, Patient 3 entered into and signed pain management agreements with the Respondent. The pain management agreements included information that stated pain medications can cause side effects including making the person sleepy and slow down reflexes, that alcohol can make pain medication side effects worse, and that pain medications with narcotics can be addictive. The pain agreements covered fentanyl, oxycodone, Ambien, and hydrocodone with acetaminophen. They agreements did not mention diazepam. On or about June 6, 2017, Patient 3 requested a refill of Ambien. The Respondent documented that he advised the patient to not take Ambien because in combination with pain medications it is dangerous and that the Respondent was worried about the mixture of medications in Patient 3's system. The Respondent had previously documented that he discussed the risk of taking with Ambien with Patient 3 on or about March 20, 2017. According to the medical records, most of these concerns were relayed to Patient 3's wife who stated that Patient 3 only used the medication occasionally. The Respondent refilled Patient 3's prescription for Ambien on June 8, 2017, December 30, 2017, and March 5, 2018, despite his stated concerns.

37. Between December 2013 and May 2019, the Respondent documented that he referred Patient 3 for a number of specialist consultations. In 2018, the Respondent referred Patient 3 to a pain management specialist. On or about September 5, 2018, Patient 3 stated that he saw the pain management specialist one time but that the injections did not help. The Respondent did not incorporate the pain management specialist's recommendations and/or evaluations into his written treatment plan and assessment. The Respondent documented that he would look into a neuropathy specialist but there was no other documentation related to this referral. The Respondent failed to refer Patient 3 for a psychiatric referral despite intermittent diagnoses over the years including depression, anxiety, and insomnia.

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Patient 4

38. On or about May 1, 2012, the Respondent began caring for Patient 4 after she transferred her care from a different provider. Patient 4 had a history of Type-1 diabetes, chronic back pain with radiation, insomnia and multiple past rib and spine fractures from an accident. According to the Respondent, Patient 4 was in constant pain and already on chronic opioids, including fentanyl, Valium, and Restoril when she first saw the Respondent. Patient 4 also suffered from other medical issues like asthma and high cholesterol. In 2017, Patient 4 was involved in a serious car accident where she hit an abandoned vehicle on the freeway and it caused her to have additional pain.

39. On or about January 5, 2014, and January 10, 2014, the Respondent prescribed 15 patches of 100 mcg/1 hour fentanyl patches, 120 tablets of 20 mg oxycodone, 180 tablets of 10 mg diazepam and 90 tablets of 30 mg temazepam to Patient 4. The Respondent's prescription of 15 patches was larger than expected as typically a one-month prescription of three-day fentanyl patches would be for ten total patches. The diazepam and temazepam prescriptions were three month prescription. Taken as directed, Patient 4 was on an opioid prescription with a daily MED of 360 in combination with 20 mg of diazepam and 30 mg of temazepam. In reviewing the CURES printout, the Respondent continued to prescribe oxycodone, diazepam, and temazepam to Patient 4 until April 2015. Fentanyl was not listed on the CURES profile during that time but according to both the Respondent and Patient 4, she remained on fentanyl throughout that time. In April 2015, the Respondent was prescribing 15 patches of 100 mcg/1 hour fentanyl patches, 180 tablets of 20 mg oxycodone, and 90 tablets of 10 mg. diazepam per month to Patient 4. If taken as prescribed, Patient 4 was on an opioid prescription with a daily MED of 420, in combination with 30 mg of diazepam and 30 mg of temazepam. The Respondent also continued Patient 4 on temazepam, having refilled the prescription in March 2015. The Respondent continued Patient 4's prescriptions on a regular basis until October 2016.

40. In February 2017, the CURES showed a final prescription for 90 tablets of 30 mg temazepam. In September 2017, the CURES showed a final prescription for 60 tablets of 20 mg oxycodone. In December 2017, the Respondent began prescribing a daily prescription of two

tablets of 10-325 mg hydrocodone with acetaminophen to Patient 4, instead of oxycodone, for breakthrough pain. In October 2018, the Respondent provided one final prescription of 180 tablets of 10/325 mg hydrocodone with acetaminophen to Patient 4. By January 2019, the Respondent was prescribing only one 10 mg tablet of diazepam per day to Patient 4. The Respondent continued to prescribe 15 patches of 100 mcg/1 hour per month to Patient 4 through May 2019.[12]

41. Between December 2013 and May 2019, the Respondent documented Patient 4 had "back pain with radiation." The Respondent did not perform a physical examination and/or document performing a physical examination related to Patient 4's diagnosis of "radiation." In addition on or about March 8, 2016, the Respondent documented that Patient 4 complained of new back and hip pain but failed to perform and/or document performing a review of systems or physical examination. On December 28, 2017, there was documentation in the medical record that Patient 4 could not raise one of her arms but Respondent failed to perform and/or document performing a review of systems or physical examination. Between December 2013 and May 2019, Respondent failed to document why Patient 4 was receiving chronic Valium for back pain.

42. On or about March 8, 2016, Patient 4 complained of back spasms and was treated with baclofen. The Respondent's documented rationale was that Patient 4 no longer responded to Valium but the Respondent continued to prescribe Valium after March 8, 2016. On or about August 10, 2017, the Respondent documented that Patient 4's benzodiazepine medication could not be cut back because of Patient 4's anxiety and "RLS[13]" but those new problems were not documented before or after the visit on August 10, 2017. In addition, in March 2018, the Respondent provided Valium as a BID medication and then did not refill it until January 2019. The Respondent failed to document a plan for weaning Patient 4 off Valium, nor did he provide an explanation for why there was a nine-month absence in prescribing, nor did he explain why he was restarting Patient 4's Valium prescription.

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[12] According to Patient 4's CURES there were additional gaps in Respondent's fentanyl prescribing but both the Respondent and Patient 4 state that she received fentanyl on a consistent basis from the Respondent.

[13] RLS commonly refers to Restless Leg Syndrome.

43. On or about May 5, 2015, the Respondent documented that he informed Patient 4 that she had developed a tolerance for benzodiazepines, such as diazepam and temazepam, and he improperly advised her to stop taking temazepam for one week so the medication would begin working again. Between December 2013 and May 2019, the Respondent prescribed fentanyl patches every 48 hours rather than every 72 hours and failed to document what Patient 4 did with the patches after each use. On or about December 4, 2017, the Respondent documented that Patient 4 had been in a motor vehicle accident in which she ran into a truck parked sideways on Highway 49. The Respondent documented that he informed Patient 4 to be "very careful of taking extra pain meds, you are already in a high dose," and documented that she could take extra Valium for a short time following the accident. Between December 2013 and May 2019, the Respondent failed to sufficiently use pain scales and urine toxicology screens as part of a comprehensive plan to perform periodic review of Patient 4's progress on chronic pain management. In addition, the Respondent failed to document why pain scales and urine toxicology screens were not used in Patient 4's chart despite his high dosing of fentanyl and oxycodone.

44. On or about April 20, 2016, August 10, 2017, October 2, 2018, and October 23, 2019, Patient 4 entered into and signed pain management agreements with the Respondent. The pain management agreements included information that stated pain medications can cause side effects including making the person sleepy and slowing down reflexes, that alcohol can make pain medication side effects worse, and that pain medications with narcotics can be addictive. Medications covered by the pain management agreements included fentanyl, oxycodone, temazepam, Valium, and hydrocodone with acetaminophen. The Respondent did document that he discussed the risks of taking opioids in combination with benzodiazepines with Patient 4. The Respondent also documented that he discussed the possible use of Narcan with Patient 4. However, on or about December 4, 2017, the Respondent failed to document whether or not he discussed with Patient 4 whether she was on her medications at the time of the motor vehicle accident and whether or not those medications may have contributed to the accident.

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45. Between December 2013 and May 2019, the Respondent failed to refer and/or document referring Patient 4 for appropriate specialist consultations despite Respondent prescribing high dose opioids in combination with benzodiazepines. For example, there is no documentation that the Respondent referred Patient 4 to a pain management specialist to review her chronic pain care. On or about October 2, 2018, there is documentation in Patient 4's chart that she would seek a consultation with a "sleep specialist" following a trip, but there is no follow-up documented in Patient 4's chart on whether that consultation occurred.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence during the care and treatment of Patients 1, 2, and 4. The circumstances are as follows:

47. Complainant realleges paragraphs 17 through 45, and those paragraphs are incorporated by reference as if fully set forth herein.

48. Respondent's license is subject to disciplinary action because he committed gross negligence between December 2013 and May 2019, during the care and treatment of Patients 1, 2, and 4, in the following distinct and separate ways:

a. By failing to provide and/or document providing a clear treatment plan and ongoing assessment for Patient 1 in regards to her chronic pain medications. By failing to perform and/or document performing periodic review of Patient 1's progress on chronic pain medications. By failing to provide and/or document providing detailed informed consent to Patient 1 regarding her chronic pain medications. By failing to arrange and/or document arranging for appropriate specialist consultations for Patient 1 regarding her chronic pain medications and general medical care;

b. By failing to perform and/or document performing physical examinations related to Patient 2's pain conditions. By failing to provide and/or document providing a clear treatment plan and ongoing assessment for Patient 2 in regards to her chronic pain medications. By failing to perform and/or document performing periodic review of Patient 2's progress on

chronic pain medications. By failing to provide and/or document providing detailed informed consent to Patient 2 regarding her chronic pain medications. By failing to arrange and/or document arranging for appropriate specialist consultations for Patient 2 regarding her chronic pain medications and general medical care; and,

c. By failing to perform and/or document performing physical examinations related to Patient 4's pain conditions. By failing to provide and/or document providing a clear treatment plan and ongoing assessment for Patient 4 in regards to her chronic pain medications. By failing to perform and/or document performing periodic review of Patient 4's progress on chronic pain medications. By failing to provide and/or document providing detailed informed consent to Patient 4 regarding her chronic pain medications. By failing to arrange and/or document arranging for appropriate specialist consultations for Patient 4 regarding her chronic pain medications and general medical care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

49. Respondent's license is subject to disciplinary action under 2234, subdivision (c), in that he committed repeated negligent acts during the care and treatment of Patients 1, 2, 3 and 4. The circumstances are as follows:

50. Complainant realleges paragraphs 17 through 48, and those paragraphs are incorporated by reference as if fully set forth herein.

51. The gross departures from the standard of care as set forth in paragraph 45, are incorporated by reference as if fully set forth herein and serve as repeated negligent acts.

52. In addition to the repeated negligent acts involving Patients 1, 2, and 4, the Respondent also engaged in repeated negligent acts with Patient 3 including the following:

a. By failing to perform and/or document performing physical examinations related to Patient 3's pain conditions;

b. By failing to provide and/or document providing a clear treatment plan and ongoing assessment for Patient 3 in regards to his chronic pain medications;

c. By failing to perform and/or document performing periodic review of Patient 3's progress on chronic pain medication;

d. By failing to provide and/or document providing detailed informed consent to Patient 3 regarding his chronic pain medications; and

e. By failing to arrange and/or document arranging for appropriate specialist consultations for Patient 3 regarding his chronic pain medications and general medical care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Records)

53. Respondent's license is subject to disciplinary action under section 2266 in that he failed to properly keep adequate and accurate medical records for Patients 1, 2, 3, and 4. The circumstances are as follows:

54. Complainant realleges paragraphs 17 through 52 and those paragraphs are incorporated by reference as if fully set forth herein.

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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 C 51972, issued to Ali Mokhlesi, M.D.;

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

3. Ordering Ali Mokhlesi, M.D., to pay the Medical Board of California the reasonable costs of the investigation and enforcement of this case pursuant to Bus. & Prof. Code 125.3[14], and, if placed on probation, to pay the Board the costs of probation monitoring; and

4. Ordering Ali Mokhlesi, M.D., if placed on probation, to notify his patients of his probation status pursuant to Business and Professions Code § 2228.1

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

DATED: MAR 0 1 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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[14] Costs of the investigation and enforcement of this case after January 1, 2022.