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

In the Matter of the Accusation Against: Uma Malempati Rao, M.D. Physician's and Surgeon's Certificate No. A 78409 Respondent.	Case No.: 800-2019-057609

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 December 1, 2023.

IT IS SO ORDERED: November 2, 2023.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: **UMA MALEMPATI RAO, M.D.** **1348 W. Herndon Ave., Ste. 101** **Fresno, CA 93711-7181** **Physician's and Surgeon's Certificate No. A 78409** Respondent.	Case No. 800-2019-057609 OAH No. 2023030187 **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 Executive Director of the Medical Board of California (Board). William Prasifka was the Executive Director of the Board when this action was brought in his official capacity[1] and both are represented in this matter by Rob Bonta, Attorney General of the State of California, by Aaron L. Lent, Deputy Attorney General.

[1] William Prasifka resigned as the Executive Director of the Board effective December 30, 2022.

2. Respondent Uma Malempati Rao, M.D. (Respondent) is represented in this proceeding by attorney Debra C. Scheufler, Esq., whose address is: 1901 First Avenue, Suite 132 San Diego, CA 92101-0308.

3. On or about March 20, 2002, the Board issued Physician's and Surgeon's Certificate No. A 78409 to Respondent Uma Malempati Rao, M.D. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-057609, and will expire on May 31, 2025, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-057609 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 10, 2022. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-057609 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-057609. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2019-057609, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-2019-056375, a true and correct copy of which is attached hereto as Exhibit A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 78409 to disciplinary action.

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

CONTINGENCY

13. 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 her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

14. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in Accusation No. 800-2019-057609 shall be

deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

15. 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.

16. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

18. 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

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 78409 issued to Respondent UMA MALEMPATI RAO, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for thirty-five (35) months on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65

hours of CME of which 40 hours were in satisfaction of this condition.

2. 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.

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.

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

The Board or its designee shall provide the approved monitor with copies of the Decision(s)

and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive 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 cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

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

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive 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 cease the practice of medicine until a

replacement monitor is approved and assumes monitoring responsibility.

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

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

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

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

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

7. 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, investigations, and subpoena enforcement, as applicable, in the amount of $61,454.10 (sixty-one thousand four hundred fifty-four dollars and ten cents). Costs shall be payable to the Medical Board of California. Failure to pay such costs shall be considered a violation of probation.

Payment must be made in full within 30 calendar days of the effective date of the Order, or

by a payment plan approved by the Medical Board of California. Any and all requests for a payment plan shall be submitted in writing by respondent to the Board. Failure to comply with the payment plan shall be considered a violation of probation.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

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

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

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any

areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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

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

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

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

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

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

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

12. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. This term does not include cost recovery, which is due within 30 calendar days of the effective date of the Order, or by a payment plan approved by the Medical Board and timely satisfied. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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

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

application shall be treated as a petition for reinstatement of a revoked certificate.

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

16. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2019-057609 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Debra C. Scheufler, Esq.. 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: 8/2/23

UMA MALEMPATI RAO, M.D.
Respondent

I have read and fully discussed with Respondent Uma Malempati Rao, 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: 8/2/2023

DEBRA C. SCHEUFLER, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/4/2023

Respectfully submitted,

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

AARON L. LENT
Deputy Attorney General
Attorneys for Complainant

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

In the Matter of the Accusation Against: **Uma Malempati Rao, M.D.** **1348 W. Herndon Ave., Ste. 101** **Fresno, CA 93711-7181** **Physician's and Surgeon's Certificate No. A 78409,** Respondent.	Case No. 800-2019-057609 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this 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 March 20, 2002, the Medical Board issued Physician's and Surgeon's Certificate No. A 78409 to Uma Malempati Rao, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2023, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code provides 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.

STATUTORY PROVISIONS

5. Section 2234 of the Code, states:

> 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.
>
> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

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

7. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

8. Section 3502 of the Code states, in pertinent part:

(a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b)(1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c)(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2)(A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

9. Section 3502.1 of the Code states, in pertinent part:

(a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502 , while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations . Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the

supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of

Regulations , and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

10. Section 3527 of the Code states, in pertinent part:

...

(c) The Medical Board of California may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

...

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1399.541, states, in pertinent part:

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician...

...

12. California Code of Regulations, title 16, section 1399.545, states:

(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

(b) A supervising physician shall delegate to a physician assistant only those

tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

(4) Other mechanisms approved in advance by the board.

(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision.

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to 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, with failure of the licensee to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FACTUAL ALLEGATIONS

14. Respondent is a licensed physician and surgeon, board certified in internal medicine, who at all times relevant to the allegations worked at EuroPhoria Medical Spa (EuroPhoria) within Kern County, California. Respondent began working at EuroPhoria on the weekends in late 2018 until August 1, 2019, when Respondent became the sole owner and medical director of EuroPhoria.

15. During Respondent's investigative interview, Respondent stated that she reviews all patient charts at EuroPhoria. Respondent also stated that she is only physically present at EuroPhoria for approximately one weekend or three days each month. Respondent further stated that she supervises two physician assistants employed at EuroPhoria who conduct the good faith examinations (GFE), are located off-site, and are never physically present at EuroPhoria.

16. On or about July 14, 2021, authorities executed a Kern County Superior Court search warrant of EuroPhoria, its warehouse, as well as the Respondent and other EuroPhoria staff and personnel. Patients who were present at EuroPhoria at the time the warrant was executed signed authorizations of release of their records and their EuroPhoria medical records were obtained with a declaration of certified records from the EuroPhoria assistant manager. Photographs and video imaging, accompanied with audio recordings were also obtained the same day by an undercover agent at EuroPhoria posing as a patient.

Patient 1[1]

17. Patient 1, a 34-year-old female patient, received cosmetic treatments at EuroPhoria beginning in early 2021 consisting of Xeomin[2] injections. /

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[1] To protect the privacy of the patients and witnesses involved, the patients and witnesses names were not included in this pleading. Respondent is aware of the identity of each patient and witness. All patients and witnesses will be fully identified in discovery.

[2] Xeomin (incobotulinumtoxinA) is Botulinum Toxin Type A, otherwise known as Botox, that blocks nerve activity in the muscles, causing a temporary reduction in muscle activity.

18. According to Patient 1's medical records, Patient 1 scheduled cosmetic wrinkle relaxer appointments at EuroPhoria on or about February 17, 2021, June 22, 2021, and July 14, 2021.

19. On or about February 17, 2021, Patient 1 signed a document titled "Botulinum A Toxin Informed Consent." The document was not co-signed by Respondent or any representative of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no indication in the medical record that it was reviewed with Patient 1 to determine Patient 1's competency, verification that she was adequately informed, and not coerced. No other informed consent document appeared in Patient 1's EuroPhoria medical records.

20. On or about February 17, 2021, Patient 1 filled out and signed a two-page EuroPhoria form document titled "Client Information & Medical History" as well as a questionnaire. Neither document was co-signed by Respondent or any representative of EuroPhoria, nor was there any indication in the medical record that they were reviewed with Patient 1. The sections of the document for the physical exam and cosmetic evaluation were blank. Neither the basis of Patient 1's office visit nor Patient 1's chief complaint were documented in Patient 1's medical records.

21. According to Patient 1's medical records, on or about February 17, 2021, a single-page largely yes/no form document titled "Good Faith Exam" (GFE) was filled out and signed with an illegible signature and no printed name of the medical provider. The GFE document classified Patient 1's Fitzpatrick skin[3] as III, stated that the "risks, alternatives, and benefits were explained to the patient in detail...all questions were answered and patient wishes to proceed with the treatment as outline above, per protocol...the patient is cleared for all the treatments marked below," and "cleared" Patient 1 for twenty-seven (27) cosmetic procedures. The document contained a small yes/no physical examination component which only determined whether there were signs of facial weakness or eyelid and eyebrow symmetry, asymmetry, facial scars, melisma, blemishes, or lesions. No specific evaluation, assessment or treatment plan of Patient 1 was documented as to any of the 27 cosmetic procedures. The GFE was not counter-signed by

[3] Fitzpatrick skin types, or phototypes refer to a skin tone scale developed to classify skin coloring and response to ultraviolet radiation to help determine a patient's risk of burning or tanning when exposed to ultraviolet light.

Respondent and there was no documented indication in the medical record that it was reviewed by Respondent.

22. On or about June 22, 2021, Patient 1 filled out and signed a two-page EuroPhoria form document titled "Client Information & Medical History." The document was not co-signed by Respondent or any representative of EuroPhoria, nor was there any indication in the medical record that it was reviewed with Patient 1. The sections of the document for the physical exam and cosmetic evaluation were blank and crossed out. No other medical history or prior treatments were documented in Patient 1's medical records other than the same document Patient 1 filled out on February 17, 2021. Neither the basis of Patient 1's office visit nor Patient 1's chief complaint were articulated or stated in Patient 1's medical records.

23. According to Patient 1's medical records, on or about June 22, 2021, a single-page largely yes/no form document titled "Good Faith Exam" was filled out and signed with an illegible signature and no printed name of the medical provider. The GFE document classified the patient's Fitzpatrick skin as IV, stated that the "risks, alternatives, and benefits were explained to the patient in detail...all questions were answered and patient wishes to proceed with the treatment as outline above, per protocol...the patient is cleared for all the treatments marked below," and "cleared" Patient 1 for only ten (10) cosmetic procedures. The document contained a small yes/no physical examination component which only determined whether there were signs of facial weakness or eyelid and eyebrow symmetry, asymmetry, facial scars, melisma, blemishes, or lesions. Other than the Fitzpatrick skin and the number of cleared cosmetic procedures, no other information changed from Patient 1's previous February 17, 2021 GFE. No specific evaluation, assessment, or treatment plan of Patient 1 was documented as to any of the 10 cosmetic procedures.

24. Patient 1's EuroPhoria medical records contain only three sets of photographs of Patient 1 dated February 17, 2021, June 22, 2021, and August 31, 2021. Each set of photographs depict Patient 1 with marked dots on her face and consisted of either two or five photographs for each date. No additional identifying information was provided with the photographs other than the typed dated and Patient 1's name at the top of each page. There was no indication documented

in Patient 1's EuroPhoria medical records as to who placed the marked dots on her face or who took the photographs on any given date.

25. Patient 1's EuroPhoria medical records contain one page of text/chat dialogue screenshots that indicate Patient 1 underwent Xeomin treatments on February 17, 2021, June 22, 2021, August 31, 2021, and January 24, 2022. Patient 1's name, date of birth, medical record number, or any other identifiers were not documented in any of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria's registered nurse or nurse practitioner appeared under each date within each screenshot without identifying what function they performed as to each treatment procedure. While each screenshot stated "Xeomin" with a series of stated facial locations and corresponding numerical values next to them, the exact botulinum toxin was not identified, nor was the lot number, expiration date, or units of measurement used. Each screenshot concluded in the same manner by stating that "post care instructions given," but does not state what the instructions were, to whom they were given, and no additional information was documented in the screenshot. None of these screenshots indicate that Respondent was consulted, reviewed and/or administered any of the treatments to Patient 1. No specific evaluation, assessment or treatment plan of Patient 1 was documented in the medical record.

Patient 2

26. Patient 2, a 52-year-old female patient, received cosmetic treatments at EuroPhoria beginning in mid-2019 consisting of Xeomin injections, vitamin infusion intravenous (IV) therapy, Phentermine,[4] "Vanquish" treatments,[5] and "Lipo-B" injections.[6]

27. On or about November 12, 2019 and August 5, 2021, Patient 2 signed documents titled "IV Nutrition Therapy/Medical Weight Loss Injections Informed Consent." The documents were signed with illegible witness signatures and no printed name of a medical provider. Neither

[4] Phentermine is a stimulant derived from amphetamine used to suppress appetite and treat obesity. It is a Schedule IV controlled substance pursuant to Code of Federal Regulations title 21 section 1308.14(c), and pursuant to Health and Safety Code section 11057(d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Vanquish treatment is a body contouring procedure utilizing radiofrequency energy against the body of a patient.

[6] Lipotropic injections contain a variety of vitamins, nutrients, and amino acids that are injected into any part of the body that has subcutaneous fatty tissue.

Respondent nor EuroPhoria were mentioned in the body of the documents. There was no indication in Patient 2's medical record that they were reviewed with Patient 2 to determine Patient 2's competency, verification that she was adequately informed, and not coerced.

28. On or about April 10, 2021, Patient 2 signed a document titled "Vanquish Treatment Consent." The document was blank in three paragraphs that required Patient 2's initials, which explained: (1) that EuroPhoria staff explained the nature of Patient 2's condition, the procedure, its alternatives, and benefits; (2) that the patient confirms not having a pacemaker, internal defibrillator, or other metal implants; and (3) that the patient understands the risks of the procedure. The document was not co-signed by Respondent or any representative of EuroPhoria, and there was no indication in the document or Patient 2's medical record that it was reviewed with Patient 2 to determine Patient 2's competency, verification that she was adequately informed, and not coerced.

29. According to Patient 2's medical record, on or about September 12, 2019, October 1, 2020, March 10, 2021, and April 27, 2022, a single-page largely yes/no form document titled "Good Faith Exam" was filled out. No other medical examination, patient medical history, physical examination, treatment or assessment plans were documented in Patient 2's medical record. None of the GFEs were counter-signed by Respondent, and there was no documented indication within the medical record that they were reviewed by Respondent.

a. The October 2020 GFE was signed with an illegible signature and no printed name of the medical provider.

b. Each GFE has a "Patient History" section that consisted of ten (10) check-mark boxes next to ten medical conditions. The September 2019 GFE "Patient History" section had all ten boxes checked with the word "no" next to them with an additional notation regarding breast implants. The October 2020 and March 2021 GFE's also had all ten boxes checked with the word "no" next to them, but without any notation regarding breast implants. The April 2022 GFE only had two boxes checked with the word "no" next to them with the other eight boxes blank and no notation regarding breast implants.

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c. Each GFE had a "Medication" section that also provided a space for allergies. Only the September 2019 GFE indicated Patient 2 had a bee allergy and no sensitivity to nitrous oxide.

d. Each GFE had a "Physical Exam" section that consisted of two to three yes/no questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma, blemishes, and lesions. Only the October 2020 and March 2021 GFE's documented Patient 2's blood pressure, heart rate, and weight. Only the September 2019 and April 2022 GFE's documented no presence of metal implants in the patient, but only the September 2019 GFE documented the presence of breast implants. Only the April 2022 documented the presence of moles on Patient 2 but did not elaborate as to their number, locations, size, color, etc. Only the March 2021 GFE documented the patient experiencing a secondary effect of Phentermine but no additional information was documented such as the extent of the effect on Patient 2.

e. Each GFE had a "Cosmetic Evaluation" section that consisted of ten yes/no check-marked boxes. Only the October 2020 GFE had no boxes that were checked.

f. Each GFE had a section at the bottom of the single-page document listing approximately thirty (30) cosmetic treatments and procedures with check-mark boxes next to each one that indicate approval or "clearance" for the patient to receive or not the treatment or procedure. The September 2019 GFE indicated Patient 2 was "cleared" to receive half of the procedures. The October 2020 GFE only had the Phentermine treatment checked. The March 2021 GFE indicated Patient 2 was "cleared" to receive eighteen of the procedures. The April 2022 GFE indicated Patient 2 was "cleared" to receive almost all of the procedures and treatments listed. No further evaluation, assessment or treatment plan of Patient 2 was documented as to any of the cosmetic procedures and treatments listed on the GFEs.

30. Patient 2's EuroPhoria medical records contained nine sets of photographs of Patient 2 dated September 12, 2019, January 25, 2020, July 15, 2020, December 9, 2020, May 1, 2021, August 5, 2021, November 3, 2021, February 1, 2022, and April 27, 2022. Each set of

photographs depicted Patient 2 with marked dots on her face, except for May 1, 2021 which depicts Patient 2's upper torso. No additional identifying information is provided with the photographs other than the typed dated and Patient 2's name at the top of each page. Some of the photographs contained the name of a EuroPhoria registered nurse at the top of the page that the photographs appear on; however, there was no indication documented in Patient 2's EuroPhoria medical records as to who placed the marked dots on her face or who took the photographs on any given date.

31. Patient 2's EuroPhoria medical records contained seven pages of text/chat dialogue screenshots that indicated Patient 2 underwent approximately twenty-one (21) cosmetic treatments and procedures at EuroPhoria from September 2019 through April 2022. Patient 2's name, date of birth, medical record number, or any other identifiers were not documented in any of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria registered nurse or nurse practitioner appeared under each date within each screenshot without identifying what function they performed as to each treatment procedure. None of these screenshots indicated that Respondent was consulted, reviewed and/or administered any of the individual treatments or procedures Patient 2 received. No specific evaluation, assessment or treatment plan of Patient 2 was documented in any of the screenshots. According to these seven pages of text/chat dialogue screenshots, Patient 2 underwent the following cosmetic treatments and procedures on the dates indicated at EuroPhoria:

a. Xeomin injections – April 27, 2022, February 1, 2022, December 21, 2021, November 3, 2021, and September 22, 2021. While each screenshot stated "Xeomin" with a series of stated facial locations and corresponding numerical values next to them, the exact botulinum toxin was not identified, nor was the lot number, expiration date, or units of measurement used. Each screenshot concluded in the same manner by stating that "post care instructions given" but does not state what the instructions were, to whom they were given, and no additional information was documented in the screenshot.

b. "Lipo-B" injections – November 3, 2021, September 22, 2021, September 15, 2021, September 8, 2021, and August 5, 2021. None of the screenshots stated the composition of

vitamins, nutrients, or amino acids that were injected into Patient 2 on each date. Each screenshot concluded in the same manner by stating that "after care instructions given" but does not state what the instructions were, to whom they were given, and no additional information was documented in the screenshot.

c. Botox injections – August 5, 2021, December 9, 2020, January 25, 2020, and September 12, 2019. While each screenshot stated "Botox" with a series of stated facial locations and corresponding numerical values next to them, the exact botulinum toxin was not identified, nor was the lot number, expiration date, or units of measurement used. Each screenshot concluded in the same manner by stating that "post care instructions given" but does not state what the instructions were, to whom they were given, and no additional information was documented in the screenshot.

d. Phentermine – June 12, 2021, April 10, 2021, March 10, 2021, October 24, 2020, October 1, 2020, and November 24, 2019.

e. "Vanquish" treatments – May 11, 2021, twice on May 1, 2021, twice on April 24, 2021, and April 10, 2021.

f. IV therapy – December 14, 2019.

32. Patient 2's EuroPhoria medical records contained a single typed page stating, "I, Dr. Rao, Have reviewed this medical chart." Patient 2's name is typed underneath the statement with a date of November 29, 2019 and the page is signed by the Respondent. There are no further explanations or descriptions of what portion of Patient 2's charts and/or medical records were reviewed and assessed, what the review encompassed, or whether Respondent approved any specific procedures or treatments given to Patient 2 or had any other comments. There are no other indications that Respondent reviewed Patient 2's medical record on any other date.

Patient 3

33. Patient 3, a 37-year-old female patient, went to EuroPhoria on July 14, 2021.

34. On or about July 14, 2021, Patient 3 signed a document titled "Botulinum A Toxin Informed Consent." The document was not co-signed by Respondent or any representative of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no

indication in the document that it was reviewed with Patient 3 to determine Patient 3's competency, verification that she was adequately informed, and not coerced. No other informed consent document appeared in Patient 3's EuroPhoria medical record.

35. On or about July 14, 2021, Patient 3 filled out and signed a two-page EuroPhoria form document titled "Client Information & Medical History" as well as a questionnaire. Neither document was co-signed by Respondent or any representative of EuroPhoria, nor was there any indication in the medical record that they were reviewed with Patient 3. The sections of the document for the physical exam and cosmetic evaluation were blank. Neither the basis of Patient 3's office visit nor Patient 3's chief complaint were articulated or stated in the medical record.

36. According to Patient 3's medical record, on or about July 14, 2021, a single-page largely yes/no form document titled "Good Faith Exam" (GFE) was filled out and signed with an illegible signature and no printed name of the medical provider. The bottom of the document contained a stamp with the identifying information of a EuroPhoria physician assistant. No other medical examination, patient medical history, physical examination, treatment or assessment plans were documented in Patient 3's medical record. The GFE was not counter-signed by the Respondent and there was no documented indication within the medical record that it was reviewed by Respondent. The "Patient History" section of the GFE consists of eight (8) check-mark boxes next to eight medical conditions, of which all eight boxes were checked with the word "no" next to them. The GFE had a "Physical Exam" section that consisted of two yes/no questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma, blemishes, and lesions. The spaces on the GFE denoting Patient 3's weight, height, blood pressure, and heart rate were blank. The "Cosmetic Evaluation" section of the GFE consisted of ten check-mark boxes, of which only four boxes were checked. At the bottom of the single-page GFE was a listing of approximately thirty (30) cosmetic treatments and procedures with check-mark boxes next to each one that indicate approval or "clearance" for the patient to receive or not the treatment or procedure, of which Patient 3 was "cleared" to receive over half of the procedures. No specific evaluation, assessment, or treatment plan of Patient 3 was documented as each of the approved cosmetic procedures.

37. Patient 3's EuroPhoria medical records contained only one set of photographs of Patient 3 dated July 14, 2021. The set of photographs depicts Patient 3 with marked dots on her face and consisted of four photographs. No additional identifying information was provided with the photographs other than the typed date and Patient 3's name at the top of the page. There was no indication documented in Patient 3's EuroPhoria medical records as to who placed the marked dots on her face or who took the photographs.

38. Patient 3's EuroPhoria medical records contained a single typed page stating, "Patient did not receive medical treatment. Raid occurred before treatment began. Did not receive any medical treatment before or after raid occurred." Patient 3's name was typed above the statement. The page was not dated or signed. No other information was contained in the page.

Patient 4

39. Patient 4, an adult female patient, received cosmetic treatments at EuroPhoria beginning in February 2021 through November 2021 consisting of Xeomin injections.

40. On or about February 18, 2021, Patient 4 signed a document titled "Botulinum A Toxin Informed Consent." The document was not co-signed by Respondent or any representative of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the document. There was no indication in the medical record that it was reviewed with Patient 4 to determine Patient 4's competency, verification that she was adequately informed, and not coerced. No other informed consent document appeared in Patient 4's EuroPhoria medical record.

41. On or about February 18, 2021, Patient 4 filled out and signed a two-page EuroPhoria form document titled "Client Information & Medical History." The document was not co-signed by Respondent or any representative of EuroPhoria, nor was there any indication in the document that it was reviewed with Patient 4. The sections of the document for the physical exam and cosmetic evaluation were blank. Neither the basis of Patient 4's office visit nor the patient's chief complaint were articulated or stated in the medical record.

42. According to Patient 4's medical record, on or about February 18, 2021, a single-page largely yes/no form document titled "Good Faith Exam" was filled out and signed with an illegible signature and no printed name of the medical provider. No other medical examination,

patient medical history, physical examination, treatment or assessment plans were documented in Patient 4's medical records. The GFE was not counter-signed by the Respondent and there was no documented indication within the GFE that it was reviewed by Respondent. The "Patient History" section of the GFE consisted of eight (8) check-mark boxes next to eight medical conditions, of which all eight boxes were checked with the word "no" next to them. The GFE had a "Physical Exam" section that consisted of two yes/no questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma, blemishes, and lesions. The spaces on the GFE denoting the patient's weight, height, blood pressure, and heart rate were blank. The "Cosmetic Evaluation" section of the GFE consisted of ten check-mark boxes, of which only four boxes were checked. At the bottom of the single-page GFE was a listing of approximately thirty (30) cosmetic treatments and procedures with check-mark boxes next to each one that indicate approval or "clearance" for the patient to receive or not the treatment or procedure, of which Patient 4 was "cleared" to receive almost all of the procedures. No specific evaluation, assessment, or treatment plan of Patient 4 was documented as each of the approved cosmetic procedures.

43. Patient 4's EuroPhoria medical record contains three sets of photographs of Patient 4 dated February 18, 2021, August 31, 2021, and November 1, 2021. Each set of photographs depicted Patient 4 with marked dots on her face and consisted of between three to five photographs for each date. No additional identifying information was provided with the photographs other than the typed dated and Patient 4's name at the top of each page. There was no indication documented in Patient 4's EuroPhoria medical record as to who placed the marked dots on her face or who took the photographs on any given date.

44. Patient 4's EuroPhoria medical records contained one page of text/chat dialogue screenshots that indicated Patient 4 underwent Xeomin treatments on February 18, 2021, August 31, 2021, and November 1, 2021. Patient 4's name, date of birth, medical record number, or any other identifiers were not documented in any of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria's registered nurse appeared under each date within each screenshot without identifying what function they performed as to each treatment procedure.

While each screenshot stated "Xeomin" with a series of stated facial locations and corresponding numerical values next to them, the exact botulinum toxin was not identified, nor was the lot number, expiration date, or units of measurement used. Each screenshot concluded in the same manner by stating that "post care instructions given" but does not state what the instructions were, to whom they were given, and no additional information was documented in the screenshot. None of these screenshots indicated that Respondent was consulted, reviewed and/or administered any of the treatments of Patient 4. No specific evaluation, assessment or treatment plan of Patient 4 was documented in any of the screenshots.

Patient 5

45. Patient 5, a 48-year-old male patient, received cosmetic treatments at EuroPhoria beginning in early-2021 consisting of Xeomin injections, Vanquish treatments, laser hair removal (LHR), and miraDry[7] treatments.

46. On or about April 29, 2021 and June 21, 2022, Patient 5 signed a document titled "Treatment Consent Form" regarding the miraDry treatment. The documents were not co-signed by Respondent or any representative of EuroPhoria, nor were Respondent or EuroPhoria mentioned in the documents. There was no indication in the document that it was reviewed with Patient 5 to determine Patient 5's competency, verification that he was adequately informed, and not coerced. The document contained four bulleted sentences regarding the side effects and risks of the treatment. The document also contained six yes/no medical condition questions posed to Patient 5, none of which were answered in either document.

47. On or about April 29, 2021, Patient 5 filled out and signed a two-page EuroPhoria form document titled "Client Information & Medical History" as well as a questionnaire. Neither document was co-signed by Respondent or any representative of EuroPhoria, nor was there any indication in the medical record that they were reviewed with Patient 5. The sections of the document for the physical exam and cosmetic evaluation were blank and crossed out. Under the section of medical history, Patient 5 indicated he was under the care of a physician, was taking

[7]The miraDry treatment uses electromagnetic and thermal energy to reduce the number of underarm sweat and odor glands, and treat excessive sweating and odor (axillary hyperhidrosis).

the medication Metformin[8], and suffered from diabetes, high blood pressure, and asthma. Neither the basis of Patient 5's office visit nor Patient 5's chief complaint were articulated or stated in the medical record. There was no documentation in Patient 5's medical history regarding the use of topical, injectable, or oral medications used to treat hyperhidrosis. There was no indication in Patient 5's medical records regarding the potential causes of hyperhidrosis, a discussion of various treatment options, or potential contraindications to miraDry treatment.

48. According to Patient 5's medical record, on or about April 29, 2021, a single-page largely yes/no form document titled "Good Faith Exam" was filled out and signed with an illegible signature and no printed name of the medical provider. The bottom of the document contained a stamp with the identifying information of a EuroPhoria physician assistant. No other medical examination, patient medical history, physical examination, treatment or assessment plans were documented in Patient 5's medical record. The GFE was not counter-signed by Respondent and there was no documented indication within the GFE that it was reviewed by Respondent. The "Patient History" section of the GFE consisted of eight (8) check-mark boxes next to eight medical conditions, of which all eight boxes were checked with the word "no" next to them, in addition to the hand written word "diabetes" and a line through the box next to it. There was no documentation in Patient 5's medical history in the GFE regarding the use of topical, injectable, or oral medications used to treat hyperhidrosis. The GFE had a "Physical Exam" section that consisted of two yes/no questions, a space for notes regarding asymmetries, and a space to list facial scars, melisma, blemishes, and lesions. The spaces on the GFE denoting Patient 5's weight, height, blood pressure, and heart rate were blank. The "Cosmetic Evaluation" section of the GFE consisted of ten check-mark boxes, of which only five boxes were checked. At the bottom of the single-page GFE was a listing of approximately thirty (30) cosmetic treatments and procedures with check-mark boxes next to each one that indicate approval or "clearance" for the patient to receive or not the treatment or procedure, of which Patient 5 was "cleared" to receive thirteen (13) of the procedures. No specific evaluation, assessment, or treatment plan of Patient 5 was documented as to each of the approved cosmetic procedures.

[8] Metformin is used in patients with type 2 diabetes to control high blood sugar.

49. Patient 5's EuroPhoria medical records contained three pages of text/chat dialogue screenshots that indicated Patient 5 underwent miraDry treatments on July 14, 2021 and June 21, 2022; Vanquish treatments on July 14, 2021, July 21, 2021, July 28, 2021, and August 12, 2021; LHR treatments on August 16, 2021, November 4, 2021, and January 17, 2022; and Xeomin treatment on October 20, 2021. Patient 5's name, date of birth, medical record number, or any other identifiers were not documented in any of the individual text/chat dialogue screenshots. The typed name of a EuroPhoria's registered nurse appeared under each date within each screenshot without identifying what function they performed as to each treatment procedure. While each screenshot stated "Miradry," no formula for creating the tumescent mixture was clearly documented. None of these screenshots indicated that Respondent was consulted, reviewed and/or administered any of the treatments to Patient 5. No specific evaluation, assessment or treatment plan of Patient 5 was documented in the medical record. The most recent screenshot was dated June 22, 2022 and it stated, "I, Uma M. Rao, M.D. have reviewed the forms, photos and plan for this patient. I agree with the medical record/treatment plan as stated. I do hereby attest that this information is true, accurate and complete to the best of my knowledge."

50. There is no documented indication that Respondent received or completed any formal training regarding the miraDry procedure.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

51. Respondent Uma Malempati Rao, M.D. has subjected her Physician's and Surgeon's Certificate No. A 78409 to disciplinary action under section 2234, subdivision (b), of the Code, and Title 16, California Code of Regulations sections 1399.541 and 1399.545, in that she committed gross negligence during the care and treatment of Patients 1, 2, 3 4, and 5. The circumstances are set forth in paragraphs 14 through 50, and those paragraphs are incorporated by reference as if fully set forth herein.

52. Respondent's license is subject to disciplinary action because she, and the mid-level providers she was supervising, committed gross negligence during the care and treatment of Patients 1, 2, 3, 4 and 5 in the following distinct and separate ways:

a. By failing to properly provide adequate supervision and oversight to mid-level practitioners who provided treatment and care to Patients 1, 2, 3, 4, and 5;

b. By failing to properly create and maintain adequate and accurate medical records for Patients 1, 2, 3, 4, and 5; and

c. By supervising and managing mid-level providers in the miraDry procedure without herself obtaining any formal training in that procedure.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

53. Respondent Uma Malempati Rao, M.D. has further subjected her Physician's and Surgeon's Certificate No. A 78409 to disciplinary action under section 2234, subdivision (c), of the Code, and Title 16, California Code of Regulations sections 1399.541 and 1399.545, in that she, and the mid-level providers she was supervising, committed repeated negligent acts during the care and treatment of Patients 1, 2, 3, 4 and 5. The circumstances are set forth in paragraphs 14 through 52, and those paragraphs are incorporated by reference as if fully set forth herein.

54. Respondent committed the following negligent acts during the care and treatment of Patients 1, 2, and 5:

a. By failing to properly obtain and document Patient 1's complete medical history prior to performing cosmetic procedures;

b. By failing to properly conduct and document Patient 1's physical examination prior to performing cosmetic procedures;

c. By failing to properly obtain and document Patient 1's informed consent prior to performing each cosmetic procedure;

d. By failing to properly conduct and document Patient 2's physical examination prior to performing cosmetic procedures; and

e. By failing to properly obtain and document Patient 5's relevant medical history and chief complaint prior to performing cosmetic procedures.

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THIRD CAUSE FOR DISCIPLINE

(Failure To Maintain Adequate And Accurate Records)

55. Respondent Uma Malempati Rao, M.D. has further subjected her Physician's and Surgeon's Certificate No. A 78409 to disciplinary action under section 2266 of Code, and Title 16, California Code of Regulations sections 1399.541 and 1399.545, in that she, and the mid-level providers she was supervising, failed to maintain adequate and accurate medical records for Patients 1, 2, 3, 4, and 5. The circumstances are set forth in paragraphs 14 through 50, and those paragraphs are incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 78409, issued to Uma Malempati Rao, M.D.;

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

3. Ordering Uma Malempati Rao, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: NOV 10 2022

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

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