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

In the Matter of the First Amended Accusation Against: Michael K. Obeng, M.D. Physician's and Surgeon's Certificate No. A 107087 Respondent.	Case No.: 800-2019-057223

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 18, 2024.

IT IS SO ORDERED: December 19, 2023.

MEDICAL BOARD OF CALIFORNIA

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

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: MICHAEL K. OBENG, M.D. MIKO Plastic Surgery 435 North Roxbury Drive, Suite 205 Beverly Hills, California 90210 Physician's and Surgeon's Certificate No. A 107087, Respondent.	Case No. 800-2019-057223 OAH No. 2023010625 **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). 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 Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Michael K. Obeng, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On March 27, 2019, the Board issued Physician's and Surgeon's Certificate No. A 107087 to Respondent. That license was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2019-057223, and will expire on March 31, 2025, unless renewed.

JURISDICTION

4. A First Amended Accusation No. 800-2019-057223 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 or about October 27, 2022. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

5. A copy of First Amended Accusation No. 800-2019-057223 is attached as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in First Amended Accusation No. 800-2019-057223. Respondent has also carefully read, 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 be represented by counsel at his own expense; 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. 800-2019-057223, 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 case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his 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 First Amended Accusation No. 800-2019-057223, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 107087 to disciplinary action.

12. 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

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. 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.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in First Amended Accusation No. 800-2019-057223 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. 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 107087 issued to Respondent Michael K. Obeng, M.D. is revoked. However, the revocation is stayed and Respondent's period of existing probation is extended for an additional four (4) years. Respondent's period of probation shall run consecutive to, and shall take effect immediately upon completion of the probationary period in case number 800-2018-043459, subject to the following terms and conditions, which shall take effect immediately and which supersede the condition of probation contained in the Order in case number 800-2018-043459.

1. 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 if it was completed in compliance with the previous Order in case number 800-2018-043459 will be accepted towards the fulfillment of this condition.

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.

2. 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, or a part thereof, completed in compliance with the Board's previous Order in case no. 800-2018-043459, will be accepted towards the fulfillment of this condition, in the sole discretion of the Board or its designee.

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.

3. 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 six (6) months 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.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, 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. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. MONITORING - PRACTICE. Within 60 calendar days of the effective date of this Decision, Respondent's practice shall be monitored through his participation in a formal Physician Enhancement Program or a Professional Enhancement Program (PEP hereafter) that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education, approved in advance by the Board or its designee. Respondent shall participate in the PEP at Respondent's expense during the term of probation.

If Respondent fails to enroll in an approved PEP 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 he is enrolled in an approved PEP.

The PEP 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 medicine within the standards of practice, summarizing Respondent's progress and making further recommendations, if appropriate. It shall be the sole responsibility of Respondent to ensure that the PEP submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If Respondent is dismissed or resigns from the PEP during his probation, or if the PEP is no longer available to Respondent for any reason, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of another professional enhancement program that will be assuming the responsibility for monitoring Respondent's practice, within 15 calendar days. If Respondent fails to obtain approval of a replacement PEP within 60 calendar days of the resignation or unavailability of previous PEP, 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 PEP is approved and assumes monitoring responsibility. If the Respondent does not enroll in a Board approved PEP, Respondent shall not resume the practice of medicine until a final decision has been rendered on an accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - BILLING. 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 billing monitor(s), 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 billing 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 billing 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 billing shall be monitored by the approved billing 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 billing 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 for billing, and whether Respondent is billing appropriately. 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 billing review, semi-annual billing practices 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.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is permitted to supervise physician assistants and advanced practice nurses.

8. 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 court orders.

9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is

hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $25,000 (twenty-five thousand dollars). 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.

10. 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.

11. 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.

12. 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.

13. 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 Boards'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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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 First Amended Accusation No. 800-2019-057223 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.

ACCEPTANCE

I have carefully read the Stipulated Settlement and Disciplinary Order. I have been given the opportunity to discuss this document with an attorney of my choice. 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: 07/18/2023

MICHAEL K. OBENG, M.D.
Respondent

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ENDORSEMENT

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

DATED: July 19, 2023

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

Electronically Signed

VLADIMIR SHALKEVICH
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 First Amended Accusation Against: **MICHAEL K. OBENG, M.D.** **435 North Roxbury Drive, Suite 205** **Beverly Hills, CA 90210** Physician's and Surgeon's Certificate Number A107087, Respondent.	Case No. 800-2019-057223 **FIRST AMENDED ACCUSATION**

PARTIES

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

2. On March 27, 2009, the Board issued Physician's and Surgeon's Certificate Number A 107087 to Michael K. Obeng, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

JURISDICTION

3. On June 15, 2022, Accusation Number 800-2019-057223 was filed against Respondent and is currently pending before the Board.

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 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

6. Section 810 of the Code states (effective January 1, 2018, to December 31, 2021):

> (a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:
>
> (1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.
>
> (2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.
>
> (b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.
>
> (c)(1) It shall constitute cause for automatic suspension of a license or certificate issued pursuant to Chapter 4 (commencing with Section 1600), Chapter 5 (commencing with Section 2000), Chapter 6.6 (commencing with Section 2900), Chapter 7 (commencing with Section 3000), or Chapter 9 (commencing with Section 4000), or pursuant to the Chiropractic Act or the Osteopathic Act, if a licensee or certificate holder has been convicted of any felony involving fraud committed by the licensee or certificate holder in conjunction with providing benefits covered by worker's compensation insurance, or has been convicted of any felony involving Medi-Cal fraud committed by the licensee or certificate holder in conjunction with the Medi-Cal program, including the Denti-Cal element of the Medi-Cal program, pursuant to Chapter 7 (commencing with Section 14000), or Chapter 8 (commencing with Section 14200), of Part 3 of Division 9 of the Welfare and Institutions Code. The board shall convene a disciplinary hearing to determine whether or not the license or certificate shall be suspended, revoked, or some other disposition shall be considered, including, but not limited to, revocation with the opportunity to petition for reinstatement, suspension, or other limitations on the license or certificate as the board deems appropriate.
>
> (2) It shall constitute cause for automatic suspension and for revocation of a license or certificate issued pursuant to Chapter 4 (commencing with Section 1600), Chapter 5 (commencing with Section 2000), Chapter 6.6 (commencing with Section 2900), Chapter 7 (commencing with Section 3000), or Chapter 9 (commencing with Section 4000), or pursuant to the Chiropractic Act or the Osteopathic Act, if a

licensee or certificate holder has more than one conviction of any felony arising out of separate prosecutions involving fraud committed by the licensee or certificate holder in conjunction with providing benefits covered by worker's compensation insurance, or in conjunction with the Medi-Cal program, including the Denti-Cal element of the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000), or Chapter 8 (commencing with Section 14200), of Part 3 of Division 9 of the Welfare and Institutions Code. The board shall convene a disciplinary hearing to revoke the license or certificate and an order of revocation shall be issued unless the board finds mitigating circumstances to order some other disposition.

(3) It is the intent of the Legislature that paragraph (2) apply to a licensee or certificate holder who has one or more convictions prior to January 1, 2004, as provided in this subdivision.

(4) Nothing in this subdivision shall preclude a board from suspending or revoking a license or certificate pursuant to any other provision of law.

(5) "Board," as used in this subdivision, means the Dental Board of California, the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, the State Board of Optometry, the California State Board of Pharmacy, the Osteopathic Medical Board of California, and the State Board of Chiropractic Examiners.

(6) "More than one conviction," as used in this subdivision, means that the licensee or certificate holder has one or more convictions prior to January 1, 2004, and at least one conviction on or after that date, or the licensee or certificate holder has two or more convictions on or after January 1, 2004. However, a licensee or certificate holder who has one or more convictions prior to January 1, 2004, but who has no convictions and is currently licensed or holds a certificate after that date, does not have "more than one conviction" for the purposes of this subdivision.

(d) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

7. Section 2234 of the Code states (effective January 1, 2014, to December 31, 2019):

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 practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

(h) The repeated 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.

8. Section 2261 of the Code states:

Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

9. 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.

10. Section 2216.2 of the Code states:

(a) It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(b) For purposes of this section, the board shall determine what constitutes adequate security.

(c) Nothing in this section shall require an insurer admitted to transact liability insurance in this state to provide coverage to a physician and surgeon.

(d) The security required by this section shall be acceptable only if provided by any one of the following:

(1) An insurer admitted pursuant to Section 700 of the Insurance Code to transact liability insurance in this state.

(2) An insurer that is eligible pursuant to Section 1765.1 of the Insurance Code.

(3) A cooperative corporation authorized by Section 1280.7 of the Insurance Code.

(4) An insurer licensed to transact liability insurance in at least one state of the United States.

11. Section 2259.7 of the Code states:

The Medical Board of California shall adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital, as defined in Section 1250 of the Health and Safety Code. In adopting those regulations, the Medical Board of California shall take into account the most current clinical and scientific information available. A violation of those extraction and postoperative care standards constitutes unprofessional conduct.

12. Health and Safety Code section 123110 states (effective January 1, 2018, to December 31, 2020):

(a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient's personal representative shall be entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, as specified in subdivision (k). However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A healthcare provider shall permit this inspection during business hours within five working days after receipt of the request. The inspection shall be conducted by the patient or patient's personal representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b)(1) Additionally, any patient or patient's personal representative shall be entitled to a paper or electronic copy of all or any portion of the patient records that he or she has a right to inspect, upon presenting a request to the health care provider specifying the records to be copied, together with a fee to defray the costs of producing the copy or summary, as specified in subdivision (k). The health care provider shall ensure that the copies are transmitted within 15 days after receiving the request.

(2) The health care provider shall provide the patient or patient's personal representative with a copy of the record in the form and format requested if it is readily producible in the requested form and format, or, if not, in a readable paper copy form or other form and format as agreed to by the health care provider and the patient or patient's personal representative. If the requested patient records are maintained electronically and if the patient or patient's personal representative requests an electronic copy of those records, the health care provider shall provide them in the electronic form and format requested if they are readily producible in that form and format, or, if not, in a readable electronic form and format as agreed to by the health care provider and the patient or patient's personal representative.

(c) Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or patient's personal representative under this section, if the original X-rays or tracings are transmitted to another health care provider upon written request of the patient or patient's personal representative and within 15 days after receipt of the request. The

request shall specify the name and address of the health care provider to whom the records are to be delivered. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

(d)(1) Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, a patient, former patient, or the personal representative of a patient or former patient, is entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records or supporting forms are needed to support a claim or appeal regarding eligibility for a public benefit program. These programs shall be the Medi-Cal program, the In-Home Supportive Services Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, social security disability insurance benefits, Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits, federal veterans service-connected compensation and nonservice connected pension disability benefits, and CalFresh.

(2) Although a patient shall not be limited to a single request, the patient or patient's personal representative shall be entitled to no more than one copy of any relevant portion of his or her record free of charge.

(3) This subdivision shall not apply to any patient who is represented by a private attorney who is paying for the costs related to the patient's claim or appeal, pending the outcome of that claim or appeal. For purposes of this subdivision, "private attorney" means any attorney not employed by a nonprofit legal services entity.

(e) If the patient's appeal regarding eligibility for a public benefit program specified in subdivision (d) is successful, the hospital or other health care provider may bill the patient, at the rates specified in subdivisions (b) and (c), for the copies of the medical records previously provided free of charge.

(f) If a patient or his or her personal representative requests a record pursuant to subdivision (d), the health care provider shall ensure that the copies are transmitted within 30 days after receiving the written request.

(g) This section shall not be construed to preclude a health care provider from requiring reasonable verification of identity prior to permitting inspection or copying of patient records, provided this requirement is not used oppressively or discriminatorily to frustrate or delay compliance with this section. Nothing in this chapter shall be deemed to supersede any rights that a patient or personal representative might otherwise have or exercise under Section 1158 of the Evidence Code or any other provision of law. Nothing in this chapter shall require a healthcare provider to retain records longer than required by applicable statutes or administrative regulations.

(h) This chapter shall not be construed to render a health care provider liable for the quality of his or her records or the copies provided in excess of existing law and regulations with respect to the quality of medical records. A health care provider shall not be liable to the patient or any other person for any consequences that result from disclosure of patient records as required by this chapter. A health care provider shall not discriminate against classes or categories of providers in the transmittal of X-rays or other patient records, or copies of these X-rays or records, to other providers as authorized by this section.

Every health care provider shall adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records that effectively prevent the discrimination described in this subdivision. A health care provider may establish reasonable conditions, including a reasonable deposit fee, to ensure the return of original X-rays transmitted to another health care provider, provided the conditions do not discriminate on the basis of, or in a manner related to, the license of the provider to which the X-rays are transmitted.

(i) Any health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. Any health care provider described in paragraphs (1) to (3), inclusive, of subdivision (a) of Section 123105 that willfully violates this chapter is guilty of an infraction punishable by a fine of not more than one hundred dollars ($100). The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.

(j) This section prohibits a health care provider from withholding patient records or summaries of patient records because of an unpaid bill for health care services. Any health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services is subject to the sanctions specified in subdivision (i).

(k)(1) Except as provided in subdivision (d), a health care provider may impose a reasonable, cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee includes only the cost of the following:

(A) Labor for copying the patient records requested by the patient or patient's personal representative, whether in paper or electronic form.

(B) Supplies for creating the paper copy or electronic media if the patient or patient's personal representative requests that the electronic copy be provided on portable media.

(C) Postage, if the patient or patient's personal representative has requested the copy, or the summary or explanation, be mailed.

(D) Preparing an explanation or summary of the patient record, if agreed to by the patient or patient's personal representative.

(2) The fee from a health care provider shall not exceed twenty-five cents ($0.25) per page for paper copies or fifty cents ($0.50) per page for records that are copied from microfilm.

13. Health and Safety Code section 123105, subdivision (a)(4), provides in relevant part (effective January 1, 2018, to December 31, 2020):

As used in this chapter:

(a) "Health care provider" means any of the following:

. . .

(4) A physician and surgeon licensed pursuant to Chapter 5 (commencing with

Section 2000) of Division 2 of the Business and Professions Code or pursuant to the Osteopathic Act.

. . . .

14. Insurance Code section 1871.4 states:

(a) It is unlawful to do any of the following:

(1) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(3) Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section.

(4) Make or cause to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

For the purposes of this subdivision, "statement" includes, but is not limited to, a notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.

(5) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(6) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(b) Every person who violates subdivision (a) shall be punished by imprisonment in county jail for one year, or pursuant to subdivision (h) of Section 1170 of the Penal Code, for two, three, or five years, or by a fine not exceeding one hundred fifty thousand dollars ($150,000) or double the value of the fraud, whichever is greater, or by both imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid. A person convicted under this section may be charged the costs of investigation at the discretion of the court.

(c) A person who violates subdivision (a) and who has a prior felony conviction of that subdivision, of former Section 556, of former Section 1871.1, or of Section 548 or 550 of the Penal Code, shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (b).

The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

(d) This section may not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

15. Section 549 of the Penal Code states:

Any firm, corporation, partnership, or association, or any person acting in his or her individual capacity, or in his or her capacity as a public or private employee, who solicits, accepts, or refers any business to or from any individual or entity with the knowledge that, or with reckless disregard for whether, the individual or entity for or from whom the solicitation or referral is made, or the individual or entity who is solicited or referred, intends to violate Section 550 of this code or Section 1871.4 of the Insurance Code is guilty of a crime, punishable upon a first conviction by imprisonment in the county jail for not more than one year or by imprisonment pursuant to subdivision (h) of Section 1170 for 16 months, two years, or three years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 or by that imprisonment and a fine of fifty thousand dollars ($50,000). Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

16. Section 550 of the Penal Code states in part:

(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of a motor vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers" compensation health benefits under the Labor Code.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(4) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

REGULATIONS

17. California Code of Regulations, title 16, section 1360, states:

(a) For the purposes of denial, suspension or revocation of a license pursuant to Section 141 or Division 1.5 (commencing with Section 475) of the code, a crime, professional misconduct, or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license if to a substantial degree it evidences present or potential unfitness of a person holding a license to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such crimes, professional misconduct, or acts shall include but not be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of state or federal law governing the applicant's or licensee's professional practice.

(b) In making the substantial relationship determination required under subdivision (a) for a crime, the board shall consider the following criteria:

(1) The nature and gravity of the crime;

(2) The number of years elapsed since the date of the crime; and

(3) The nature and duties of the profession.

18. California Code of Regulations, title 16, section 1356.6, subdivision (b), states in relevant part:

> (b) The following standards apply to any liposuction procedure not required by subsection (a) to be performed in a general acute-care hospital or a setting specified in Health and Safety Code Section 1248.1:
>
> . . .
>
> (4) Records. Records shall be maintained in the manner necessary to meet the standard of practice and shall include sufficient information to determine the quantities of drugs and fluids infused and the volume of fat, fluid and supernatant extracted and the nature and duration of any other surgical procedures performed during the same session as the liposuction procedure.

COST RECOVERY

19. Section 125.3[1] 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

Patient 1

20. The respondent is a board-certified plastic and reconstructive surgeon. He owns Miko Plastic Surgery, Miko Surgery Center, and Miko Anesthesia Group. He is the sole stockholder of Miko Surgery Center and Miko Anesthesia Group.

21. On August 30, 2018, Respondent performed surgery on Patient 1,[2] a then forty-six-year-old female. The anesthesia start time was 1117 (11:17 a.m.) and the stop time was 1735 (5:35 p.m.). The surgical time would be somewhat less. The dictated operative report shows the

[1] Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians and surgeons from paying recovery of the costs of investigation and prosecution by the Board, was repealed.

[2] The names of the patients are omitted in this public filing in order to protect their privacy.

surgery was for "1. Bilateral breast open capsulectomy; 2. Removal of Bilateral Implants." The pathology report, dated September 4, 2018, for submitted left and right specimens shows a final diagnosis of "1. Left breast capsule demonstrating fibrosis and fibroplasia and fibrosis. There is no identifiable polarizable material within the wall having the appearance of silicone. 2. Right breast capsule demonstrating fibrosis and fibroplasia and extensive calcification. There is no identifiable polarizable material. 3. Left breast tissue containing microcysts and adenosis. 4. Right breast tissue containing microcysts, adenosis and stromal fibrosis. There is no malignancy in these sections." The procedure was covered by insurance and was not cosmetic. The respondent also performed liposuction, a cosmetic procedure.

22. Respondent billed Blue Cross/Blue Shield of Arizona as an out-of-network provider for the non-cosmetic procedure. The total charges billed were $157,280.00, an exorbitant sum. Specifically, on or about November 1, 2018, Respondent/Miko Plastic Surgery billed $52,960 for Respondent's professional fee. Separately, on or about November 1, 2018, Miko Anesthesia Group billed an additional $10,400 for the anesthesia. Finally, on or about November 2, 2018, Miko Surgery Center billed an additional $93,920 for use of the surgery center. Patient 1 paid $5,000 out of pocket through CareCredit for the non-covered cosmetic surgery performed at the same time.

23. The respondent's professional fee of $52,960 for the removal of the breast implants and capsulectomy alone is exorbitant. In addition, he double-billed when he billed (a) $10,260 per breast for the removal of the breast implants and (b) $16,220 per breast for the capsulectomy. By billing for the capsulectomy and using Diagnosis Code 99654, Respondent was prohibited from also billing for removal of the breast implants and using Diagnosis Code 19328. The capsulectomy charges alone covered the removal of the breast implants. Furthermore, Respondent billed $16,220 per breast. It is the community standard to discount the second breast by fifty percent.

24. On March 14, 2019, Respondent again performed surgery on Patient 1. The anesthesia start time was 1425 (2:25 p.m.) and the stop time was 1840 (6:40 p.m.). The surgical time would be less. The dictated operative report lists the procedures as: "1. Excision of bilateral

fat necrosis. 2. Revision of hypertrophic breast scars. 3. Fat grafting to bilateral breast." The pathology report, dated March 19, 2019, for a submitted left breast specimen shows a final diagnosis of "extensive traumatic panniculitis (fat necrosis), granulomatous mastitis and cicatrix. There are cysts and adenosis with adjacent breast tissue. There is no malignancy in these sections."

25. Respondent billed Blue Cross/Blue Shield of Arizona as an out-of-network provider for the non-cosmetic procedure. The total charges were $233,000, which were exorbitant. Specifically, on or about April 1, 2019, Miko Surgery Center billed $140,000 for use of the surgery center. On or about April 1, 2019, Miko Anesthesia Group billed $13,000 for the anesthesia. On or about July 3, 2019, Respondent/Miko Plastic Surgery billed $80,000 for his professional fee.

26. Respondent's professional fee of $80,000 for the March 14, 2019 surgery alone is exorbitant. In addition, he billed $40,000 per breast. As stated earlier, it is the community standard to discount the second breast by fifty percent.

27. On or about April 16, 2019, Patient 1 submitted a request via e-mail to the Respondent's office for copies of her medical records from January 18, 2019, to April 2019. She had submitted a release of medical information on March 14, 2019. She asked that the records be sent to her insurance adjuster. On April 22, 2019, Patient 1 followed-up with the Respondent's billing manager concerning her request for copies of her medical records. The respondent's billing manager responded that the Respondent needed to review Patient 1's chart, and once the Respondent approved, the medical records would be provided to the insurance adjuster. On June 3, 2019, Patient 1 submitted another request via e-mail to Respondent's office for copies of her medical records, citing Health and Safety Code sections 123100, through 123149, which address a patient's rights to see and receive copies of his or her medical records within 15 days after receiving the request. She also attached a completed Authorization for Release of Medical Information form, dated June 3, 2019. On June 7, 2019, Patient 1 sent another request via facsimile, marked urgent, for copies of her medical records. Patient 1 did not receive the requested records from Respondent until December 4, 2019.

28. The respondent's medical and billing records for Patient 1 are inadequate and inaccurate. Missing entries and omissions in the chart include:

a. Patient 1's medical records contain a back-dated consultation note generated on February 26, 2020, for a consultation held on January 21, 2019, with the following explanation, "February 26, 2020, 1037. This note is for original entry date of patient's visit on 01/21/2019 for missing entry notes: . . . ." His original handwritten notes and intake form, dated January 21, 2019, are missing;

b. Respondent's medical records for Patient 1 show that, on March 14, 2019, he performed bilateral fat necrosis resections. However, the operative report does not indicate that he sent any of the two specimens dissected on that day to pathology for analysis. A pathology report shows analysis of a left breast specimen only;

c. The typed operative report dated March 14, 2019, indicates the total blood loss was "[a]bout 200 cc," but a handwritten note indicates the total blood loss was less than "100 cc;"

d. There are no chart notes or entries for March 18, 2019, and April 4, 2019, which are dates that the Respondent treated Patient 1, per a U.S. Department of Labor, Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act), dated April 8, 2019;

e. Respondent did not document the August 30, 2018 liposuction procedure in an operative report, or elsewhere in Patient 1's medical records; and

f. Respondent claims not to have financial, billing, and/or claims records for Patient 1.

Patient 2

29. In approximately April of 2018, Patient 2 had breast augmentation surgery performed by Dr. Vishal Kapoor, a plastic surgeon whose office and surgical center were located at 436 N. Roxbury Drive in Beverly Hills, California. Dr. Kapoor's office was across the street from Respondent's office and surgery center, which Respondent operates under the fictitious name "MIKO Plastic Surgery."

30. Patient 2 returned to see Dr. Kapoor in approximately September, 2018, inquiring about a vaginal rejuvenation surgery. Patient 2 was then brought from Dr. Kapoor's office to

Respondent's office by one of Dr. Kapoor's medical assistants or patient coordinators. Respondent explained in his interview with the Board's investigators that Patient 2 "introduced herself to me and asking me that Dr. Kapoor said that I can do a vaginal rejuvenation on her and vaginal tightening. I answered yes, I can and I said okay."

31. Respondent further explained: "We basically stood outside, and I told her that's fine. Just go to Dr. Kapoor. Let him schedule the surgery. And they'll coordinate with my office. I will see you that morning. I will go over the medical history again since you don't have any medical history, and then I'll examine you." Patient 2's elective cosmetic surgery, was scheduled for October 2, 2018. Neither Respondent nor Dr. Kapoor, nor any of their employees discussed the cost of the operation with Patient 2 at any time prior to the surgery.

32. Patient 2 presented to Dr. Kapoor on October 2, 2018 for the surgery, described as "Labioplasty/Vaginal tightening and Clitoral unhooding" in Respondent's records. Respondent explained: "they were running late, so they asked me – around 2:00 – if I had any cases going on here [at Respondent's surgery center across the street from Dr. Kapoor's office]. They asked me if the patient come here if I can do the case here, I said of course. When the patient came here, I sat down with her. I did an H&P [history and physical examination] I examined her. We went over all her options. And we went over the risks, the benefits, and the alternatives. Patient agreed, and she was a candidate for vaginal rejuvenation including labia reduction and unhooding the clitoris, because she had a lot of skin on top of the clitoris, and she said that it affected her sex life. And then, she also reported a large vaginal vault, and she wanted the walls to be brought together – so she can enjoy her sexual life. And I examined her. We went over everything. She was a candidate. She signed an informed consent. And we took her to the operating room."

33. When Respondent took Patient 2 to the operating room at his outpatient surgery center, Respondent had no insurance of any kind to provide adequate security for claims by any patient arising out of surgical procedures he was performing in the outpatient setting.

34. The surgery was performed under general anesthesia. The anesthesiologist's record indicates that the surgery began at 3:00 p.m. and ended at approximately 5:30 p.m. Respondent

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did not prepare a surgery report, or an operative note, describing the procedure or any complications.

35. After she woke up from her procedure, Patient 2 went to the restroom and noticed that her urine in the bowl was a light red color, because drops of blood seeped out of her body and into the toilet bowl while she was using it. She told the Respondent, who explained to her that this was normal. Prior to leaving, Patient 2 was given a bottle of antibiotics to take. The respondent or his staff prepared and he signed a recovery room record, which falsely indicated that Patient 2 was discharged at 8:38 p.m. In fact, at approximately 6:00 to 6:15 p.m., (half an hour to forty-five minutes after completion of her surgery) Patient 2 was taken outside in a wheelchair by Respondent's employee, where a driver arranged by Dr. Kapoor, or Respondent, was waiting to drive her home. Patient 2 felt a wet sensation and believed that she was bleeding from her vaginal area. She notified Respondent's employee who was pushing her wheelchair. Respondent's employee reassured Patient 2 that this was a normal side effect of her procedure and placed her in the car.

36. While riding home, Patient 2 called her boyfriend and explained that she felt as though she was bleeding heavily. She was drenched in blood and wrapped a sweater around her because she was concerned about dirtying the seat in the vehicle with her blood. Her boyfriend advised her to go to the nearest hospital. The driver overheard the conversation and drove Patient 2 to the nearest hospital, a Kaiser Hospital in West Los Angeles. During the drive, Patient 2 was dizzy and sweaty, and upon arriving at the hospital was in excruciating pain in her vaginal area.

37. According to Kaiser's certified medical records, Patient 2 arrived at the emergency room at approximately 7:00 p.m., with tachycardia, and a blood pressure of 106/79. She developed lightheadedness. A CT scan ordered by the emergency room physician showed that Patient 2 was suffering from active bleeding with a large accumulation of internal bleeding into a perineal hematoma measuring 13x7 cm, in addition to the observable external bleeding. Given the ongoing hemorrhage with unstable vitals and signs of hemorrhagic shock, Patient 2 was admitted to the hospital to undergo a surgery that involved the evacuation of a massive vulvar hematoma, ligation of a bleeding artery in Patient 2's rectovaginal septum, and extensive vaginal

reconstruction. Patient 2 received six units of Packed Red Blood Cells before and/or during her surgery at Kaiser.

38. The respondent said in his interview, approximately three years after the event: "I saw the patient myself before the patient walked out, which is what I do when I'm here in the building... We come over here to the office and leave. Yeah, I check them, you know, give them hugs, and I say, okay. We'll see you. And I left to go to dinner. I remember this vividly. I was at dinner eating not too far from my office, and Dr. Kapoor called me.... He said, oh, the patient that you did surgery on just called – the husband just called and said that the patient is bleeding. There is bleeding in the pads. And I said, okay, let's – uh – maybe it's just from the – the wound... That's okay. Let them turn around. I can meet them back in the office. I'm not too far. I was about maybe a mile and a half away, about ten minutes – tops. So, Kapoor said, let me call you back. Kapoor called, and by the time Kapoor got a hold of them, they said, - uh – they were closer to Kaiser. So, they're now going to Kaiser, because they are freaking out. And I said that's fine."

39. In his interview, Respondent told the Board investigators: "And I told Dr. Kapoor, that's fine. Can the Kaiser doctor call me? They called me, and I asked questions. The patient was hemodynamically stable. Her hemoglobin was about ten. Blood pressure was fine. She was not tachycardic. And I was shocked how they managed the patient. They told me they gave her two units of blood. And I found it very disturbing for, you know, a 28-year-old woman who is hemodynamically stable, hemoglobin over ten, she is not tachycardic; blood pressure is fine – to give units."

40. Following her surgery at the Kaiser Hospital, Patient 2 remained hospitalized for three days. She was discharged from the hospital on October 4, 2018.

41. Following her surgery at the Kaiser Hospital, the Beverly Hills Wellness Institute -- Dr. Kapoor's practice -- billed Patient 2's insurance $50,985, for a "soft tissue tumor resection" performed on October 2, 2018; Lotus Surgery Center, Dr. Kapoor's outpatient surgery center, billed Patient 2's insurance $78,730.86, for surgical center services, rendered on October 2, 2018, and Roxbury Anesthesia Group billed Patient 2's insurance $3,600 for services rendered on

October 2, 2018. Respondent did not prepare a surgical report, but Dr. Kapoor presented a false surgical report and documents to the insurance company, claiming that the surgery was a soft tissue tumor resection. Respondent did not bill Patient 2 or Dr. Kapoor for performing the surgery on Patient 2, the use of MIKO Plastic Surgery, or for anesthesia services.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

42. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed grossly negligent acts related to his care and treatment of Patients 1 and 2. The circumstances are as follows:

43. The facts and allegations in paragraphs 20 through 41, above, are incorporated by reference and re-alleged as if fully set forth herein.

44. Respondent committed an extreme departure from the standard of practice with regard to Patient 1, when Respondent/Miko Plastic Surgery, Miko Surgery Center, and Miko Anesthesia Group billed Patient 1's health insurance carrier outrageous and exorbitant fees for uncomplicated surgeries that Respondent performed on Patient 1. The charges are at least three to four times in excess of the usual and customary charge for those surgeries in the community. The billing was done under the Respondent's name and that of corporate entities of which he is the owner and sole stockholder.

30. Discharge of Patient 2 to the care of a driver after undergoing surgery, under general anesthesia, in an anatomic area notorious for robust vascularity, when Patient 2 noted bleeding after the operation and brought it to Respondent's and his employee's attention, was an extreme departure from the standard of care.

31. The manner in which Respondent carried out the informed consent process with Patient 2 was an extreme departure from the standard of care.

32. Respondent's irregular billing practices, including failure to discuss the cost of the procedure with Patient 2, represented an extreme departure from the standard of care.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

45. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), Health and Safety Code section 123110, subdivision (b)(1), and California Code of Regulations, title 16, section 1356.6, subdivision (b)(4), in that he committed repeated negligent acts related to his care and treatment of Patients 1 and 2. The circumstances are as follows:

46. The facts and allegations in paragraphs 20 through 41, above, are incorporated by reference and re-alleged as if fully set forth herein.

47. Respondent committed repeated negligent acts as follows:

a. Respondent departed from the standard of practice when he billed Patient 1's health insurance carrier outrageous and exorbitant fees for uncomplicated surgeries that he performed on Patient 1. The charges are at least three to four times in excess of the usual and customary charge for those surgeries in the community. The billing was done under the Respondent's name and corporate entities of which he is the owner and sole stockholder;

b. Respondent departed from the standard of practice when he delayed approximately six months in providing Patient 1 her medical records; and

c. Respondent departed from the standard of practice when he maintained inadequate and inaccurate medical, financial, billing, and claims records for Patient 1.

d. Discharge of Patient 2 to the care of a driver after undergoing surgery, under general anesthesia, in an anatomic area notorious for robust vascularity, when Patient 2 noted bleeding after the operation and brought it to Respondent's and his employee's attention, was a departure from the standard of care.

e. The manner in which Respondent carried out the informed consent process with Patient 2 was a departure from the standard of care.

f. Respondent's irregular billing practices, including failure to discuss the cost of the procedure with Patient 2, represented a departure from the standard of care.

g. Respondent's failure to prepare an appropriate operative note or report about Patient 2's operation on October 2, 2018, was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Making False Representations)

48. Respondent is subject to disciplinary action under Code sections 2234, subdivision (a), and 2261, by making false representations to Patient 1's health insurance company. The circumstances are as follows:

49. The facts and allegations in paragraphs 20 through 28, above, are incorporated by reference and re-alleged as if fully set forth herein.

50. Respondent committed acts involving dishonesty in the course of his practice by submitting false and fraudulent insurance claims to the insurance carrier for payment of services rendered to Patient 1 on August 30, 2018, and on March 14, 2019. Specifically, Respondent excessively billed the carrier for his services and did so in a manner that did not truly represent the uncomplicated nature of the services that were actually performed. The charges billed for the procedures were outrageous and exorbitant. He also double-billed for services rendered on August 30, 2018. He billed full price for performing surgery on both breasts on August 30, 2018, and March 14, 2019. He failed to discount the surgery performed on the second breast by fifty percent on each occasion.

FOURTH CAUSE FOR DISCIPLINE

(Commission of Dishonest or Corrupt Acts)

51. Respondent is further subject to disciplinary action under Code, section 2234, subdivision (e), for the commission of dishonest or corrupt acts which are substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

52. The facts and allegations in paragraphs 20 through 41, above, are incorporated by reference and re-alleged as if fully set forth herein.

53. Respondent committed acts involving dishonesty in the course of his practice by submitting false and fraudulent insurance claims to the insurance carrier for payment of services rendered to Patient 1 on August 30, 2018, and on March 14, 2019. Specifically, Respondent excessively billed the carrier for his services and did so in a manner that did not truly represent

the uncomplicated nature of the services that were actually performed. The charges billed for the procedures were outrageous and exorbitant. He also double-billed for services rendered on August 30, 2018. He billed full price for performing surgery on both breasts on August 30, 2018, and March 14, 2019. He failed to discount the surgery performed on the second breast by fifty percent on each occasion.

54. Respondent committed acts involving dishonesty and corruption by aiding or abetting insurance fraud in connection to the care and treatment of Patient 2

FIFTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping)

55. Respondent is subject to disciplinary action under Code section 2266 and California Code of Regulations, title 16, section 1356.6, subdivision (b)(4), in that Respondent maintained inadequate and inaccurate records in the care and treatment of Patients 1 and 2. The circumstances are as follows:

56. The facts and allegations in paragraphs 20 through 41, above, are incorporated by reference and re-alleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Committing Insurance Fraud and Aiding or Abetting Insurance Fraud)

57. Respondent Michael K. Obeng, M.D. is subject to disciplinary action under sections 2234, 2261, and 810 of the Code, as well as Insurance Code section 1871.4 and Penal Code sections 549 or 550, in that Respondent participated in presenting fraudulent insurance claims, and/or aided or abetted others to do so. The circumstances are as follows:

58. Allegations of paragraphs 20 through 41 are incorporated herein by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Carry Malpractice Insurance)

59. Respondent Michael K. Obeng, M.D. is subject to disciplinary action under section 2216.2 of the Code in that he failed to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed at his outpatient surgery center. The circumstances are as follows:

60. Allegations of paragraphs 20 through 41 are incorporated herein by reference.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

61. Respondent is subject to disciplinary action under Code section 2234 for general unprofessional conduct by engaging in the conduct unbecoming a licensed physician and surgeon in connection with his care and treatment of Patients 1 and 2. The circumstances are as follows:

62. The facts and allegations in paragraphs 20 through 41, above, are incorporated by reference and re-alleged as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

63. To determine the degree of discipline, if any, to be imposed on Respondent Michael K. Obeng, M.D., Complainant alleges that on or about September 23, 2022, in a prior disciplinary action titled *In the Matter of the Accusation Against Michael K. Obeng, M.D.* before the Medical Board of California, in Case Number 800-2018-043459, Respondent's license was revoked, but the revocation was stayed and his license was placed on probation for five years, based on allegations of making false representations, engaging in the unlawful corporate practice of medicine, using an unapproved fictitious name, the commission of corrupt or dishonest acts, failure to maintain accurate medical records, gross negligence, and repeated acts of negligence. That decision is now final and is incorporated by reference as if fully set forth herein.

64. To further determine the degree of discipline, if any, to be imposed on Respondent Michael K. Obeng, M.D., Complainant alleges that on or about October 7, 2019, in a prior disciplinary action titled *In the Matter of the Accusation Against Michael K. Obeng, M.D. before the Medical Board of California*, in Case Number 800-20170-36690, the Board issued a Citation to Respondent because his medical documentation lacked appropriate information in connection to the care and treatment of the patient with initials T.T.

65. To further determine the degree of discipline, if any, to be imposed on Respondent Michael K. Obeng, M.D., Complainant alleges that on or about October 7, 2019, in a prior disciplinary action titled *In the Matter of the Accusation Against Michael K. Obeng, M.D.* before the Medical Board of California, in Case Number 800-2017036690, the Board issued a Citation to

Respondent because his medical documentation lacked appropriate information in connection to the care and treatment of the patient with initials D.A.

PRAYER

WHEREFORE, the 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 A 107087, issued to Respondent Michael K. Obeng, M.D.;

2. Revoking, suspending, or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering him to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

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

DATED: OCT 27 2022

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

Complainant

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