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

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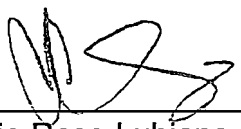
|---|---|
| In the Matter of the Accusation Against:<br><br>**Jeff Jones, M.D.**<br><br>Physician's and Surgeon's<br>Certificate No. **G 46282**<br><br>Respondent. | MBC File # **800-2019-055244** |

## ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error on page 4 of the Decision in the above-titled matter in the first paragraph under Condition 1 – CONTROLLED SUBSTANCES – PARTIAL RESTRICTION. This paragraph currently states: "Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) III and IV of the Act." The Board finds that Schedule V was left off by mistake and that such clerical error should be corrected.

IT IS HEREBY ORDERED that the first paragraph under Condition 1 - CONTROLLED SUBSTANCES – PARTIAL RESTRICTION is corrected to state: "Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) III, IV, and V of the Act.".

Dated: January 26, 2024



Laurie Rose Lubiano, J.D.
Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
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STATE OF CALIFORNIA

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| In the Matter of the Accusation Against:<br><br>Jeff Jones, M.D.<br><br>Physician's and Surgeon's Certificate No. G 46282<br><br>Respondent. | Case No.: 800-2019-055244 |

## DECISION

The attached Stipulated Settlement 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

Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
MARIANNE A. PANSA
Deputy Attorney General
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**JEFF JONES, M.D.**<br>**1524 McHenry Ave, Suite 445**<br>**Modesto, CA 95350-4500**<br><br>**Physician's and Surgeon's Certificate No. G 46282**<br><br>Respondent. | Case No. 800-2019-055244<br><br>OAH No. 2022060004<br><br>**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 Marianne A. Pansa, Deputy Attorney General.[1]

[1] The Accusation was initially filed by the former Executive Director of the Medical Board, William Prasifka.

2. Respondent Jeff Jones, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Hodges, Esq., whose address is: 3480 Buskirk Avenue, Suite 250, Pleasant Hill, CA 94523-7310.

3. On or about October 5, 1981, the Board issued Physician's and Surgeon's Certificate No. G 46282 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-055244, and will expire on January 31, 2025, unless renewed.

## JURISDICTION

4. Accusation No. 800-2019-055244 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 April 18, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2019-055244 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. 800-2019-055244. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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## CULPABILITY

9. Respondent admits that the charges and allegations in Accusation No. 800-2019-055244, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. G 46282.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie factual basis for the charges in the Accusation No. 800-2019-055244, a true copy of which is attached hereto as Exhibit A, and that Respondent hereby gives up his right to contest those charges.

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

## CONTINGENCY

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

13. 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 Accusation No. 800-2019-055244 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.

14. 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.

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

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 46282 issued to Respondent JEFF JONES, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years from the effective date of the Disciplinary Order on the following terms and conditions:

1. CONTROLLED SUBSTANCES – PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) III, IV and V of the Act.

Respondent shall immediately surrender Respondent's DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, Respondent shall submit proof that Respondent surrendered his DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, Respondent shall submit a true copy of the permit to the Board or its designee.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully

complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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. 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.

4. 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.

5. 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(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 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. At the Board's

discretion, the Practice monitoring condition may be discontinued after twenty-four months of monitoring from the effective date of this Disciplinary Order, provided no deficiencies are discovered during the first twenty-four month period of practice monitoring; otherwise, Respondent's practice will be monitored throughout the entire three year probationary term. 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.

6. 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.

7. 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.

8. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, including, but not limited to, expert review, amended accusations, legal reviews, investigation(s), and subpoena enforcement, as applicable, in the amount of $27,311.00 (twenty-seven thousand three hundred and eleven dollars and zero 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.

9. 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.

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10. 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. Respondent may perform telemedicine from his residence to respond to patient and staff concerns, but Respondent shall not engage in any clinical practice from his residence or engage in any clinical practice at a patient's place of residence.

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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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. 800-2019-055244 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 above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert W. Hodges, 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: 7-22-23

JEFF JONES, M.D.
*Respondent*

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

DATED: 7-24-2023

ROBERT W. HODGES, ESQ.
*Attorney for Respondent*

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## ENDORSEMENT

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

DATED: July 24, 2023

Respectfully submitted,

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

MARIANNE A. PANSA
Deputy Attorney General
*Attorneys for Complainant*

ROB BONTA
Attorney General of California
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Facsimile: (559) 445-5106

*Attorneys for Complainant*

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

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| In the Matter of the Accusation Against:<br><br>**JEFF JONES, M.D.**<br>**1524 McHenry Ave., Suite 445**<br>**Modesto, CA 95350-4500**<br><br>**Physician's and Surgeon's Certificate No. G 46282,**<br><br>Respondent. | Case No. 800-2019-055244<br><br>**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 October 5, 1981, the Medical Board issued Physician's and Surgeon's Certificate No. G 46282 to Jeff Jones, 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 January 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 states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

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

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

6. 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.

7. Section 741 of the Code[1] states, in pertinent part:

(a) Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed within a year from the date a prescription for benzodiazepine has been dispensed to the patient.

(C) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

...

## COST RECOVERY

8. Section 125.3 of the Code states:

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

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

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

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

[1] This section became effective January 1, 2019.

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

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

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

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

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

## FIRST CAUSE FOR DISCIPLINE

**(Repeated Negligent Acts)**

9. Respondent has subjected his Physician's and Surgeon's Certificate No. G 46282 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A-F,[2] as more particularly alleged hereinafter:

**PATIENT A**

10. In or around 2006,[3] Respondent began providing pain management treatment to Patient A, a then fifty-five-year-old male diagnosed with failed back surgery syndrome, right

[2] To protect the privacy of the patients involved, the patients' names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

[3] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

lumbar facet pain, and right piriformis syndrome.[4] When Patient A was initially referred to Respondent, he was already being prescribed a high dose of opioids for pain.

11. On or about May 14, 2012, Patient A was seen by Respondent. The chart notes for that visit identify that Patient A was approved to receive Suboxone.[5]

12. Between in or around January 2014 and in or around March 2017, Respondent provided treatment to Patient A that included regular prescriptions of diazepam,[6] carisoprodol,[7] and Suboxone. Patient A's certified complete record contains no records for that time period.[8]

13. Between on or about April 6, 2017, and on or about August 9, 2018, Respondent provided treatment to Patient A that included regular prescriptions of Suboxone, diazepam, and Soma.

14. On or about September 6, 2018, Patient A was seen by Respondent. At that visit, Patient A informed Respondent that he was scheduled to be evaluated for a hip replacement and a subsequent knee replacement, and wanted to switch his buprenorphine to oxycodone for surgery purposes. Respondent advised Patient A that he needed to stop taking Suboxone prior to surgery,

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[4] Piriformis syndrome is a condition in which the piriformis muscle, located in the buttock region, spasms and causes buttock pain. The piriformis muscle can also irritate the nearby sciatic nerve and cause pain, numbness and tingling along the back of the leg and into the foot.

[5] Suboxone (brand name for buprenorphine and naloxone), is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Buprenorphine is in a class of medications called opioid partial agonist-antagonists, and naloxone is in a class of medications called opioid antagonists. Buprenorphine alone and the combination of buprenorphine and naloxone prevent withdrawal symptoms when someone stops taking opioid drugs by producing similar effects to these drugs.

[6] Diazepam (brand name Valium), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety and muscle spasms.

[7] Carisoprodol (brand name Soma), is a Schedule IV controlled substance as of January 11, 2012, pursuant to Health and Safety Code section 11057, and a dangerous drug pursuant to Business and Professions Code section 4022. It is a muscle relaxant medication used to treat pain.

[8] During his subject interview on or about September 25, 2020, Respondent indicated that he believed Patient A's paper chart was lost during a transition to an electronic medical record.

and he would need to taper off Suboxone if taking opiates. At the conclusion of that visit, Respondent prescribed Patient A oxycodone,[9] diazepam, and Soma.

15. Between on or about September 6, 2018 on or about March 11, 2019, Respondent maintained Patient A on monthly prescriptions of oxycodone, diazepam and Soma. Throughout that time, Respondent did not prescribe Patient A naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

16. On or about March 12, 2019, Patient A was seen by Respondent. At that visit, Respondent discontinued Patient A's oxycodone prescription, but prescribed him Soma, and resumed his prescription for Suboxone.

17. On or about April 9, 2019, Patient A was seen by a mid-level practitioner under Respondent's supervision pursuant to standardized procedures and protocols. At that visit, the mid-level practitioner discontinued Patient A's diazepam prescription, but maintained his prescription for Suboxone.

18. Between on or about June 18, 2019, and on or about January 21, 2020, Patient A was seen by Respondent for approximately five (5) clinical visits. On each of those visits, Patient A's documented history of present illness and physical examination contains the exact same wording. Although the patient's diazepam prescription was discontinued on April 9, 2019, and not renewed, the chart notes throughout that time contains conflicting statements, "no longer taking diazepam," and "reports taking diazepam 5 mg during daytime."

19. On or about March 19, 2020, and on or about May 18, 2020, Patient A was seen by Respondent for telephonic visits. On those dates, the patient's chart notes contain a physical examination even though one was not performed. Although the patient's diazepam prescription was discontinued on April 9, 2019, and not renewed, the chart notes for both dates contain conflicting statements, "no longer taking diazepam," and "reports taking diazepam 5 mg during daytime."

[9] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat pain.

20. Respondent committed negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

A. Prescribing an opioid and a benzodiazepine without prescribing naloxone and without discussing and/or documenting a discussion with the patient regarding prescribing naloxone; and

B. Failing to maintain adequate and accurate records.

**PATIENT B**

21. On or about October 18, 2011, Respondent began providing pain management treatment to Patient B, a then forty-five-year-old male diagnosed with muscular sclerosis and related symptoms that included pain, neuropathy, weakness, and fatigue. When Patient B was initially referred to Respondent, he was already being prescribed opioid medication.

22. Between in or around October 2011, and in or around November 2014, Respondent provided treatment to Patient B that included regular prescriptions of methadone,[10] alprazolam,[11] and Norco.[12]

23. On or about December 6, 2014, Patient B was seen by Respondent. At that visit, Patient B reported concerns with attempting to reduce his medications since he was running short of methadone trying to manage his pain.

24. On or about May 28, 2015, Patient B was seen by Respondent. At that visit, Patient B expressed concerns regarding his opioid dependence. Respondent noted that, "at this point it does appear that all we are doing is treating his tolerance rather than his pain." At that time,

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[10] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. It is in a class of medications called opioid partial agonist, that is used to treat pain and narcotic addiction.

[11] Alprazolam (brand name Xanax), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety.

[12] Norco (brand name for hydrocodone-acetaminophen combination), is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat pain.

Respondent believed the patient had an opioid use disorder, but did not document that diagnosis in the patient's chart at any time. Respondent identified his plan at that time was to switch the patient from conventional opiates to buprenorphine.

25. On or about November 10, 2015, Patient B signed an "Opioid Treatment Contract." This document identified that Patient B was a participant in buprenorphine treatment for opioid misuse and dependence, that he understood that mixing buprenorphine with other medications, especially benzodiazepines, can be dangerous, and that he agreed to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances.

26. Between in or around February 2016, and in or around April 2019, Respondent provided treatment to Patient B that included regular prescriptions of buprenorphine-hydrochloride,[13] diazepam, and tramadol.[14] Throughout that time, Respondent did not prescribe the patient naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

27. On or about September 23, 2016, Patient B's chart indicates that his urine drug screen tested positive for cocaine, but that he adamantly denied any use of illegal substances. A copy of the urine screen results was not contained in Patient B's certified medical records.

28. On or about April 23, 2019, Patient B met with Respondent. At that visit, Patient B asked to be switched from Valium to Xanax.

29. Between in or around May 2019, and in or around May 2020, Respondent provided treatment to Patient B that included regular prescriptions of buprenorphine, alprazolam, and tramadol. Throughout that time, Respondent did not prescribe Patient B naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

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[13] Buprenorphine-hydrochloride (brand name Subutex), is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid partial agonist medication that is used to treat pain and narcotic addiction.

[14] Tramadol (brand name Ultram), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a synthetic opioid medication used to treat pain.

30. Between on or about December 14, 2017, and on or about May 26, 2020, Patient B was seen for approximately seventeen (17) clinical visits by either Respondent or a mid-level practitioner under Respondent's supervision pursuant to standardized procedures and protocols. Throughout that time, the patient's physical examinations documented on each visit contain the exact same wording.

31. On or about April 29, 2020, and on or about May 26, 2020, Patient B was seen by Respondent for telephonic visits. On those dates, the patient's documented history of present illness contains the exact same wording, and a physical examination is documented for each visit even though a physical examination was not performed. Although the patient had not been prescribed Valium since approximately April 2019, the patient's chart on both of those dates indicated, "He takes Valium for anxiety. He is excessively sleeping with that, and asked us to switch to Xanax..."

32. Respondent committed negligence in his care and treatment of Patient B, which included, but was not limited to, the following:

A. Prescribing an opioid and a benzodiazepine without prescribing naloxone, and without discussing and/or documenting a discussion with the patient regarding prescribing naloxone;

B. Prescribing buprenorphine to the patient on November 10, 2015, for substance abuse but failing to document that diagnosis at any time; and

C. Failing to maintain adequate and accurate records.

**PATIENT C**

33. In or around 2011, Respondent began providing pain management treatment to Patient C, a then forty-nine-year-old male diagnosed with a work-related injury that had been treated with an intrathecal pump.

34. Between in or around October 2012, and in or around July 2020, Respondent provided treatment to Patient C that included regular maintenance of an intrathecal pump

containing morphine,[15] and regular oral prescriptions of Norco, oxycodone, carisoprodol, and clonazepam.[16] Throughout that time, Respondent did not prescribe the patient naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

35. On or about April 2, 2013, Patient C was seen by Respondent. At that visit, Respondent noted the patient's issues were primarily related to his opiates. Respondent informed the patient that his treatment plan included absolutely no early refills of medications. At that time and thereafter, Respondent recognized Patient C had an opiate use disorder, but did not diagnose him with an opiate abuse disorder or refer him for treatment at any time.

36. On or about July 2, 2013, Patient C was seen by Respondent. At that visit, Patient C admitted running out of his medication in only 18 days. At the conclusion of the visit, Respondent provided Patient C with an additional 14 days' worth of oxycodone.

37. On or about September 30, 2015, Patient C called Respondent's office after the pharmacist refused to fill his Norco prescription written by another physician. Patient C had recently undergone shoulder surgery and ran out of his medications because he had been "taking whatever he needs." Staff from Respondent's office contacted the pharmacist and were told the pharmacist was not comfortable releasing more medications, particularly since the patient was receiving Adderall[17] from another physician.

38. On or about December 5, 2015, Patient C was seen by Respondent. At that visit, Respondent informed Patient C that he was concerned about his doses of oral opioids particularly since he has an intrathecal pump.

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[15] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat pain.

[16] Clonazepam (brand name Klonopin) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety.

[17] Adderall (brand name for dextroamphetamine and amphetamine) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salts medication used for attention-deficit hyperactivity disorder and narcolepsy.

39. On or about July 27, 2016, Patient C was seen by Respondent. At that visit, the patient informed Respondent that he would be gone for three months. At the conclusion of the visit, Respondent wrote Patient C three months of triplicate prescriptions for his medications.

40. Between on or about July 27, 2016, and on or about March 3, 2020, Patient C was seen by Respondent for clinical visits approximately every three months.[18]

41. On or about July 12, 2017, Patient C's urine drug screen tested negative for carisoprodol. At the patient's following visit with Respondent on or about October 5, 2017, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

42. Between in or around January 2019, and in or around August 2019, in addition to maintaining Patient C on an intrathecal pump, Respondent prescribed Patient C oral medications that included a combination of benzodiazepines and 90 or more morphine milligram equivalents of opioid medications per day.

43. On or about September 5, 2019, Patient C's urine drug screen was negative for all prescribed medications. At the patient's following visit with Respondent on or about December 3, 2019, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

44. On or about December 3, 2019, Patient C's urine drug screen was positive for amphetamine and negative for all prescribed medications. At the patient's following visit with Respondent on or about March 3, 2020, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

45. On or about March 3, 2020, Patient C's urine drug screen was positive for amphetamine, and negative for hydrocodone, clonazepam, morphine and carisoprodol. At the patient's following clinical visit with Respondent on or about April 14, 2020, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

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[18] At his subject interview on or about September 25, 2020 Respondent claimed the patient's worker's compensation adjuster wanted the patient to be seen every three months. This fact is not documented anywhere in the patient's chart.

46. Between on or about September 20, 2018, and on or about March 3, 2020, Patient C was seen by Respondent and a mid-level practitioner under Respondent's supervision pursuant to standardized procedures and protocols on approximately eight (8) clinical visits. Throughout that time, Patient C's documented history of present illness for each visit contains the exact same wording.

47. On or about April 14, 2020, on or about June 23, 2020, and on or about July 1, 2020, Patient C was seen by Respondent for telephonic visits. On those dates, the patient's chart notes contain a physical examination even though one was not performed.

48. Respondent committed negligence in his care and treatment of Patient C, which included, but was not limited to, the following:

A. Prescribing 90 or more morphine milligram equivalents of an opioid per day and/or an opioid and a benzodiazepine without prescribing naloxone, and without discussing and/or documenting a discussion with the patient regarding prescribing naloxone;

B. Seeing the patient every three months despite concerns of misuse, abuse, and diversion;

C. Failing to diagnose the patient with an opiate abuse disorder, and failing to adequately address behaviors concerning for abuse, misuse, and diversion; and

D. Failing to maintain adequate and accurate records.

**PATIENT D**

49. On or about August 9, 2017, Respondent began providing pain management treatment to Patient D, a then thirty-two-year-old female diagnosed with hip pain from congenital hip dysplasia, Crohn's disease, and depression. At that initial visit, Respondent did not discuss and/or document a discussion with the patient regarding any mental health history or history of illicit drug use. Respondent did not review and/or document review of CURES,[19] and did not

[19] CURES is the Controlled Substances Utilization Review and Evaluation System (CURES), a database maintained by the Department of Justice of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

document the patient's risk for misuse or abuse of medications. Although Respondent was uncomfortable providing treatment to Patient D because she was a licensed health care professional and the girlfriend of his business partner, at the conclusion of this visit, Respondent prescribed Patient D oxycodone for pain.

50. On or about August 25, 2017, Patient D was seen by Respondent. At that visit, Respondent added buprenorphine to the patient's treatment regimen.

51. On or about April 17, 2018, Patient D was seen by Respondent. At that visit, Patient D informed Respondent that the buprenorphine was making her tired. At the conclusion of the visit, Respondent discontinued the patient's buprenorphine and prescribed her morphine for pain.

52. Between on or about April 17, 2018, and on or about June 16, 2020, Respondent provided treatment to Patient D that included regular prescriptions of morphine and oxycodone.

53. On or about October 11, 2018, Patient D was seen by Respondent. At that visit, Patient D informed Respondent that she had recently been in a bicycle accident resulting in broken ribs and a sacral fracture. Due to her increased pain, Respondent increased Patient D's oxycodone prescription from three (3) to eight (8) tablets per day. Despite her significant painful injuries, Patient D's documented physical examination that day revealed normal findings.

54. On or about October 23, 2018, Patient D was seen by Respondent. At that visit, Respondent informed Patient D that he was not comfortable prescribing opiates to a health care professional. His plan at that time was to dismiss Patient D but to continue to prescribe her pain medications for three months until she could find a health care provider to take over her pain medications.

55. Between in or around January 2019, and in or around June 2020, Respondent prescribed Patient D medications that included 90 or more morphine milligram equivalents of opioid medications per day. Throughout that time, Respondent did not prescribe Patient D naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

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56. Between on or about October 22, 2019, and on or about January 7, 2020, Patient D was seen by Respondent for approximately four (4) clinical visits. On each of those visits, Patient D's documented history of present illness contains the exact same wording.

57. Between on or about March 31, 2020, and on or about June 16, 2020, Patient D was seen by Respondent for four (4) telephonic visits. On those dates, the patient's documented history of present illness contains the exact same wording, and a physical examination is documented for each visit even though a physical examination was not performed.

58. Respondent committed negligence in his care and treatment of Patient D, which included, but was not limited to, the following:

A. Prescribing controlled substances without first completing an appropriate and detailed evaluation;

B. Prescribing 90 or more morphine milligram equivalents of an opioid per day without prescribing naloxone, and without discussing and/or documenting a discussion with the patient regarding prescribing naloxone; and

C. Failing to maintain adequate and accurate records.

**PATIENT E**

59. In or around 2010, Respondent began providing pain management treatment to Patient E, a then eighty-year-old female complaining of neck, sciatica, shoulder, and lower back pain.

60. Between on or about April 8, 2010, and on or about December 5, 2013, Respondent provided care and treatment to Patient E that included prescriptions for controlled substances. The patient's chart throughout that time contains handwritten notes that are difficult to read.

61. Between in or around January 2014 and in or around April 2017, Respondent provided care and treatment to Patient E that included prescriptions for opioids. Patient E's certified complete record contains no records for that time period.

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62. On or about May 17, 2017, Patient E was seen by Respondent with complaints of knee and back pain. At the conclusion of that visit, Respondent prescribed Patient E fentanyl[20] and oxycodone.

63. Between on or about May 17, 2017, and on or about June 10, 2020, Respondent provide care and treatment for Patient E that included regular prescriptions of fentanyl and oxycodone.

64. On or about February 6, 2018, Patient E's urine drug screen tested positive for medications that were not being prescribed by Respondent, including morphine, codeine, and benzodiazepines.

65. On or about April 4, 2018, Patient E's urine drug screen tested positive for medications that were not being prescribed by Respondent, including morphine, codeine, and benzodiazepines. At the patient's following clinical visit with Respondent on or about May 1, 2018, the patient informed Respondent that she takes Valium as needed, but Respondent otherwise did not discuss and/or document a discussion with the patient regarding her two prior inconsistent urine screen results.

66. On or about June 12, 2018, Patient E was seen by Respondent. At that visit, Respondent knew he was prescribing Patient E approximately 345 morphine milligram equivalents of an opioid per day, but determined that he would not increase or decrease her medications unless for good reason.

67. On or about September 10, 2018, Patient E's urine screen tested positive for alcohol. At the patient's following visit on or about October 8, 2018 with a mid-level practitioner under Respondent's supervision pursuant to standardized procedures and protocols, the practitioner did not discuss and/or a document a discussion with the patient regarding the prior urine screen result.

68. On or about November 12, 2018, Patient E's urine screen tested negative for fentanyl. At Patient E's following visit on or about December 10, 2018 with a mid-level practitioner under

[20] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat pain.

Respondent's supervision pursuant to standardized procedures and protocols, the practitioner did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

69. Between on or about July 29, 2019, and on or about March 16, 2020, Patient E was seen by Respondent and multiple mid-level practitioners under Respondent's supervision pursuant to standardized procedures and protocols, on approximately eight (8) clinical visits. On each of those visits, the patient's physical examination contains the exact same wording.

70. Between on or about December 18, 2019, and on or about June 10, 2020, Patient E was seen by a mid-level practitioner under Respondent's supervision pursuant to standardized procedures and protocols, on approximately seven (7) clinical visits. Throughout that time, the patient's documented history of present illness contains the exact same wording, including the statements, "Pt had a fall 6 weeks ago on her front porch and was in the ER for 6 hours with 9 stitches. Healing up well with some scab remaining on her forehead. Pt had her steroid injections on both knee today on 12/18/19."

71. Respondent committed negligence in his care and treatment of Patient E, which included, but was not limited to, the following:

A. Failing to adequately address inconsistent urine screens; and

B. Failing to maintain adequate and accurate records.

**PATIENT F**

72. On or about August 10, 2010, Respondent began providing treatment to Patient F, a then forty-seven-year-old male diagnosed with testicular pain and left ankle pain related to the rupture of his peroneus brevis tendon. Respondent had concerns with prescribing chronic opioids to a young person, but refilled his prescriptions.

73. On or about March 3, 2011, Patient F was seen by Respondent. At that visit, Patient F expressed a desire to stop opiates. At the conclusion of the visit, Respondent prescribed Patient F Subutex for his opiate use disorder and for pain.

74. Between in or around March 2011, and in or around July 2020, Respondent provided treatment to Patient F that included regular prescriptions of buprenorphine, oxycodone, and carisoprodol.

75. On or about July 2, 2015, Patient F's urine drug screen was positive for buprenorphine, and negative for other prescribed medications. At the patient's following visit with Respondent on or about July 8, 2015, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

76. Between on or about November 18, 2016, and on or about March 19, 2018, Respondent maintained Patient F on regular prescriptions of buprenorphine, oxycodone, and carisoprodol. Throughout that time, Respondent saw Patient F approximately four (4) times for epidural steroid injections but did not perform and/or document his performance of a physical examination or assessment and evaluation of the patient regarding his controlled medications.

77. Between on or about March 20, 2018, through on or about July 14, 2020, Patient F was seen by Respondent on approximately ten (10) clinical visits. On each of those visits, Patient F's physical examination contains the exact same wording.

78. On or about March 20, 2018, Patient F's urine drug screen was negative for oxycodone and carisoprodol. At Patient F's following visit with Respondent on or about April 24, 2018, Respondent did not discuss and/or document a discussion with the patient regarding the prior urine screen result.

79. Between on or about December 17, 2018, and on or about July 14, 2020, Respondent prescribed Patient F approximately 8 mg of buprenorphine per day, and 90 or more morphine milligram equivalents of opioid medications per day. Throughout that time, Respondent did not prescribe Patient F naloxone, and did not discuss and/or document a discussion with the patient regarding prescribing naloxone.

80. On or about May 19, 2020, on or about June 16, 2020, and on or about July 14, 2020, Patient F was seen by Respondent for telephonic visits. On those dates, the patient's history of present illness contains the same wording, and the patient's chart notes contain physical examinations even though one was not performed.

81. Respondent committed negligence in his care and treatment of Patient F which included, but was not limited to, the following:

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A. Prescribing 90 or more morphine milligram equivalents of an opioid per day without prescribing naloxone and without discussing and/or documenting a discussion with the patient regarding prescribing naloxone;

B. Failing to assess the patient between on or about November 18, 2016, and on or about March 19, 2018, while regularly prescribing controlled substances;

C. Failing to adequately address inconsistent urine screens; and

D. Failing to maintain adequate and accurate records.

**SECOND CAUSE FOR DISCIPLINE**

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

82. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 46282 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients A-F, as more particularly alleged in paragraphs 9 through 81 (D), above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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## PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 46282, issued to Respondent, Jeff Jones, M.D.;

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

3. Ordering Respondent Jeff Jones, 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: APR 18 2022

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

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