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

In the Matter of the Accusation Against: **Leonard Frederick Liss, M.D.** **3046 S. Virmargo Ct.** **Visalia, CA 93292-1796** **Physician's and Surgeon's Certificate No. G 74715,** Respondent.	Case No. 800-2021-079021 **ACCUSATION**

PARTIES

1. Reji Varghese (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 July 21, 1992, the Medical Board issued Physician's and Surgeon's Certificate Number G 74715 to Leonard Frederick Liss, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2026, 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:

> (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:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (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.
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> (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.
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> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

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:
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> (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.
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> (b) Gross negligence.
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> (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.

. . .

6. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

7. Section 4021 of the Code states: "Controlled Substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

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8. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self use, except veterinary drugs that are labeled as such, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, that blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 2290.5 of the Code states, in pertinent part:

(a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means either of the following:

(A) A person who is licensed under this division.

(B) An associate marriage and family therapist intern or trainee functioning pursuant to Section 4980.43.3.

(C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code.

(D) An associate clinical social worker functioning pursuant to Section 4996.23.2.

(E) An associate professional clinical counselor or clinical counselor trainee functioning pursuant to Section 4999.46.3.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) This section does not preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to the patient's medical information shall apply to telehealth interactions.

(g) All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

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(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FACTUAL ALLEGATIONS

Patient A[1]

11. Respondent began treating Patient A, then a 26-year-old male, on July 25, 2019, and documented a diagnosis of chronic pain syndrome and osteoarthritis of the shoulder.

12. Respondent's electronic SOAP notes[2] for this visit and following encounters do not provide any objective information or assessment details supporting Respondent's diagnoses for Patient A, nor do his notes include a physical examination of Patient A's shoulder.

13. Between approximately July 25, 2019 and December 28, 2021, Respondent provided regular treatment to Patient A that included monthly prescriptions of 120 tablets of 5-325 mg hydrocodone-acetaminophen (Norco)[3] and occasional prescriptions of ibuprofen and 350 mg of carisoprodol.[4]

14. Although Patient A had not been prescribed opiates for long-term use prior to establishing care with Respondent, Respondent's notes for his first visit and for all subsequent encounters with Patient A fail to document objective information or assessment details supporting the long-term prescription of controlled substances to Patient A, informed consent concerning

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[1] The patients herein are identified by letter in order to maintain patient confidentiality.

[2] A SOAP note is a method of documentation employed by healthcare providers to write out notes in a patient's chart. The headings of a SOAP note include Subjective, Objective, Assessment, and Plan.

[3] Acetaminophen and hydrocodone bitartrate (Vicodin® and Norco®) is a combination of two medicines used to treat moderate to severe pain. Hydrocodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Hydrocodone has a high potential for abuse. Hydrocodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

[4] Carisoprodol, also known as Soma®, is a muscle relaxant with a known potentiating effect on narcotics. It works by blocking pain sensations between the nerves and the brain. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions.

long-term opiate use, a controlled substances agreement,[5] and documentation of diagnostics or other monitoring to ensure Patient A was compliant with his prescription use, including but not limited to, documentation that CURES[6] reports were reviewed.

15. At some point in 2020, Respondent converted his appointments with Patient A to be conducted via telehealth; however, his notes for encounters after on or about March 2020 and through 2021 continued to document each encounter as an "office visit." Respondent never obtained or documented informed consent from Patient A concerning the telehealth appointment method. All progress notes from the telehealth visits had minimal notation of subjective reports from Patient A, no objective notes, assessments or plans, and failed to add any new information regarding the source of Patient A's pain, alternative treatment options, or evaluations.

Patient B

16. Respondent began treating Patient B, a 50-year-old male, on or about November 30, 2017, and documented a diagnosis of hypertension, chronic pain syndrome, and osteoarthritis of the shoulder, with occasional insomnia.

17. Prior to establishing treatment with Respondent, Patient B had been prescribed approximately 60 tablets of 10-325 mg hydrocodone-acetaminophen a month by another provider. CURES reports reveal that Respondent increased that prescription to 90 tablets a month on or about November 30, 2017, and again to 120 tablets a month from on or about September 7, 2018, at least until on or about July 23, 2021. Respondent was also prescribing Patient B 30 tablets of 350 mg of carisoprodol monthly beginning on or about November 2, 2018 through on or about August 3, 2021, as well as prescriptions of various doses of amlodipine/amlodipine

[5] Controlled substances agreement is also known as a pain management contract or pain management agreement. A pain management agreement is recommended for patients on short-acting opioids at the time of the third visit; on long acting opioids; or expected to require more than three months of opioids. A pain management agreement outlines the responsibilities of the physician and patient during the time that controlled substances are prescribed.

[6] Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, IV, and V controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

besylate,[7] Lisinopril,[8] hydrochlorothiazide,[9] Lisinopril hydrochlorothiazide and cyclobenzaprine.[10]

18. Although Respondent was treating and prescribing medication to Patient B as early as on or about November 30, 2017, Respondent's electronic SOAP notes for encounters do not begin until on or about March 22, 2018, and the notes do not provide any objective information or assessment details supporting Respondent's diagnoses for Patient B.[11]

19. On or about March 22, 2018, Patient B's blood pressure was noted to be very elevated at 157/107.[12] Patient B's progress note indicated "[h]ypertension" as a diagnosis, but Respondent did not qualify it as a hypertensive urgency, or benign hypertension, nor did Respondent mention EKG or labs to evaluate for possible organ injury from this significantly elevated blood pressure. There is no documentation of what medications Patient B had already been on for his hypertension and Respondent only prescribed Lisinopril at a low dose. Additionally, this note did not mention if the patient was having chest pain, headache, nausea, or vision changes, which are signs of medical emergency in hypertensive patients.

20. On or about April 19, 2018, Patient B's blood pressure was still high at 155/108, and Respondent again failed to mention if this was hypertensive urgency, benign, or other. There is

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[7] Amlodipine and amlodipine besylate are medications used to treat high blood pressure.

[8] Lisinopril is a medication to treat high blood pressure that is used to tighten blood vessels so that blood flows through them more smoothly.

[9] Hydrochlorothiazide is a diuretic to treat high blood pressure.

[10] Cyclobenzaprine is a muscle relaxant. It works by blocking nerve impulses (or pain sensations) that are sent to the brain.

[11] Respondent's treatment notes are unavailable prior to March 22, 2018, however, CURES and other pharmacy records reveal that Respondent began prescribing controlled substances to Patient B on or around November 30, 2017.

[12] Blood pressure is determined by measuring the systolic (the top number) and the diastolic (the bottom number). The systolic number measures the force the heart exerts on the walls of the arteries each time it beats. The diastolic number measures the force the heart exerts on the walls of the arteries in between beats. Blood pressure is measured in mm Hg, which is millimeters of mercury. A normal blood pressure reading of below 120 and below 80 is normal blood pressure. A reading of 120-129 and below 80 is elevated blood pressure. A reading of 130-139 or 80-89 is stage 1 high pressure. A reading of 140 or higher or 90 or higher is stage 2 blood pressure.

no mention, again, of an EKG or labs to assess for potential organ injury. Patient B's medication was changed to Lisinopril-HCTZ,[13] which included a diuretic, but labs were not drawn to make sure that Patient B's kidneys and electrolytes could handle this new medication.

21. Patient B was seen monthly until on or about January 11, 2022. Each subsequent monthly visit in May, June, July and August 2018, demonstrated elevated blood pressures in the 150/100 range.[14] Medications were adjusted, but work-up to assess for potential injury from the hypertension was not done. Respondent failed to conduct or document any labs, EKGs, or other tests to evaluate for possible organ injury resulting from Patient B's significantly elevated blood pressure, or to ensure Patient B's organs and systems were properly functioning and could handle the medications Respondent prescribed to Patient B, at any point during his treatment.

22. On or about November 1, 2018, Respondent noted that Patient B was planning to undergo shoulder surgery. Patient B's blood pressure on this date was noted as 155/104. Respondent's notes for this appointment do not document any discussion with Patient B about the risks and complications of undergoing surgery with a significantly elevated blood pressure. Furthermore, when Respondent was interviewed as part of the investigation, he did not convey that he understood his role in optimizing a patient for surgery and the potential ramifications of allowing a patient's blood pressure to remain that high in preparation for surgery.

23. Despite diagnosing Patient B with high blood pressure, and continuing to prescribe medications to treat Patient B's high blood pressure throughout his care, Respondent failed to document any vitals were taken, including Patient B's blood pressure, on or about March 20 and April 4, 2019, and every subsequent visit beginning on or about April 17, 2020 until on or about January 11, 2022, while he was conducting telehealth visits.

24. Between on or about March 22, 2018 and January 11, 2022, Patient B's records consistently identify "left shoulder pain" or "chronic pain syndrome" as the diagnosis for prescribing hydrocodone-acetaminophen. None of these notes indicate that a musculoskeletal

[13] Lisinopril-HCTZ is Lisinopril and hydrochlorothiazide combined and is a medication to treat high blood pressure.

[14] Patient B's blood pressure remained consistently significantly elevated from on or about March 22, 2018 through on or about February 21, 2020, during the time that vitals were taken.

exam or further work up had been done to evaluate the need for opiates. There is also no documentation that alternative treatments (such as physical therapy, non-opiate medications, or referrals) were discussed. Patient B's records do not contain objective information or assessment details that would support the long-term prescription of controlled substances, informed consent concerning long-term opiate use, a controlled substances agreement, and documentation of diagnostics or other monitoring to ensure Patient B was compliant with his prescription use, including but not limited to, documentation that CURES reports were reviewed.

25. At some point in 2020, Respondent converted his appointments with Patient B to be conducted via telehealth; however, his notes for encounters beginning on or about March 2020, in 2021, and in 2022, continued to document each encounter as an "office visit." Respondent never obtained or documented informed consent from Patient B concerning the telehealth appointment method, particularly in light of Patient B's persistent hypertension. All progress notes from the telehealth visits had minimal notation of subjective reports from Patient B, no objective notes, assessments or plans, and failed to add any new information regarding the source of Patient B's pain, alternative treatment options, or evaluations.

Patient C

26. Respondent began treating Patient C, then a 33-year-old male, on or about May 29, 2018, whom he diagnosed with chronic pain syndrome, osteoarthritis, pain in left leg, and a partial traumatic amputation of the left lower leg. The progress note only mentions a complaint of "leg pain, prosthetic leg," and fails to mention any significant details such as the cause of the prosthetic leg, length of time since the injury, the source of pain (neuropathic, phantom limb, open wound), and previously tried medications, such as Gabapentin,[15] which is often successfully used for pain following amputation.

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[15] Gabapentin is used to treat nerve pain, but it primarily prevents and controls seizures.

27. Patient C had been receiving regular monthly prescriptions of 150 10-325 mg tablets of hydrocodone-acetaminophen and occasional prescriptions for Hysingla ER[16] from a prior provider for several years before establishing care with Respondent. The progress report for Respondent's first encounter with Patient C on or about May 29, 2018, reflects Patient C received a prescription for hydrocodone-acetaminophen from Respondent. The progress note does not mention a discussion of the risks, benefits, or alternatives to the use of hydrocodone-acetaminophen, or mention that Patient C's CURES report had been reviewed. Patient C's blood pressure was elevated at 122/92 at this appointment. Patient C was not diagnosed with hypertension, nor was his blood pressure addressed at this appointment.

28. Respondent's electronic SOAP notes for this and following encounters do not provide any objective information or assessment details supporting Respondent's diagnoses for Patient C.

29. Between on or about May 29, 2018 through June 6, 2021, Respondent provided regular treatment to Patient C that included monthly (or more frequent) prescriptions of 120 tablets of 10-325 mg hydrocodone-acetaminophen. Respondent reduced that monthly prescription to approximately 112 tablets of 10-325 mg hydrocodone-acetaminophen between on or about July 7, 2021 until on or about August 16, 2021.

30. Respondent's notes for his first visit and for all subsequent visits with Patient C fail to document objective information or assessment details supporting the long-term prescription of controlled substances to Patient C, informed consent concerning long-term opiate use, a controlled substances agreement, and documentation of diagnostics or other monitoring to ensure Patient C was compliant with his prescription use, including, but not limited to, documentation that CURES reports were reviewed.

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[16] Hysingla ER is the brand name for hydrocodone and is an opioid pain medication used for around-the clock treatment of severe pain. Hysingla ER is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

31. On or about August 31, 2019, Respondent prescribed an extra 28 tablets of hydrocodone-acetaminophen to Patient C. Respondent was unable to recall why he had done so, nor did any progress note indicate that this error had occurred.

32. The monthly progress notes from on or about May 29, 2018 until on or about March 5, 2020 for Patient C are nearly identical, with the exception of the date and vital signs. These notes lack information of alternative treatments tried, the effect the pain had on Patient C's quality or function of life, and a failure to discuss alternate treatments such as non-opiate therapies or pain specialist referrals.

33. On or about June 6, 2019, Patient C's blood pressure was 142/100, and Respondent did not diagnose or address the hypertension. Despite recording consistently elevated high blood pressure in Patient C from approximately May 29, 2018, through March 5, 2020, Respondent did not diagnose, document, or treat Patient C for hypertension at any time, including a referral for a lab workup or EKG, or signs and symptoms of potential complications.

34. At some point on or around April 24 2020, Respondent converted his appointments with Patient C to be conducted via telehealth; however, his notes for encounters in or around April 24, 2020 until on or about July 8, 2021, continued to document each encounter as an "office visit." Respondent never obtained or documented informed consent from Patient C concerning the telehealth appointment method. All progress notes from the telehealth visits had minimal notation of subjective reports from Patient C, no objective notes, assessments, or plans, and failed to add any new information regarding the source of Patient C's pain, alternative treatment options, or evaluations.

35. Respondent's monthly progress reports for Patient C from on or about April 24, 2020 until on or about July 8, 2021 are nearly identical, again, with an absence of a notation of the effect pain had on Patient C's life. Despite having recorded consistently elevated high blood pressure in Patient C, Respondent did not document any vitals, diagnostics, or other monitoring of Patient C's blood pressure following the March 5, 2020 appointment.

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Patient D

36. Respondent treated Patient D, a 27-year-old male, from on or about April 18, 2019 through on or about April 14, 2022, for leg pain resulting from a deforming gunshot wound. During his treatment, Respondent diagnosed Patient D with chronic pain syndrome, post-surgical pain, osteoarthritis, and anxiety. On Patient D's first visit, Respondent prescribed 45 tablets of 10-325 mg of hydrocodone bitartrate-acetaminophen, and increased the dosage to 120 tablets on or about May 2019.

37. The April and May 2019 treatment notes lack any further details as to the kind or source of the pain, and they do not list what medications or treatments had been tried and failed, including non-opiate therapies such as Gabapentin, physical therapy or pain management. They also do not list how the pain affected Patient D's quality of life or daily function. There is no indication that Respondent reviewed Patient D's CURES report.

38. Respondent's electronic SOAP notes for this visit and following encounters do not provide any objective information or assessment details supporting Respondent's diagnoses for Patient D.

39. Respondent saw Patient D monthly from on or about July 2019 until on or about July 22, 2021,[17] and provided monthly opiate prescriptions for 120 10-325 mg tablets of hydrocodone bitartrate-acetaminophen. Each of the corresponding progress notes did not have a change in the exam.

40. On or about January 30, 2020 and continuing through on or about April 14, 2022, Respondent prescribed Xanax (alprazolam),[18] a benzodiazepine, for Patient D's anxiety, despite

[17] Treatment notes indicate that Respondent continued to prescribe hydrocodone bitartrate-acetaminophen through on or about April 14, 2022; however, those later prescriptions are not reflected on Patient D's CURES report. Treatment notes dated on or about June 27, 2019, and June 2019 CURES reports, also indicate that Respondent prescribed 95 10-325 mg tablets of hydrocodone bitartrate-acetaminophen to Patient D.

[18] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that 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. When properly prescribed as indicated, it is used for the management of anxiety disorders, or of the short-term relief of anxiety. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction, and diversion.

its contraindication in use in patients taking long-term opiates. This January 30, 2020 note, as well as subsequent notes, do not indicate any discussion regarding the risks of opiate and benzodiazepine concomitant use. Similarly, the corresponding notes fail to mention any discussion of non-benzodiazepine treatment options for anxiety.

41. Respondent's notes for his first visit and for all subsequent visits with Patient D fail to document objective information or assessment details supporting the long-term prescription of controlled substances to Patient D, informed consent concerning long-term opiate use, a controlled substances agreement, and documentation of diagnostics or other monitoring to ensure Patient D was compliant with his prescription use, including, but not limited to, documentation that CURES reports were reviewed.

42. On or about May 1, 2020, Respondent converted his appointments with Patient D to be conducted via telehealth; however, his notes for encounters beginning on or about May 1, 2020, 2021, and 2022 continued to document each encounter as an "office visit." Respondent never obtained or documented informed consent from Patient D concerning the telehealth appointment method. Progress notes from the telehealth visits from on or about May 1, 2020 to April 2022, had minimal notation of subjective reports from Patient D, no objective notes, assessments or plans, and failed to add any new information regarding the source of Patient D's pain, alternative treatment options, or evaluations.

Patient E

43. Respondent diagnosed and treated Patient E, a then 24-year-old male, from on or about February 21, 2017, for complaints of pain resulting from a "rib fracture."[19]

44. Respondent's electronic SOAP notes for this encounter do not provide any objective information or assessment details supporting Respondent's diagnosis for Patient E's rib fracture, such as a physical examination or review of X-rays. Respondent nonetheless prescribed 70 10-350 mg tablets of hydrocodone bitartrate-acetaminophen to Patient E at this February visit.

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[19] References to assessments completed and medications prescribed seven years prior to the filing of this Accusation are for information purposes only.

45. Respondent did not see Patient E again until on or about October 10, 2019, at which time he diagnosed him with "back pain disorder." Respondent prescribed 50 10-350 mg tablets of hydrocodone bitartrate-acetaminophen at that visit, and increased this dose to 60 tablets on or about January 7, 2020.

46. On or about February 7, 2020, Respondent began treating Patient E for complaints of scoliosis. At that time, Respondent diagnosed Patient E with scoliosis, chronic pain syndrome, and back pain disorder. Beginning on or about February 13, 2020, Respondent prescribed 90 10-350 mg of hydrocodone bitartrate-acetaminophen tablets monthly to Patient E until on or about August 9, 2021.

47. Respondent's electronic SOAP notes for this encounter and following encounters do not provide any objective information, physical examination, or assessment details supporting Respondent's diagnoses for Patient E related to his complaints of scoliosis. There is a lack of documentation as to the degree of pain and how it interfered with Patient E's quality and functionality of life, and a lack of documentation discussing evaluation options including imaging assessments to appropriately diagnose Patient E's condition. As scoliosis is generally not painful, the lack of documentation of the severity of scoliosis and the lack of confirmation that another medical condition was causing pain creates questions as to the reasoning for opiate use in this patient.

48. Respondent's notes for his first visit and for all subsequent visits with Patient E fail to document objective information or assessment details supporting the long-term prescription of controlled substances to Patient E, informed consent concerning long-term opiate use, a controlled substances agreement, and documentation of diagnostics or other monitoring to ensure Patient E was compliant with his prescription use, including, but not limited to, documentation that CURES reports were reviewed.

49. On or about April 2, 2020, Respondent converted his appointments with Patient E to be conducted via telehealth; however, his notes for encounters after on or about April 2, 2020 and 2021 continued to document each encounter as an "office visit." Respondent never obtained or documented informed consent from Patient E concerning the telehealth appointment method.

Progress notes from the telehealth visits had minimal notation of subjective reports from Patient E, no objective notes, assessments or plans, and failed to add any new information regarding the source of Patient E's pain, alternative treatment options, or evaluations.

FIRST CAUSE FOR DISCIPLINE

(Prescribing Without Prior Examination)

50. Respondent Leonard Frederick Liss, M.D. is subject to disciplinary action under section 2242 of the Code, in that he prescribed dangerous drugs as defined in section 4022 to Patients A, B, C, D, and E, without an appropriate prior examination. The circumstances giving rise to this cause for discipline are set forth in paragraphs 11 through 49 above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

51. Respondent failed to conduct an appropriate examination prior to prescribing hydrocodone-acetaminophen, a dangerous drug defined in Code section 4022, to Patient A.

52. Respondent failed to conduct an appropriate examination prior to prescribing hydrocodone-acetaminophen, a dangerous drug defined in Code section 4022, to Patient B.

53. Respondent failed to conduct an appropriate examination prior to prescribing hydrocodone-acetaminophen, a dangerous drug defined in Code section 4022, to Patient C.

54. Respondent failed to conduct an appropriate examination prior to prescribing hydrocodone-bitartrate-acetaminophen and Xanax, which are both dangerous drugs defined in section 4022, to Patient D.

55. Respondent failed to conduct an appropriate examination prior to prescribing hydrocodone-bitartrate-acetaminophen, a dangerous drug defined in Code section 4022, to Patient E.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

56. Respondent Leonard Frederick Liss, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated acts of negligence as to Patients A, B, C, D, and E. The circumstances giving rise to this cause for discipline are set forth

in paragraphs 11 through 55 above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

Standard of Care Related to Patient Evaluation for Appropriate Use of Narcotics and Risk Stratification Related to Opioid Treatment

57. The standard of care requires that each patient being fully assessed with a medical history and focused physical exam to include evaluation of the patient's pain, prior successful and failing treatments, assessments of risks of treatment options, including but not limited to co-existing conditions or risk of addiction. The standard of care also includes reviewing the indications for the use of opiates as opposed to non-opiate treatment options for pain control.

58. Respondent failed to perform a focused physical examination (namely a musculoskeletal or shoulder exam) of Patient A to determine the causes for pain prior to prescribing opiates. He failed to document a definitive diagnosis for the pain, or any objective findings to confirm any diagnosis. Respondent did not describe how Patient A's pain limited his functionality, and therefore Respondent did not describe symptoms that warranted long-term opiate therapy. Respondent also failed to evaluate and document the need for opiates and what non-opiate alternative treatments had been attempted prior to prescribing opiates to Patient A, all of which constitutes one simple departure from the standard of care.

59. Respondent failed to perform a focused physical examination (namely a musculoskeletal exam) of Patient B to determine the causes for pain prior to prescribing opiates. He failed to document a definitive diagnosis for the pain, or any objective findings to confirm that diagnosis. Respondent did not describe how Patient B's pain limited his functionality, and therefore Respondent did not describe symptoms that warranted long-term opiate therapy. Respondent also failed to evaluate and document the need for opiates and document what non-opiate alternative treatments had been attempted and failed including, but not limited to, Tylenol, Motrin, physical therapy, or shoulder injections, prior to prescribing opiates to Patient B, all of which constitutes one simple departure from the standard of care.

60. Respondent failed to perform a focused physical examination (namely a musculoskeletal exam, level of amputation, or evaluation of the stump) of Patient C to determine

the causes for pain prior to prescribing opiates. He failed to document a definitive diagnosis for the pain, or any objective findings to confirm that diagnosis. Respondent did not describe how Patient C's pain limited his functionality, and therefore Respondent did not describe symptoms that warranted long-term opiate therapy. Respondent also failed to evaluate and document the need for opiates and document what non-opiate alternative treatments had been attempted and failed including, but not limited to, Tylenol, Motrin, physical therapy, or a pain management referral, prior to prescribing opiates to Patient C, all of which constitutes one simple departure from the standard of care.

61. Respondent failed to perform a focused physical examination (namely a musculoskeletal exam, examination of the leg wound, or neurological evaluation) of Patient D to determine the causes for pain prior to prescribing opiates. He failed to document a definitive diagnosis for the pain, or any objective findings to confirm that diagnosis. Respondent did not describe how Patient D's pain limited his functionality, and therefore Respondent did not describe symptoms that warranted long-term opiate therapy. Respondent also failed to evaluate and document the need for opiates and document what non-opiate alternative treatments had been attempted and failed including, but not limited to, Tylenol, Motrin, Gabapentin, physical therapy, or a pain management referral, prior to prescribing opiates to Patient D, all of which constitutes one simple departure from the standard of care.

62. Respondent failed to perform a focused physical examination on or about October 10, 2019 and on or about February 7, 2020 (namely a musculoskeletal exam, spinal exam, or range of motion) of Patient E to determine potential causes for his back pain and scoliosis prior to prescribing opiates. He did not document any non-opiate measures that had already been tried and failed such as Tylenol, Motrin, Gabapentin, physical therapy, or a pain management referral. Respondent did not describe how Patient E's back pain limited his functionality, and therefore did not describe symptoms that warranted long-term opiate therapy, all of which constitutes one simple departure from the standard of care for Patient E.

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Standard of Care Related to Patient Consent and Pain Management Agreements

63. The standard of care mandates that the patient is provided risks, alternatives and benefits to the opiates being prescribed and that the patient consents to have treatment with opiates. Additionally, the standard of care also mandates that the provider have a signed pain management agreement between the provider and patient regarding the pain management. The California Medical Board guidelines recommends that an agreement be signed if a patient is expected to require more than three months of opiates or long-acting opiates are prescribed. The standard in the community is to have the agreement signed before any refills are provided.

64. Respondent failed to document verbal consent, nor did he document the discussion of the risks, benefits, or alternatives to opioid treatment with Patients A, B, C, D, or E. Respondent also did not have a signed management agreement with Patients A, B, C, D, or E. The lack of documentation of the discussion of risks, benefits and alternatives, in addition to the lack of a signed pain management agreement with Patients A, B, C, D, and E constitutes one simple departure from the standard of care for each patient, respectively.

Standard of Care Related to Medical Record Maintenance and Periodic Review

65. The standard of care requires that a physician must maintain accurate and complete records demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation. This periodic review includes documentation of the review of CURES reports, review of patient compliance, and assessment for possible diversion, when prescribing controlled substances.

66. Respondent failed to maintain complete records documenting a physical examination and proper symptoms that would warrant long-term opiate therapy for Patients A, B, C, D, or E. His progress notes were insufficient documentation for a visit, whether or not an opiate was prescribed. He failed to document any monitoring or periodic reviews of Patient A, B, C, D, or E's opiate use, compliance, and continued treatment plan. Respondent did not maintain complete records to demonstrate a proper history or exam to warrant the use of opiates, nor did he review any CURES reports, or otherwise assess for Patients A, B, C, D, or E's diversion. Respondent's

failure to perform periodic reviews and his failure to document periodic assessments of CURES reports constitutes one simple departure from the standard of care for Patients A, B, C, D, and E, respectively.

Standard of Care Related to the Management of Hypertension

67. The standard of care for a hypertension work up and management includes baseline blood test evaluation for liver and kidney function. Additionally, it is the standard of care to perform an EKG on any persons with significantly elevated blood pressure (diastolic above 100) or in persons with symptoms of end organ injury such as chest pain, palpitations, headache, or vision changes. Close monitoring is warranted in patients with significantly elevated blood pressure and a discussion of the warning signs of stroke, heart attack, or other medical emergencies is required.

68. Respondent failed to perform diagnostic tests, not only to assess for possible secondary causes of Patient B's hypertension, but also to confirm the safety of medications he was prescribing. Additionally, despite multiple visits with high blood pressure, Respondent failed to document conversations of screening for end organ injury with symptoms such as headache, chest pain, and palpitations, and he failed to document discussions of when to seek urgent medical attention. The lack of proper evaluation of a hypertensive patient coupled with the significant delay in getting Patient B's blood pressure under control constitutes a simple departure from the standard of care.

69. Respondent failed to diagnose hypertension in Patient C, despite numerous appointments with a diastolic blood pressure greater than 90. Respondent did not perform any diagnostic tests not only to assess for possible secondary causes of hypertension, but to confirm if it was safe to use the other medications he was prescribing. Additionally, despite multiple visits in which the patient had high blood pressure, Respondent's charts fail to document conversations of screening for end organ injury with symptoms such as headache, chest pain, and palpitations, and failed to document discussions of when to seek urgent medical attention. Additionally, Respondent's records show a lack of further evaluation such as EKG.

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Standard of Care Related to Appropriate Pre-operative Optimization

70. The standard of care of an internist in a patient about to undergo surgery of any kind is to optimize this patient for surgery. This includes reviewing all of the patient's previous surgeries and possible complications, reviewing active medications and allergies, assessing the risk of the surgery and assessing and managing any potential risks of anesthesia. Most notably, blood pressure optimization is warranted to reduce risks of stroke, bleeding, or heart attack while under anesthesia.

71. Respondent failed to optimize Patient B for shoulder surgery, failed to document any conversations about the risks of anesthesia or surgery, failed to document a complete medication list and surgical history, and failed to review Patient B's medication allergies. Respondent's failure to optimize Patient B is a simple departure from the standard of care.

Standard of Care Related to the Use of Benzodiazepines and Opiates Concomitantly

72. The standard of care mandates that a provider attempt to use non-benzodiazepine forms of treatments for anxiety unless these forms have been unsuccessful. Additionally, the standard of care mandates that benzodiazepines be avoided in patients chronically managed on opiates. If benzodiazepines are necessary, the standard of care is to document that risks, benefits and alternatives were discussed with the patient.

73. Respondent prescribed benzodiazepines to Patient D despite Patient D's long-term use of opiates, and he did not document any discussion of alternatives provided, or of the risks of concomitant use, which constitutes a simple departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

74. Respondent Leonard Frederick Liss, M.D. is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records as to Patients A, B, C, D and E. The circumstances giving rise to this cause for discipline are set forth in paragraphs 11 through 73 above, and are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

75. The standard of care requires the physician must maintain accurate and complete records demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed and periodic review documentation.

76. In addition, when prescribing controlled substances, the standard of care requires that a physician must also maintain accurate and complete records demonstrating a patient's assessment which includes an evaluation of the patient's pain, prior successful and failing treatments, and assessments of risks of treatment options, including but not limited to co-existing conditions or risk of addiction, prior to prescribing opioid medications. The standard of care mandates that the patient is provided the risks, alternatives and benefits to the opiates being prescribed and that the patient consents to have treatment with opiates. Additionally, the standard of care also mandates that the provider documents and has a signed agreement between the provider and patient regarding the pain management.

77. Respondent failed to document a medical record of taking a history, doing a physical examination, making a diagnosis, assessment and plan, and then prescribing a therapy, including the proper assessment, management and monitoring when prescribing controlled substances consistent with the above standards of care for Patients A, B, C, D, and E.

78. Although Respondent was treating and prescribing medication to Patient B as early as November 2017, Respondent's treatment notes for encounters do not begin until on or about March 22, 2018.

FOURTH CAUSE FOR DISCIPLINE

(Improper Telehealth Visits)

79. Respondent Leonard Frederick Liss, M.D. is subject to disciplinary action under section 2290.5 of the Code, in that he failed to obtain consent and provide proper treatment to Patients A, B, C, D, and E during telehealth visits. The circumstances giving rise to this cause for discipline are set forth in paragraphs 11 through 78 above, which are incorporated here by reference as if fully set forth. Additional circumstances are as follows:

80. The standard of care during the COVID-19 pandemic crisis was to adjust in-person appointments to virtual appointments when appropriate, with the consent of the patient. Physicians are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties, including assessment and treatment, associated with practicing medicine regardless of whether they are providing treatment via telehealth or face-to-face, in-person.

81. Respondent did not document consent for telehealth visits with Patients A, B, C, D, or E. Respondent also documented each encounter as an "office visit" even though he was providing care via telehealth visits.

82. All progress notes from the telehealth visits for Patients A, B, C, D, and E, had minimal or no notation of subjective reports, no objective notes, no assessments or treatment plans, and failed to add any new information regarding the source of each patient's pain, alternative treatment options, or evaluations.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 74715, issued to Respondent Leonard Frederick Liss, M.D.;

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

3. Ordering Respondent Leonard Frederick Liss, 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: MAY 02 2024

Jenna Jones for
REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant