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

In the Matter of the First Amended Accusation Against:	)	
GLENN N. LEDESMA, M.D. Physician's and Surgeon's Certificate No. G 44761	)	Case No. 09-2009-198356
Petitioner	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Richard L. Johnson, Esq., on behalf of Glenn N. Ledesma, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on **August 31, 2015**.

IT IS SO ORDERED: August 31, 2015

Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against:	
GLENN N. LEDESMA, M.D.	MBC No. 09-2009-198356
Physician's and Surgeon's Certificate No. G 44761	OAH No. 2012051093
Respondent	**ORDER GRANTING STAY**
	(Goverment Code Section 11521)

Richard L. Johnson, Esq., on behalf of respondent, Glenn N. Ledesma, M.D., has filed a Petition for Reconsideration of the Decision in this matter with an effective date of August 21, 2015.

Execution is stayed until August 31, 2015.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: August 20, 2015

Kimberly Kirchmeyer
Executive Director
Medical Board of California

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

In the Matter of the First Amended Accusation Against:	)	
GLENN N. LEDESMA, M.D.	)	**Case No. 09-2009-198356**
Physician's and Surgeon's Certificate No. G 44761	)	**OAH No. 2012051093**
Respondent	)	

DECISION

The attached Proposed Decision 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 August 21, 2015.

IT IS SO ORDERED July 22, 2015.

MEDICAL BOARD OF CALIFORNIA

By: _____
Jamie Wright, J.D., Chair
Panel A

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

In the Matter of the First Amended Accusation Against:	Case No. 09-2009-198356
GLENN N. LEDESMA, M.D.	OAH No. 2012051093
Physician's and Surgeon's Certificate No. G 44761,	
Respondent.	

PROPOSED DECISION

This matter came on regularly for hearing on September 8, 10, 11, 12, 15, and 16, 2014, and June 15, 16, and 17, 2015, in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

On September 8-16, 2014, Michael S. Cochrane and Harinder Kapur, Deputies Attorney General, represented Complainant, Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board). Complainant was represented by Matthew M. Davis and Harinder Kapur, Deputies Attorney General, on June 15-17, 2015.

On September 8-16, 2014, Respondent, Glenn N. Ledesma, M.D., was present and was represented by Henry Fenton and Nicholas Jurkowitz, Attorneys at Law. Respondent was present and was represented by Richard L. Johnson, Attorney at Law, on June 15-17, 2015.

During the hearing, Complainant amended the Accusation at page 23, lines 11 and 21, page 24, lines 4 and 22, and page 25, line 27, by replacing "12" with 12A through 12 CC."

During the hearing, Complainant amended the First Amended Accusation at page 24, line 18, by adding "and T.M." after "R.P-Z."

Oral and documentary evidence was received. The record was closed on June 17, 2015, and the matter was submitted for decision.

PROTECTIVE ORDER OVER PERSONAL INFORMATION

Exhibits 6-32, 34, 35-40, 42-51,68-80, 83, 85, 86, 91, 1105, 1106, 1107, 1108, 1109, 1111, D, AAAD, AAAG, AAAH, AAAI, AAAJ, AAAK, AAAM, AAAO, and transcripts (if any) of the hearing on September 11, 2014 and September 15, 2014, contain unredacted personally identifiable information including names, identifying numbers, and medical records of Respondent and patients who are the subjects of this action. It was not possible to redact that information and preserve the right of public access without obliterating relevant content. Accordingly, on June 25, 2015, to safeguard the privacy of the information, a protective order was issued for those exhibits and transcripts to be sealed.

RESPONDENT'S COMPLAINT TO THE STATE BAR OF CALIFORNIA

On June 11, 2015, the Administrative Law Judge received a copy of a complaint Respondent had filed with the State Bar of California regarding his former attorneys. A proof of service indicated that Respondent had also served a copy of the complaint on Complainant's counsel. Therefore, the Administrative Law Judge did not prepare a notice of ex parte communication.

Nothing in or with the complaint indicated that Respondent wanted the complaint to be part of the administrative record. Therefore, Respondent's complaint to the State Bar of California was neither marked for identification as an exhibit, nor considered as evidence in the instant action.

FACTUAL FINDINGS

Background Information

1. According to paragraph 2 of the First Amended Accusation, the Board issued Physician's and Surgeon's Certificate Number G 44761 to Respondent on or about June 15, 1981. The certificate was in full force and effect at all relevant times, and it was scheduled to expire on March 31, 2015, unless renewed. Complainant did not offer any evidence to support those allegations, but Respondent did not dispute them. Basing a finding of accuracy on Respondent's silence, the Board maintains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).

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2. Respondent is a dermatologist. He attended medical school at SUNY Downstate. His dermatology residency began in Virginia, but he transferred after three months when a position opened at New York Medical College that would enable him to remain closer to his home. After moving to California in 1986, Respondent worked for FHP, a health maintenance company, where he performed many skin cancer surgeries, flaps, and graphs. In September 1986, he became the owner of California Dermatology (Cal Derm), a medical clinic specializing in dermatology. His practice grew and, at various times, Respondent had offices in Garden Grove, Beverly Hills, Diamond Bar, Corona, Covina, and La Jolla.

3. In 1995, Respondent hired Marshall Goldberg, M.D. as a part-time physician. In 1997, Respondent was diagnosed with a serious illness. He remained on as Cal Derm's owner performing various tasks as detailed below. After his diagnosis, Respondent made Dr. Goldberg a full-time employee and gave him the title of Cal Derm's Medical Director.[1] Dr. Goldberg served in that capacity as Respondent's employee until 2008. As the Medical Director, Dr. Goldberg oversaw the medical management aspect of the practice, including overseeing the physician assistants (PA's) and nurse practitioners who assessed and treated the patients,[2] and he signed off on the required number of charts pursuant to their delegation of services agreements. However, Dr. Goldberg was not in charge of the business aspects of the practice such as record transcription and billing. Those responsibilities remained with Respondent.

4. For approximately one year between the time Dr. Goldberg left Cal Derm and the time Respondent hired a replacement for him, Respondent served as Cal Derm's Medical Director and supervising physician. Respondent was again the Medical Director and supervising physician in 2010. (Exhibit 55, AGO-28665.)

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[1] Although Respondent testified that Dr. Goldberg signed a contract to serve as Cal Derm's Medical Director, neither party offered the contract into evidence.

[2] The physician assistants and nurse practitioners who treated patients at Cal Derm are also referred to as health care providers in this Decision.

Record Keeping and Billing Practices at California Dermatology

5. During the relevant time period, Respondent oversaw a global system of fraudulent billing to insurance carriers and patients that was accomplished by altering providers' handwritten notes to reflect more extensive treatment than was rendered and by "upcoding." Upcoding involved the use of Encounter Forms, also known as Superbills. Health care providers used those forms to record diagnoses, treatments and visit durations by checking appropriate boxes on the forms. The boxes contained the correct Current Procedural Terminology (CPT) code numbers. Each code number was billed at a certain rate depending on the nature of the diagnosis, the extensiveness of the treatment, and the length of the patient visit. Upon receipt of the Superbills, office personnel billed health insurance carriers using other CPT codes that generated higher income than those marked by the health care providers.

6. Health care providers also generated handwritten chart notes for each patient encounter. Those notes were sent to a central transcription office where office personnel used them to create typed or computer-generated notes that were inconsistent with the handwritten ones. The computer-generated notes, known as Evaluation and Management Reports, reflected diagnoses and treatment that was more serious and complex than those on the hand-written notes and, on many occasions, reflected treatments that were never rendered and diagnoses that did not exist. This was done in order to justify the higher billings from the adjusted Superbills. Each diagnosis had a number of pre-set entries stored on the office's computer that personnel were instructed to enter on the Evaluation and Management Report. The reports were then forwarded to the patients' insurance carriers. The office personnel varied the entries on each report so as to avoid raising the carriers' suspicions. The providers' handwritten notes were destroyed after the fraudulent computer-generated Evaluation and Management Reports were created from them. At least one office worker was provided with a "cheat sheet" that correlated CPT codes to appropriate, but false, note entries to use instead of the entries on the providers' handwritten notes. Occasionally, transcribers were instructed to change the Tax ID number on the Evaluation and Management Reports.

7. When a PA or nurse practitioner performed a treatment, transcribers were instructed to indicate on the Evaluation and Management Reports that a physician had performed it, so the treatment could be billed at a higher rate. All of the above fraudulent practices were followed without the transcriber consulting with the individual who provided the treatment to the patient. The Evaluation and Management Forms were not given to the providers who treated the patients for review. Respondent reviewed some of the Evaluation and Management Reports and occasionally asked the transcriber to make changes to them. Dr. Goldberg did not review any Evaluation and Management Reports for changes.

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8. In addition, management personnel urged the health care providers to encourage patients with rosacea to undergo laser treatments with micro-dermabrasion by telling the patients the treatment was medically necessary, and that the patients would not be billed for the treatment even if their insurance carriers refused payment. Office personnel were instructed to inform inquiring patients that Cal Derm would accept as payment in full only the sums the insurance carriers would pay. The laser and micro-dermabrasion treatments were not medically necessary and were used by Cal Derm office personnel to increase patients' bills. When carriers declined payment for the elective treatment, Cal Derm billed the patients directly in contravention of the employees' representation.

9. Patient R.P-Z.[3] is an example of Cal Derm's fraudulent billing practices. R.P-Z. was a 16-year-old male who treated in Cal Derm's Corona office. He presented on May 2, 2008, complaining of acne on his face, chest and back. He had a history of acne, dry skin patches and sensitive skin. He was treated by a PA. The PA rendered treatment and created a handwritten note following each of R.P-Z.'s visits. Each handwritten note was destroyed after office personnel generated a fraudulent Evaluation and Management Report. Each such report also contained signed consent forms written in technical medical terms rather than in lay terms a patient could understand. The reports contained numerous falsehoods including diagnoses of conditions that did not exist and treatments that were not performed. Cal Derm sent bills for the false diagnoses and treatments to R.P-Z.'s insurance carrier for payment. The bills were based on false CPT codes that were generated by office personnel and not by the PA. Those fraudulent practices occurred in no fewer than three office visits.

10. R.P-Z.'s medical records include a note dated April 2, 2009, which reads: "After receiving the correspondence from the patient's mother, an audit was performed. Cryotherapy not performed on 5/30. Corrected claim sent to insurance on April 2, 2009." Respondent's initials appear on that note indicating that he was involved in the audit and/or the decision to reduce the bill upon a complaint from the patient's mother. (Exhibit 80, AGO-01614.)

11. A second example was patient T.M., a 32-year-old female who presented on February 26, 2006, at the Cal Derm Corona office complaining of scaly, dry and flaky skin around the face and neck. The condition had started three months earlier as intermittent red patches that responded to treatment with Hydrocodone. A PA diagnosed the condition as contact dermatitis with resulting eczema, which she treated with ultraviolet light therapy, a 10 mg Kenalog injection and a prescription for Vanos cream. On March 2, 2006, the same PA slightly altered the diagnosis to atopic dermatitis with resultant eczema-neck which she again treated with ultraviolet light therapy and a 10 mg Kenalog injection.

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[3] Patients' initials are used in lieu of their names in order to protect their privacy.

12. T.M. had approximately 33 visits between February 26, 2006, and December 11, 2006. She was seen each time by either the same PA or a nurse practitioner. Both providers were under Dr. Goldberg's medical supervision. Those providers' handwritten notes were destroyed upon the creation of fraudulent Evaluation and Management forms based on upcoding from the original handwritten notes and Superbills. Only Dr. Goldberg's name appeared on the Evaluation and Management forms, implying that the patient had been seen and treated by a physician rather than a PA or nurse practitioner, thus triggering an inflated bill. Consent forms were written in complex medical terms. The Evaluation and Management forms contained several diagnoses that were never made for conditions that did not exist, and treatments that were never administered. Among the false diagnoses Cal Derm assigned to T. M. were pain, infection, folliculitis, psychological impairment, emotional distress, boil, abscess, proliferated vascular lesions, actinitic keratosis, 12 facial lesions, 15 or more facial lesions, 18 facial lesions, and psychosis.

13. In addition, T.M. was persuaded to undergo a series of laser treatments and micro-dermabrasion for "acne rosacea." She was promised that Cal Derm would accept only what her insurance carrier would pay, and that T.M. would pay nothing for the treatment, even if the carrier refused payment. Cal Derm later charged T.M. close to $40,000 for those treatments when her insurance carrier declined payment.

14. As with many other patients, in order to avoid raising the carrier's suspicions, office personnel varied the language on the forms for R.P-Z. and T.M. by using the pre-sets on their computers' hard drives.

15. At all relevant times, Respondent oversaw the operations of the transcription and billing departments for Cal Derm.

The Disability Insurance Policies

16. In approximately March 1994, Respondent applied for an individual disability income protection insurance policy with Unum Life Insurance Company (Unum). In May 1994, Respondent, through Cal Derm, applied for a group policy with Paul Revere Life Insurance Company (Paul Revere). Unum issued the individual policy (the Unum policy) on March 5, 1994. Paul Revere issued the group policy (the Paul Revere policy) on May 1, 1994.[4]

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[4] Through a series of mergers and acquisitions, Unum and Paul Revere eventually became part of the Unum Group.

17. The Paul Revere policy contained the following definitions:

DISABLED OR DISABILITY – These terms may mean either total disability or residual disability. The Group Policy provides benefits for:

1. total disability from any occupation;
2. total disability from your own occupation, and
3. residual disability.

The definitions of these terms follow. One or more may apply to you.

Totally disabled from any occupation, or total disability from any occupation means:

1. because of injury or sickness, you are completely prevented from engaging in any occupation for which you are or may become suited by education, training or experience, and
2. you are under the regular care of a doctor.

Totally disabled from your own occupation or total disability from your own occupation means:

1. that because of injury or sickness you cannot perform the important duties of your own occupation; and
2. you are under the regular care of a doctor; and
3. you do not work at all.

Totally disabled or total disability may mean either totally disabled from any occupation or totally disabled from your own occupation. If you work other than full time at your own job you may be considered to be residually disabled.

Residually disabled or residual disability means, after a continuous period of total disability which lasts at least as long as your elimination period,

1. you are prevented, by the same injury or sickness which caused your total disability from performing one or more of the important duties of your own occupation on a full-time basis; and
2. you are under the care of a doctor, and

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3. you work:

a. at your own occupation, but cannot perform one or more of the important duties of your own occupation on a full-time basis; or

b. at some other occupation; and

4. you do not earn more than 30% of your prior earnings.

(Exhibit 4, AGO-12851-12852.)

18. The Unum policy contained the following definitions:

"Regular occupation" means your occupation at the time the Elimination Period begins. If you engage primarily in a professionally recognized specialty at that time, your occupation is that specialty.

"To work full time in your regular occupation" means you work approximately the same number of hours in the same regular occupation as you were working before disability began.

"Disability" and "disabled" mean the period while you are satisfying the Elimination Period, or while the Total Disability Benefit, the Residual Disability Benefit, the Recovery Benefit or the Loss of Use Benefit is payable.
"Total disability" and "totally disabled" mean:

1. injury or sickness restricts your ability to perform the material and substantial duties of your regular occupation to an extent that prevents you from engaging in your regular occupation; and

2. you are receiving medical care from someone other than yourself which is appropriate for the injury or sickness. We will waive this requirement when continued care would be of no benefit to you.

"Residual disability" and "residually disabled" during the Elimination Period mean:

1. injury or sickness does not prevent you from engaging in your regular occupation, BUT does restrict your ability to perform the material and substantial duties of your regular occupation;

a. for as long a time as you customarily performed them before the injury or sickness; or

b. as effectively as you customarily performed them before the injury or sickness; and

2. you are receiving medical care from someone other than yourself which is appropriate for the injury or sickness. We will waive the requirement when continued care would be of no benefit to you.

After the Elimination Period has been satisfied, "Residual disability" and "residually disabled" then mean that as a result of the same injury or sickness which caused you to satisfy the Elimination Period:

1. you experience at least a 20% loss of net income in your regular occupation; and

2. you are receiving medical care from someone other than yourself which is appropriate for the injury or sickness. We will waive this requirement when continued care would be of no benefit to you.

"Elimination Period" means the number of days stated on page 3 preceding the date benefits become payable (other than the Loss of Use Benefit), during which you are totally or residually disabled.

The Elimination Period begins on the first day that you are totally or residually disabled. . . .

(Exhibit 5, AGO-12877-12878.)

19. In October 1997, following his diagnosis, Respondent submitted disability claims to Unum Group against both of his policies claiming he was totally disabled from his material and substantial duties as a physician. He listed his most important or essential functions as "surgery" and "interaction with patients." (Exhibit 6, AGO-11729.) Thereafter, Unum Group began making regular payments on Respondent's claim. Respondent continued to submit monthly or quarterly disability claims to Unum Group, which continued to issue regular payments on the claims. Respondent also continued on as Cal Derm's owner, performing such tasks as ensuring proper licensure and making sure payroll was completed.

20. On various claim forms Respondent submitted to Unum Group, he represented that he was unable to perform the duties of his profession and that he had not engaged in any other occupation. He also represented that his daily activities were limited to resting, going to the doctor, and running errands. He added "limited exercise" to approximately three forms in 2000. The statements Respondent made on the claim forms were not true.

21. Between 2003 and 2007, Respondent applied for medical licensure in Nevada three times. In all three applications, he represented that he did not have a medical condition which impaired or limited his ability to practice medicine safely. In a letter to the Nevada State Board of Medical Examiners, he represented that he was extremely busy in his private practice. At the administrative hearing, Respondent testified that he did not recall applying for licensure in Nevada. He maintained that position even when he was confronted with all three applications. Respondent's testimony in that regard was not credible in that the three applications were in evidence, he remembered small details in other aspects of his testimony, and because the three applications for Nevada licensure should have been sufficient to jog his memory as to at least one of them.

22. Dr. Goldberg left Cal Derm in 2008. At that time, Respondent assumed the additional role of Medical Director and Physician Supervisor for PAs and nurse practitioners which required him to, among other tasks, review chart notes. Respondent did not inform the Unum Group of his change of status. At the administrative hearing, he testified that he hired another medical director in 2009. That credibility of that testimony is questionable given the deposition testimony of Cal Derm's CEO, Johnathan Ledesma, that Respondent was the Medical Director as of March 29, 2010.

23. On October 7, 2008, Respondent signed a delegation of services agreement with PA Suzanne Freeseman. Thereafter, Ms. Freeseman saw Respondent in one of the offices a few times per month. Respondent occasionally accompanied Ms. Freeseman into an examination room where they assessed the patient together, discussed differential diagnoses, and agreed on appropriate treatment. This occurred with every patient Ms. Freeseman saw in the Beverly Hills and Burbank offices. On other occasions, Ms. Freeseman saw the patient alone and then presented the case to Respondent. If she had a question for Respondent when he was not present, staff reached him by telephone. As her supervisor, Respondent reviewed a percentage of Ms. Freeseman's charts.

24. Respondent signed delegation of services agreements with at least two other PA's after Dr. Goldberg resigned.

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25. Between July 9, 1999, and July 30, 1999, a private investigator with Universal Insurance Services conducted surveillance on Respondent in connection with an investigation by Unum. The investigator prepared the following summary:

> During the course of the investigation, I was able to develop that the claimant [Respondent] has three different offices. The claimant has offices in Garden Grove, Covina and Diamond Bar. Five out of nine weekdays the claimant was observed at one [of] his offices from one to four hours at a time. During the first week of surveillance from 7-13-99 through 7-16-99, the claimant was observed going to either his Garden Grove office or his Diamond Bar office. This is where he spent from one to four hours at a time at these locations. During the course of the second full week of surveillance, the claimant was observed going to his Garden Grove office on only one day and remaining there for approximately an hour and a half. Every morning during the weekday, the claimant was observed leaving his residence and going to Liddy's Health Works in West Hollywood, Ca. This is a workout/chiropractic facility that the claimant attends every morning at approximately 8:00 A.M. and he remains there for approximately an hour. The claimant was observed going to lunch with his roommate and running various errands. His movements were at a moderate pace and he showed no signs of disability, nor did he show any signs of fatigue.
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> During the course of the first weekend of the surveillance, the claimant on Saturday was observed going to his Laguna Beach home. On the way to the house, the claimant's vehicle encountered a flat tire. The claimant was observed conversing with people, walking his dog, and bending at the hips and knees to examine the damage done to his vehicle. On Sunday, the claimant was not observed leaving his residence in Laguna Beach. During the second weekend of the surveillance, the claimant was observed each day leaving the residence for a half hour and directing the gardeners and his staff at his residence.

(Exhibit 13, AGO-25562.)

26. It was not until 2008 that Respondent acknowledged that, during the time he had been receiving disability benefits for total disability, he had been a clinical assistant professor at the University of California, Irvine and had been appointed to the Board of Governors at Cedar Sinai Medical Center.

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27. On November 15, 2010, an investigator hired buy Unum Group conducted surveillance on Respondent. The investigator observed Respondent leave his home in a BMW and drive to a gym in the North Hollywood area where he participated in a spin cycle class with 7-10 people and an instructor. Respondent then drove to a Coffee Bean shop and then returned home. He left again and traveled to an office on Melrose in Beverly Hills where he parked in a designated parking space that read "Ledesma." Between three and four hours later, Respondent left the building as a passenger in a Land Rover the investigator had seen earlier. Respondent traveled to a doctor's office in Beverly Center and then returned to the office. He exited the Land Rover and drove home in the BMW.

28. The results of an investigation conducted by Unum's Special Investigations Unit in approximately November 2010 showed that, between May 18, 2005 and July 14, 2006 alone, Cal Derm billed Blue Cross of California a total of $1,826,272.70 for medical procedures performed by Respondent. (Exhibit 31.) Between March 15, 2006 and December 1, 2010, Blue Cross of California paid to the various Cal Derm offices a total of $260,491.29 for services provided by Respondent. (Exhibit 33, AGO-14468.) Respondent billed under five different Tax ID numbers for his five office locations plus his own individual Tax ID number. Respondent continued to bill Blue Cross of California into 2010. According to the billings, between March 2006 and December 2010, Respondent treated or evaluated 706 Blue Cross patient/members. Many of the records also show that Respondent was supervising PA's and nurse practitioners who treated the patients.

29. During the course of the same investigation, Unum requested an interview with Respondent. Respondent agreed to the interview only on the condition that he be provided with the questions beforehand. The interview never took place.

30. In 2010, Respondent performed volunteer work, discussing patients' cases with medical students and residents at a clinic operated by Cedar Sinai Medical Center.

31. Respondent stopped receiving disability benefits under the policies in 2012.

32. Anthony Scarsella, M.D. is Respondent's physician. Dr. Scarsella filled out the physician statements on all of Respondent's claims for disability benefits. At the administrative hearing, Dr. Scarsella credibly testified that he based his opinions regarding Respondent's inability to perform the functions of his occupation primarily on what Respondent told him, and that his opinion on that issue would have been different had he known certain facts such as (1) Respondent was acting as a sole practitioner supervising PA's; and (2) Respondent was continuing to work.

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33. On February 24, 2011, Respondent was interviewed by a Board investigator. He informed the investigator that his health was "good" and that he was not taking prescription medications; that while Dr. Goldberg was Medical Director, Respondent was looking into other kinds of scientific issues; that he saw patients during the week; and that he visited all of his offices every week to keep in touch with his employees. At the administrative hearing, Respondent attempted to distance himself from those statements by saying he must have been confused at the time of the interview. Aside from his testimony, no evidence was offered to establish his claim of confusion, and his testimony in that regard was not credible.

34. During the same interview, Respondent stated that he was in charge of the day-to-day medical aspects of the practice (Exhibit 68, AGO-7621-7622), that he saw the PA's he supervised several times per month, and that he was always available to them by telephone. (*Id.* at AGO-7682.) He also stated that he reviewed PAs' charts every week and initialed the ones he reviewed. (*Id.* at AGO-7682-7684.) Respondent further stated that he worked on expanding the business and on research projects after he hired Dr. Goldberg, and that he was continuing to work on research as of the time of the interview. (*Id.* at AGO-7689-7690.)

35. As of March 29, 2010, Respondent was the supervising physician at Cal Derm. (Exhibit 55, AGO-28665.) At that time, he and Cal Derm's CEO, Johnathan Ledesma, were responsible for deciding on changes to the company's billing system. (*Id.* at AGO-28625; AGO-28667.) Respondent drew a salary from Cal Derm until an unspecified date in 2008. (*Id.* at AGO-28810.)

36. On March 31, 2010, Respondent was deposed in connection with a lawsuit between Cal Derm and United Healthcare. He testified that he had been Cal Derm's medical director in 2010; that he had been so for a year; that he was in the office five days per week and sometimes on Saturday; that, in 2010, he referred four patients out for chemotherapy; and that he saw patients, advised on treatment, and performed evaluation management at Cal Derm. At the administrative hearing, Respondent testified that he did not recall making those statements and that, if he did, he must have been confused. Aside from that testimony, no evidence was offered to establish Respondent's confusion during the deposition. If Respondent had indeed been confused, he had the opportunity to correct the deposition transcript. No evidence was offered to show that he did so. Respondent's testimony regarding his confusion during his deposition was not credible.

37. Respondent showed no indication of confusion during his testimony at the administrative hearing.

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38. Respondent offered the testimony of Stephen Prater, a consultant for the insurance industry. With respect to disability policies, Mr. Prater testified that Respondent's main activity as a dermatologist was surgery and that, if Respondent could not perform surgery with reasonable continuity, he was totally disabled and free to work in any occupation. He also testified that the standard in the insurance industry is that the policy cannot be applied literally. No evidence was offered to prove that Respondent's main professional activity was as a surgeon. In fact, the opposite was proven. He was active running the business, supervising PA's and nurse practitioners, and assessing and treating patients conservatively. Mr. Prater offered no authority for his assertions regarding a loose reading of insurance policies. That testimony ran directly contrary to California contract law under which policies of insurance are interpreted. It also ran contrary to the carrier's specific statement to Respondent in a May 23, 1994 explanatory letter: "If your important or material duties were restricted and you were not engaged in any gainful occupation, you would be considered Totally Disabled. If you were working but because of your [condition], you suffered at least a 20% loss of earnings, you would be eligible for Residual Disability benefits, if included in your policy." (Exhibit D.)[5]

39. Mr. Prater also testified that if a policy holder lies on a claim for benefits, it is not fraud if it is not relevant to the claim, and that Respondent's statements on his claim form indicate only that he had not returned to his pre-disability occupation. Mr. Prater went on to say that a totally disabled person can make a million dollars a year in another occupation even if related to his/her pre-disability occupation. That testimony is directly contrary to the definitions in the Unum and Paul Revere policies and California law. In *Hecht v. Paul Revere Life Insurance Company* (2008) 168 Cal.App.4th 30, 32-33, the court stated:

> "[T]he term 'total disability' does not signify an absolute state of helplessness but means such a disability as renders the insured unable to perform the substantial and material acts necessary to the prosecution of business or occupation in the usual or customary way. Recovery is not precluded under a total disability provision because the insured is able to perform sporadic tasks or give attention to simple or inconsequential details incident to the conduct of business. (Citations) Conversely, the insured is not totally disabled if he is physically and mentally capable of performing a substantial portion of the work connected with his employment. He is not entitled to benefits because he is rendered unable to transact one or more of the duties incidental to his business." (Citation.)

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[5] See also, a carrier's warning at Exhibit 28, page 28054: "For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

40. Lastly, Mr. Prater admitted that he has a bias against Unum's practices and procedures.

41. Based on the strong evidence and case law to the contrary, Mr. Prater's testimony was not credible, and his opinions are given little weight.

LEGAL CONCLUSIONS

1. Cause does not exist to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (c), for repeated negligent acts, as set forth in Findings 2 through 15 and Legal Conclusion 14.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234, subdivision (e), for acts involving dishonesty and corruption, as set forth in Findings 2 through 41 and Legal Conclusions 15 through 23.

3. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, 2234, and 2261, for knowingly making or creating a false medical record, as set forth in Findings 2 through 15 and Legal Conclusions 15 through 21.

4. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, 2234, and 2262, for creation of false medical records with fraudulent intent, as set forth in Findings 2 through 15 and Legal Conclusions 15 through 21.

5. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, 2234, and 2266, for failure to maintain adequate and accurate records, as set forth in Findings 2 through 15 and Legal Conclusions 15 through 21.

6. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 810, subdivisions (a)(1) and (a)(2), 2227, and 2234, for insurance fraud, as set forth in Findings 2 through 41 and Legal Conclusion 15 through 23.

7. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, and 2234, for general unprofessional conduct, as set forth in Findings 2 through 41 and Legal Conclusions 15 through 23.

8. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code sections 2227, and 2234, subdivision (a), for violations of the Medical Practice Act, as set forth in Findings 2 through 41 and Legal Conclusions 15 through 23.

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Laches

9. In closing argument, for the first time since the filing of this action in 2012, Respondent raised the affirmative defense of laches. Although laches had not been pled in the Notice of Defense, Complainant did not object to its being asserted in closing argument. Accordingly, it is considered as an affirmative defense.

10. A successful laches defense requires the establishment of two elements: An unreasonable delay in bringing the action, and resulting prejudice to the responding party. (*Mt. San Antonio Community College District v. Public Employment Relations Board* (1989) 210 Cal.App.3d 178; *Finnie v. Town of Tiburon* (1988) 199 Cal.App.3d 1, review denied.)

11. In closing argument, Respondent argued that the Board delayed three years before filing the Accusation, that witnesses' memories had faded, and that one key witness regarding the billing issue had died. However, Respondent failed to offer any evidence that there had been a delay in filing, that any delay that may have occurred was unreasonable, that witnesses' memories had faded, the identity of those witnesses, the identity of the key witness who died, whether that witness would have testified, or prejudice of any kind.

12. In *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 614, 624, the court stated:

> Prejudice is never presumed; rather it must be affirmatively demonstrated by the defendant in order to sustain his burdens of proof and the production of evidence on the issue.

13. Respondent failed to establish the necessary elements to support the affirmative defense of laches.

Negligence

14. A physician or surgeon must have the degree of learning and skill ordinarily possessed by other practitioners in the same locality. He/she must exercise ordinary care in applying his/her learning and skill to patient treatment. (*Keen v. Prisinzano* (1972) 23 Cal.App.3d 275, 279.) This case does not involve a respondent who failed to exercise ordinary care. It involves intentional dishonesty. Respondent did not overlook his office staff upcoding and creating false and fraudulent medical records. Absent instructions from Management, they had no motive to create them. Respondent was the owner of Cal Derm. He was the only person who stood to profit from his company's fraudulent practices. Respondent was not negligent. He was dishonest.

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Insurance Fraud

15. Business and Professions Code section 810 states in pertinent part:

(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

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

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

(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.

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16. Penal Code section 550 states in relevant part:

> a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:
>
> (1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance. [¶] . . . [¶]
>
> (5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.
>
> (6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit. [¶] . . . [¶]
>
> (b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:
>
> (1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
>
> (2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
>
> (3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

Vicarious Liability

17. A licensee "may not insulate himself from regulation by electing to function through employees or independent contractors." (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 165.)

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18. Respondent argues that Dr. Goldberg was the medical director for Cal Derm during the relevant time period, that Dr. Goldberg was responsible for the wrongdoing at Cal Derm while he was the medical director, and that Respondent cannot be held vicariously liable for Dr. Goldberg's wrongdoing. He relies on *James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096 in support of that proposition. Respondent's argument is not persuasive for two reasons: (1) Dr. Goldberg was not in Cal Derm's employ at all relevant times. Respondent was directly liable in Dr. Goldberg's absence; and (2) although Respondent is not vicariously liable for any medical errors Dr. Goldberg might have made, he is vicariously liable for the office staff's upcoding and creating false and fraudulent medical records.

19. In *James, supra*, Dr. James owned a dental practice with other dentists. The Dental Board of California disciplined his license based in part on acts and omissions of the other dentists in his office, pursuant to the doctrine of respondeat superior. The Court held that "any attack to revoke the personal license to practice dentistry of Dr. James of course must be based upon findings of his own acts of misfeasance, or on such acts by those working with him on which he had personal knowledge and which he actually ratified. (Citation.)" (*Id.* at 1110.) The Court distinguished *Camacho v. Youde, supra,* and *Arenstein v. California State Board of Pharmacy* (1968) 265 Cal.App.2d 179, both of which upheld the respondeat superior doctrine in administrative actions. The *James* court found that *Camacho* and *Youde* involved "improper activity . . . 'done in the course of [the respondent's] business in the operation of the license,' not in the personal practice of medicine, dentistry or law under a professional license." (*James, supra,* at page 1112.)

20. *James* is not applicable in this case. Cal Derm physicians, PA's, and nurse practitioners are not alleged to have been negligent or incompetent in the actual treatment of patients. Rather, Cal Derm's office personnel are alleged to have committed insurance fraud through the use of upcoding and the creation of fraudulent records. It was Respondent, not Dr. Goldberg, who oversaw the transcription and billing departments. He is vicariously liable for their wrongdoing.

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21. In making the finding that Respondent is vicariously liable for the dishonest and fraudulent acts of his employees, it is of no import that his liability is related to the business aspects, rather than the medical aspects, of his practice. In *Windham v. Board of Medical Quality Assurance* (1980) 104 Cal.App.3d 461, 470, the court stated:

> First of all, we find it difficult to compartmentalize dishonesty in such a way that a person who is willing to cheat his government out of $65,000 in taxes may yet be considered honest in his dealings with his patients. In this connection, however, we should point out that today's doctor deals financially with the government—state, local and federal—in many ways that have nothing to do with his own personal tax obligation . . . Above, all, however, there is the relation between doctor and patient. It is unnecessary to describe the extent to which that particular relationship is based on utmost trust and confidence in the doctor's honesty and integrity.

It is that trust that Respondent betrayed.

The Disability Insurance Claims

22. Respondent offered little evidence in defense of the allegations of insurance fraud with respect to his disability insurance claims. The evidence established that, during the period Respondent claimed he was totally disabled, (1) he maintained control over the Cal Derm business, including the transcription and billing departments, at all relevant times including while Dr. Goldberg served as the medical director and supervising physician. (2) Respondent assumed the role of Medical Director and Supervising Physician after Dr. Goldberg left in 2008. (3) Respondent maintained an active lifestyle and did much more than rest, go to the doctor, and run errands. His activities included going to restaurants, working out at a gym, and working in his various offices, work that included supervising PA's and nurse practitioners and reviewing their records. (4) Respondent performed volunteer work and taught medical students and residents at a clinic operated by Cedar Sinai Medical Center. He was a clinical assistant professor at the University of California, Irvine. (5) Respondent saw, assessed, and treated patients and billed for his services. (6) Respondent engaged in all of these activities while collecting disability insurance benefits on two policies by repeatedly claiming, over an approximate 15 year period, that he was totally disabled and incapable of performing any work at all.

23. At the hearing, Respondent testified that he denied all of the charging allegations in the First Amended Accusation. However, he admitted to engaging in some of the activities referenced above while he was averring to total disability and applying for and accepting disability insurance benefits under two policies. Further, he did not deny the fraudulent transcription and billing practices at Cal Derm, and he did not claim to have been unaware of them while they were occurring. He simply blamed Dr. Goldberg for them, even after Dr. Goldberg left the practice.

Disposition

24. Business and Professions Code section 2229 states:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.
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> (c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

25. In *Golde v. Fox* (1979) 98 Cal.App.3d 167, 176, the court stated:

> The crime here, of course, does not relate to the technical or mechanical qualifications of a real estate licensee, but there is more to being a licensed professional than mere knowledge and ability. Honesty and integrity are deeply and daily involved in various aspects of the practice.

26. The importance of honesty for a real estate licensee is at least equaled for a physician. The evidence evinced Respondent's ongoing predilection for dishonesty in both his private and professional life. For many years, he operated his medical practice by defrauding insurance carriers with false records and bills, and his patients with promises that they would not be charged by Cal Derm for treatments not covered by their health insurance policies. For many years, he defrauded his disability insurance carriers with false statements that he was totally disabled and unable to do anything but visit his doctor, run errands and rest when, in fact, he was quite active and working in his regular occupation as a dermatologist and business owner. Such conduct bodes poorly for public protection.

27. Although artificial acts of contrition are not required in an administrative proceeding (*Calaway v. State Bar* (1986) 41 Cal.3d 743, 747-748), acceptance of responsibility and appropriate remorse are necessary elements of rehabilitation. Remorse for one's conduct and the acceptance of responsibility are the cornerstones of rehabilitation. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Fully acknowledging the wrongfulness of past actions is an essential step towards rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933, 940.)

28. In this case, Respondent has not accepted responsibility for his conduct, he has shown no remorse, and he has not yet begun the process of rehabilitation. The public safety, welfare, and interest cannot be adequately protected if Respondent remains licensed to practice medicine, even on a probationary basis.

ORDER

Physician's and Surgeon's Certificate No. G 44761 issued to Respondent, Glenn N. Ledesma, M.D., is revoked.

Dated: June 29, 2015

H. Stuart Waxman

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the First Amended Accusation Against: **GLENN N. LEDESMA, M.D.** **P. O. Box 15807** **Beverly Hills, CA 90209** **Physician's and Surgeon's Certificate No. G 44761,** Respondent.	Case No. 09-2009-198356 OAH No. 2012051093 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about June 15, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 44761 to Glenn N. Ledesma, 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 March 31, 2015, unless renewed.

JURISDICTION

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

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

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.[1] In addition to other provisions of this article, unprofessional conduct[2] includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

[2] Unprofessional conduct has been defined as conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 654.)

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

". . . ."

6. Section 2261 of the Code states:

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

7. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

8. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

9. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

10. Section 810 of the Code states, in pertinent part, that:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

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

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

"(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871 of the Insurance Code or Section 549 or 550 of the Penal Code.

"..."

11. Section 3502 of the Code states:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the board prohibiting that supervision or prohibiting the employment of a physician assistant.

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

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

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

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

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

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

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

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

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"(3) Notwithstanding any other provision of law, the board or committee may establish other alternative mechanisms for the adequate supervision of the physician assistant.

". . . ."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

12 Respondent Glenn N. Ledesma, M.D., is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in the care and treatment of patients R.P-Z. and T.M., as more particular alleged hereinafter:

INTRODUCTION

A. Respondent has owned California Dermatology (CD) since about the 1990's. CD provides dermatological services in southern California. At various times, CD had clinic locations in Garden Grove, Beverly Hills, Diamond Bar, Corona, Covina and La Jolla. CD employs physician assistants (PAs) and nurse practitioners (NAs) to provide the majority of the care to patients at the clinic locations. The physician assistants included S.A., S.V., J.R., B.H. and S.F. D.W., a nurse practitioner also provided care to patients at the various clinics. In about 1997, respondent employed M.P.G., M.D. to serve as the Medical Director for CD. Dr. M.P.G.'s responsibilities included attending to dermatology patients at the various clinics and supervising the physician assistants and a nurse practitioner (physician extenders) who provided dermatologic treatment to patients at the clinics. In about October 2008, Dr. M.P.G. terminated his employment with CD. Since about October 2008, respondent has been CD's Medical Director and has been responsible for the supervision of the physician extenders.

B. All CD providers prepared handwritten notes on all patients treated at the clinics. These handwritten notes were destroyed after they were "transcribed" and converted to Evaluation and Management Reports. Often, the providers would not compare the handwritten notes to the Evaluation and Management Reports before destruction of the

handwritten notes.[3] The Evaluation and Management Reports are fraudulent in that most of the noted medical procedures and treatments were, in fact, not performed. CD utilized the Evaluation and Management Reports and Encounter Forms,[4] to generate billing statements submitted to insurance companies and patients.

In addition, the CD providers engaged in "upcoding," a fraudulent practice whereby dermatologic services provided were billed at the higher CPT codes, regardless of the nature of the actual services rendered. Moreover, CD offered incentives to the physician assistants and nurse practitioner to recommend and promote laser therapy treatments to patients with Telengietatic Rosacea (Rosacea) regardless of the appropriateness or necessity of the treatment.[5]

Patient R.P-Z.

C. On or about May 2, 2008, patient R.P-Z., a male patient then 16 years of age, made a visit to CD's dermatology offices in Corona known as Corona Dermatology. Patient R.P-Z. was accompanied by his mother. Patient R.P-Z. was attended to by physician assistant S.A. (PA S.A.). Patient R.P-Z. complained of acne on the face, chest and back. His medical history included sensitive skin, dry skin patches and acne for which he had received regularly treatments from K.L.G., M.D.[6] Since about May 2006, Dr. K.L.G. treated patient R.P-Z.'s condition with Minocycline, Evodin, Klaron 10% lotion and

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[3] Respondent indicated at his physician's interview on or about February 24, 2011, that CD stopped the practice of destroying the handwritten notes in about January 2011.

[4] Providers utilized Encounter Forms to indicate dermatologic services provided for billing purposes. Encounter Forms contain several "blocks" or categories. Each "block" contains several levels or degrees of service, and the provider is required to encircle or place a check mark on one line to indicate the level of service rendered. Examples of the blocks are Office Services, Minor Surgical Procedures and Complex Repair of Wounds. A Current Procedural Terminology Code (CPT Code) is assigned to each line for billing.

[5] The patients were informed that the laser therapy treatment would be covered by their insurance plans, and that the patients would not be billed for the treatments even if the treatments were not covered by their insurance plan. CD billed the patients for the laser therapy treatments when the insurance companies refused to cover the laser therapy treatments.

[6] Dr. K.L.G. practiced medicine with the R.B.&G. Medical Group.

Clindamycin. Patient R.P-Z.'s last office visit with Dr. K.L.G. was on or about December 27, 2007. On this visit, Dr. K.L.G. noted that the patient had "few scattered erythomatous papules on temple, cheeks and forehead, and that his acne was "well controlled with meds." Dr. K.L.G. ordered refills for a three-month supply of Minocycline, Evodin, Klaron 10% lotion and also ordered blood tests.[7] On or about January 3, 2008, Dr. K.L.G. prescribed a three-month supply of Clindamycin Lotion for patient R.P-Z.

D. On patient R.P-Z.'s visit on or about May 2, 2008 visit, PA S.A. obtained a history, performed a physical examination and evaluated the prescriptions and medications patient R.P-Z.'s was using. PA S.A. administered cryotherapy and actinotherapy to the patient's face, chest and back, and prescribed medications, including Minocycline, Salicyclic acid and Clindamycin solution for the patient. PA S.A. prepared a handwritten note (including diagrams) of the care she provided to patient R.P-Z., but the handwritten notes were destroyed after they were transcribed and converted into the Evaluation and Management Report.[8]

E. The Evaluation and Management Report consists of three separate sections: a History and Physical section, an Incision and Drainage Report section and a Treatment Report section.[9] The Evaluation and Management Report includes consent forms purportedly signed by the patient. The medical treatment proposed in the consent forms are written in abbreviated "medical jargon" and not in "lay" terms. Dr. M.P.G.'s printed name appear on the last page of each section of the Evaluation and Management Report, however, the name and credentials of the actual provider (PA S.A.) are not indicated on the Evaluation and Management Report. The Evaluation and Management Report of patient

[7] Patient R.P-Z. stopped treatment with Dr. K.L.G. because his family relocated to another city.

[8] All handwritten notes PA S.A. prepared in the course of treatment of patient R.P-Z. were similarly destroyed. Neither Dr. M.P.G. nor PA S.A. compared the handwritten notes to the transcribed version before the handwritten notes were destroyed.

[9] Earlier versions of the Evaluation and Management Report consisted of just the Evaluation Report and a Treatment/Surgical Report.

R.P-Z.'s visit of May 2, 2008, contains false statements in that it contains medical services, procedures and treatments that were in fact, not provided. According to the May 2, 2008, Evaluation and Management Report, the physical exam included examination of the patient's anus, genitalia, groin and buttocks. The diagnosis included "Xerosis[10]-arms bilaterally, Seborrheic[11] Dermatitis-Forehead Face and Eczema-face."[12] This diagnosis is false because, in truth and in fact, patient R.P-Z. was only treated for acne on the face, chest and back on this visit.

F. The Incision and Drainage Report section contains the following false statement: "Pt failed to respond to prior topical retinoid therapy, (sic) and oral and topical antibiotic therapy in the past," and the statement: "The pt's condition is not improving with over-the-counter therapies; therefore, pt. would like to try more aggressive treatment until condition to be (sic) affected areas are clear." The Incision and Drainage Report also contains six (6) separate diagnoses including, "abscess on his right cheek," "boil on his left cheek," "cyst on his forehead" and "emotional distress." These diagnoses are false in that patient R.P-Z. did not have any boils or abscesses on his face and did not suffer any emotional distress. It also contains the statements that the patient consented for an incision and drainage procedure, and that the cysts, boil and abscess were incised and drained with a Scalpel #11 blade. This is false because patient R.P-Z. did not consent to an incision and drainage procedure with a Scalpel. The Treatment Report includes the statement that patient R.P-Z.'s cyst, abscess and boil and eczema were treated with Intralesional Injection.[13] This is false because patient R.P-Z. did not have any abscesses or boils on his face.

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[10] Xerosis is pathologic dryness of skin.

[11] Seborrhea is over-activity of the sebaceous glands resulting in an excessive amount of sebum.

[12] Eczema is a generic term for inflammatory conditions of the skin.

[13] The Treatment Report section also contains inconsistent statements that the treated cyst was located on the left cheek (instead of the forehead) and the treated abscess was located on the chin (instead of the right cheek).

G. Based on the false statements in the Evaluation and Management Report, CD billed the patient's insurance company for multiple complicated incision and drainage procedures under CPT Code 10061.[14] This is false, because in truth and in fact, patient R.P-Z. did not have cysts or boils or abscesses on his face, and multiple incision and drainage procedures with a Scalpel #11 blade were not performed on the patient on this date. Billing for the treatment provided on this date under CPT Code 10061 also represents inappropriate and fraudulent "upcoding" of procedures performed.

H. Patient R.P-Z. made another visit on or about May 16, 2008 and was attended to by PA S.A. The Evaluation and Management Report of patient R.P-Z.'s May 16, 2008 visit, contains the same false and fraudulent statements found in the Evaluation and Management Report of May 2, 2008. Indeed, the May 16, 2008 Evaluation and Management Report is a virtual "clone" of the May 2, 2008 Evaluation and Management Report. The entries in all three parts of the Evaluation and Management Report of the May 16, 2008 visit are almost identical to and a virtual "clone" of the entries on all three sections of the Evaluation and Management Report on the visit of May 2, 2008. For instance, the same vital signs are listed for patient R.P-Z. on the two visits; the list of systems reviewed on physical examination (including examination of the genitalia) are the same for both visits; and (with some minor exceptions) the listed of incision and drainage procedures performed are the same for both visits; and the listed treatments provided are the same for both visits.

I. Based on the false statements in the Evaluation and Management Report of the May 16, 2008 visit, CD billed the patient's insurance company for multiple complicated incision and drainage procedures under CPT Code No. 10061. This is false, because in truth and in fact, patient R.P-Z did not have cysts or boils or abscesses on his face, and multiple incision and drainage procedures with a Scalpel #11 blade were not performed on

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[14] CPT Code 10061 is utilized to bill for significant surgical procedures involving the opening and draining of complicated "cutaneaous and subcutaneous abscess."

the patient on this date. Billing for the treatment provided on this date under CPT Code 10061 also represents inappropriate and fraudulent "upcoding" of procedures performed.

J. Patient R.P-Z. made another visit on or about May 30, 2008 and was again attended to by PA S.A. The Evaluation and Management Report on this date contains the same false and fraudulent statements found in the Evaluation and Management Reports of May 2, 2008 and May 16, 2008. The May 30, 2008 Evaluation and Management Report is a virtual "clone" of the May 2, 2008 and May 16, 2008 Evaluation and Management Reports. The entries in all three sections of the Evaluation and Management Report for the May 30, 2008 visit are almost identical to the entries on all three sections of the Management and Management Reports on the visits of May 2, 2008 and May 16, 2008. For instance, list of systems reviewed on physical examination (including examination of the genitalia) during this visit is the same as the lists on systems reviewed on the visits of May 2, 2008 and May 16, 2008; and the listed incision and drainage procedures performed and treatments provided on this visit (May 30, 2008) are the same as the procedures performed and treatments provided during the visits of May 2, and May 16, 2008.

K. Based on the false statements in the May 30, 2008 Evaluation and Management Report, CD billed the patient's insurance company for multiple complicated incision and drainage procedures under CPT Code No. 10061. This is false, because in truth and in fact, patient R.P-Z. did not have cysts or boils or abscesses on his face, and multiple incision and drainage procedures with a Scalpel #11 blade were not performed on the patient on this date. Billing for the treatment provided on this date under CPT Code 10061 also represents inappropriate and fraudulent "upcoding" of procedures performed.

Patient T.M.

L. On or about February 26, 2006, patient T.M., a then 32-year-old female, went to respondent's clinic located in Corona. Patient T.M. complained of scaly, dry and flaky skin around the eyelids, mouth, nose, and on the left side of the neck. As history of the condition, patient T.M. stated that the skin condition started in December 2005 as red patches that would "come and go" but which responded to treatment with Hydrocodone

1%. Patient T.M. was attended to by physician assistant S.V. (PA S.V.) who examined the patient and obtained a medical history.[15] PA S.V.'s diagnosis was "contact dermatitis with resulting eczema." She treated patient T.M. with ultraviolet light therapy, injection with Kenalog 10 mg and a prescription for Vanos cream. Patient T.M. made a follow up visit on or about March 2, 2006. PA S.V.'s diagnosis on this visit was "atopic dermatitis with resultant eczema-neck." She treated patient T.M. with ultraviolet light therapy and injection with Kenalog 10 mg and scheduled a follow visit in one week.

M. Patient T.M. made a follow up visit on or about March 13, 2006. PA S.V. prepared handwritten notes on this visit. The handwritten notes were destroyed after they were transcribed and converted into an Evaluation and Management Report and an Operative/Surgical Report.[16] The Evaluation and Management Report includes consent forms purportedly signed by the patient. The medical treatment proposed in the consent forms are written in abbreviated "medical jargon" and not in "lay" terms. Dr. M.P.G.'s initials are contained at the end of each report, however, the name and credentials of the actual provider (PA S.V.) are not indicated on the Evaluation and Management Report. Six separate diagnoses are noted for patient T.M. in the Evaluation and Management Report. These include pain, infection and folliculitis[17] of the face and psychological impairment. These diagnoses are false because, in truth and in fact, patient T.M. did not have folliculitis of her face and did not suffer from any psychological impairment. In spite of these diagnoses, patient T.M. was only treated with ultraviolet therapy and slush therapy treatment on this visit. However, on this visit, patient T.M. also underwent a biopsy of the

[15] Although patient T.M. was attended to on each visit by either PA S.V. or NA D.W., the typewritten notes in the Evaluation and Management Reports on the patient do not include the name and credentials of these providers. Rather, Dr. M.P.G. initials are contained at the end of each report in the Evaluation and Management Report.

[16] At her interview on or about February 24, 2011, PA S.V. stated that on occasion she compared her handwritten notes to Evaluation and Management Reports before destruction of the handwritten notes. She stated, however, that the treatments noted in the Evaluation and Management Reports have been "embellished."

[17] Folliculitis is inflammation of one or more hair follicles as a result of infection with Staphylococcus bacteria.

right cheek to "rule out dysplastic nevus,"[18] which was diagnosed by the pathologist as solar keratosis.[19]

N. Patient T.M. made a follow up visit on or about March 20, 2006. On this visit patient T.M. was diagnosed with rosacea.[20] On this visit, CD staff advised patient T.M. that laser treatments together with micro-dermabrasion represent the best treatment for rosacea; that laser treatment was considered a "medically necessary" treatment for rosacea; that the laser treatment would be covered by her insurance; that she would only have to pay her normal 10% co-payment for each laser treatment; and that CD would "write off" the charges if her insurance did not cover the laser treatments.[21] These representations are false because, in truth and in fact, laser treatment was (and is) not a "medically necessary" treatment for acne rosacea. Based on these representations, patient T.M. signed a consent form for laser treatment for "acne rosacea."

O. The Evaluation Management Report on this visit (March 20, 2006) contains the same false diagnoses as in the Evaluation and Management Report of the visit on March 13, 2006. The Evaluation and Management Report lists the same six (6) separate diagnoses including psychological impairment. It also contains the statement patient T.M. received treatment for a "boil" and an "abscess." This is false because the patient did not have a boil or an abscess on her face. The Evaluation and Management Report of this visit (March 20, 2006) contains the following false statement: "The patient presents with active rosacea involving the chin, forehead, and central facial area. This patient failed to show adequate

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[18] Dysplastic nevus is malformation of the skin due to hyper pigmentation or increased vascularity.

[19] Keratosis is any lesion on the epidermis marked by the presence of circumscribed overgrowth of the horny layer.

[20] Rosacea is chronic vascular and follicular dilation involving the nose and contiguous portions of the cheeks.

[21] CD billed patient T.M. for all laser treatments when Blue Cross, her insurance company, refused to cover the laser treatments because they are not medically necessary for treatment of acne rosacea.

improvement on standard treatments such as metronidazole and sodium sulfacetamide and sulfur washes."

P. Based on the false statements in the March 20, 2006, Evaluation and Management Report, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" procedures under CPT Code No. 17108.[22] This is false and inappropriate billing because a vascular lesion destruction procedure was not performed on patient T.M. on this visit. .

Q. Patient T.M. made regular follow up visits on or about April 3 and 17, 2006. On these visits, patient T.M. received laser and/or micro-dermabrasion treatments to the patient's face. However, for these visits, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" procedures under CPT Code No. 17108. This is false and inappropriate billing in that vascular lesion destruction procedures were not performed on patient T.M. on these visits.

R. Patient T.M. made follow up visits on or about April 27, May 4, 11, 18 and 25, 2006, [23] during which she received laser and/or micro-dermabrasion treatments to the face. The Evaluation Management and Surgery/Operative Reports for these visits contain the same "canned," "cloned" and false diagnoses as on the earlier visits. These reports list six (6) separate diagnoses including psychological impairment. The reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The Evaluation and Management Reports of the April 27, May 4, 11 and 18 visits, contain the statement that the lesions on patient T.M.'s face were treated with 5 mg injection "intralesionally."

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[22] CPT Code 17108 is utilized to bill for procedures involving "destruction of proliferated lesions."

[23] Nurse Practitioner D.W. (NP D.W.) attended to patient T.M. on the visits of April 27, May 4, 11 and 18, 2006, and PA SV attended to the patient on the visit of May 25, 2006.

S. The Evaluation and Management Report for the April 27, 2006, visit contains the diagnosis of "actinitic kerotosis." This is false because, in truth and in fact, patient T.M. did not have actinitic kerotosis." This report also contains the statement that twelve (12) lesions on the patient's face were destroyed with "cryosurgery." This is false in that patient T.M. did not have twelve (12) lesions on her face. The Evaluation and Management Report for the May 25, 2006, visit contains the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed. Based on these false statements, CD billed the patient's insurance company for destruction of fifteen (15) or more premalignant lesions under CPT Code No. 17004.[24]

T. The Evaluation and Management Report for the visits of May 4, 11 and 18, 2006, contain the statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face. This is false because, in truth and in fact, Scalpel No. 11 was not utilized to perform and incision and drainage procedure on patient T.M.'s face. These Evaluation and Management Reports also contain the false statement that Monsel's solution was utilized in the incision and drainage procedures. For the May 4 and 18 visits, CD falsely billed for "destruction of proliferated vascular lesions" procedures under CPT Code No. 17108.

U. Patient T.M. made follow up visits on or about June 1, 8, 15, 22, and 29, 2006, during which she received laser and/or micro-dermabrasion treatments to the face. The Evaluation and Management Reports for these visits contain the same false diagnoses as the Evaluation and Management Reports on earlier visits. These reports list same six (6) separate diagnoses including folliculitis, infection and psychological impairment. These reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The Evaluation and Management Reports for the June 1, 8, and 15 visits, contain the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face.

[24] CPT Code 17004 was utilized to bill for the surgical destruction of fifteen (15) or more lesions.

Based on the false statements in these Evaluation and Management Reports, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" procedures under CPT Code No. 17108. In addition, the Evaluation and Management Reports contain the statement that the lesions on patient T.M. face were treated with Kenalog 5 mg injection "intralesionally."

V. Patient T.M. made follow up visits on or about July 6, 13, 20 and 27, 2006, during which she received laser and/or micro-dermabrasion treatments to the face. The Evaluation and Management Reports for these visits contain the same "canned" "clone" and false diagnoses as in the Evaluation and Management Reports on earlier visits. These reports list six (6) separate diagnoses including folliculitis, infection and psychological impairment. The reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The Evaluation and Management Report for the July 6, 2006, visit contains the false diagnosis of "actinitic kerotosis," the false statement that eighteen (18) lesions were destroyed on patient T.M.'s face, and the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face.

W. The Evaluation and Management Reports for the visits of July 13, 2006 and July 27, 2006, contain the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed on patient T.M.'s face. Based on the false statements in these Evaluation and Management Reports, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" procedures under CPT Code No. 17108 and for "destruction of 15 or more lesions" procedures under CPT Code No. 17004. In addition the Evaluation and Management Reports contain the statement that patient T.M. was administered Kenalog 5 mg injection "intralesionally."

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X. Patient T.M. made follow up visits on or about August 3, 10, 17, 24 and 31, 2006, during which she received laser and/or micro-dermabrasion treatments to the face. [25] The Evaluation Management Reports for these visits contain the same "canned" false diagnoses as in the evaluation and surgery/operative reports of earlier visits. These reports list six (6) separate diagnoses including folliculitis, infection and psychological impairment. These reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The Evaluation and Management Report for the August 17, 2006, visit contains the false diagnosis of "actinitic kerotosis," the false statement that eighteen (18) lesions were destroyed on patient T.M.'s face, and the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face. The Evaluation and Management Reports for the visits of August 3 and 24, 2006, contain the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed on patient T.M.'s face. The Surgical/Operative Report for the visit of August 10, 2006, contains the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face.

Y. Based on the false statements in these evaluation and management and surgical/operative reports, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" and "destruction of 15 or more lesions" procedures under CPT Code No. 17108 and CPT Code No. 17004, respectively. In addition the Evaluation and Management reports contain the statement that patient T.M. was administered Kenalog 5 mg injection "intralesionally."

Z. Patient T.M. made follow up visits on or about September 7, 14 and 28, 2006, during which she received laser and/or micro-dermabrasion treatments to the face. The Evaluation and Management Reports (reports) for these visits contain the same "canned"

[25] All laser and/or dermabrasion treatment were provided by PA S.V. or NA D.W.

"clone" and false diagnoses as the Evaluation and Management Reports on earlier visits. These reports list the same six (6) separate diagnoses including folliculitis, infection and psychological impairment. The reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The reports for the September 7 and 14, 2006 visits contain the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face. The report for the visit September 28, 2006 contains the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed on patient T.M.'s face.

AA. Based on the false statements in these evaluation and management and surgical/ operative reports, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" and "destruction of 15 or more lesions" procedures under CPT Code No. 17108 and CPT Code No. 17004, respectively. In addition the Evaluation and Management Reports contain the statement that the lesions on patient T.M. were treated with Kenalog 5 mg. injection "intralesionally."

BB. Patient T.M. made follow up visits on or about October 5, 19, and 26, 2006, during which she was administered laser and/or micro-dermabrasion treatments to the face. The Evaluation and Management Reports (reports) for these visits contain the same "canned," "cloned" and false diagnoses as in the evaluation and surgery/operative reports of earlier visits. These reports list same six (6) separate diagnoses including folliculitis, infection and psychological impairment. The reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The reports for the October 19, 2006 and October 26, 2006 visits contain the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed on patient T.M.'s face. Based on the false statements in these reports CD billed the patient's insurance company for "destruction of 15 or more lesions" procedures under CPT Code No. 17004. In addition, the reports contain the statement that the lesions on patient T.M. were treated with Kenalog 5 mg. injection "intralesionally."

CC. Patient T.M. made follow up visits on or about November 9, 2006 and December 11, 2006, during which she received laser and/or micro-dermabrasion treatments to the face. The Evaluation and Management Reports (reports) for these visits contain the same "canned," "cloned" and false diagnoses as in the Evaluation and Management Reports of earlier visits. These reports list the same six (6) separate diagnoses including folliculitis, infection and psychological impairment (psychosis). The reports also contain the false statement that patient T.M. received treatment for a "boil" and an "abscess" on her face. The report for the November 9, 2006 visit, contains the false diagnosis of "actinitic kerotosis" and the false statement that fifteen (15) lesions were destroyed on patient T.M.'s face. The report for the December 11, 2006 visit, contains the false statement that a Scalpel No. 11 blade was utilized to perform incision and drainage procedures to drain abscess, cysts and pustules on patient T.M.'s face. Based on the false statements in these evaluation and management and surgical/operative reports, CD billed the patient's insurance company for "destruction of proliferated vascular lesions" and for "destruction of 15 or more lesions" procedures under CPT Code No. 17108 and CPT Code No. 17004, respectively.

13. Respondent committed repeated negligent acts in his care and treatment of patients R.P-Z. and T.M. which included, but is not limited to, following:

Patient R.P-Z.

A. In his care and treatment of patient R.P-Z., respondent repeatedly created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew or should have known, would be utilized by California Dermatology (CD) to bill patient R.P-Z.'s insurance company for dermatologic services that were not actually provided to the patient.

B. Respondent engaged in fraudulent and inappropriate "upcoding" of procedures in that he billed and /or caused to be billed, the dermatologic services provided to patient R.P-Z., on May 2, 2008 as "multiple complicated repair" under CPT Code 10061.

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C. Respondent engaged in fraudulent and inappropriate "upcoding" in that he billed and/or caused to be billed, the dermatologic services provided to patient R.P-Z., on May 16, 2008 as "multiple complicated repair" under CPT Code 10061.

D. Respondent engaged in fraudulent and inappropriate "upcoding" of procedures in that, he billed and/or caused to be billed, the dermatologic services provided to patient R.P-Z. on May 30, 2008 as "multiple complicated repair" under CPT Code 10061.

E. Respondent failed to obtain patient R.P-Z.'s informed consent for the medical treatments proposed during the patient's three visits in that the written informed consent documents were written in "medical jargon" and not in "lay" terms.

F. Respondent failed to generate appropriate charts notes of the medical services provided to patient R.P-Z., in that, the chart notes do not include the name and credentials of the provider who actually provided the medical services on each of the patient's visit.

Patient T.M.

G. In his treatment and care of patient T.M., respondent repeatedly created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew would be utilized by, and which were in fact utilized by California Dermatology (CD) to bill patient T.M.'s insurance company for dermatologic services that were not actually provided to the patient.

H. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M., on March 20 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, a destruction of vascular lesion procedure was not performed on patient T.M. on this date.

I. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M., on April 3 and 17, 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, destruction of vascular lesion procedures were not performed on patient T.M. on these dates.

J. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on April 27, 2006 and May 25, 2006 as destruction of twelve (12) and fifteen (15) premalignant lesions, respectively, under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 12 or 15 lesions on her face during these visits or at any time during the period of treatment.

K. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on May 18, June 1, 18, 15 and July 6, 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, destruction of vascular lesion procedures were not performed on patient T.M. on these dates.

L. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on July 6 and 18, 2006, as destruction of twelve (12) and fifteen (15) premalignant lesions, respectively, under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 12 or 15 lesions on her face during these visits or at any time during the period of treatment.

M. Respondent billed and/or caused to be billed, the dermatology services provided to patient T.M. on August 3, 17, 24, 2006, as destruction of fifteen (15) premalignant lesions, for each visit, under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 15 lesions on her face during these visits or at any time during the period of treatment.

N. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on August 10 and 17, 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, destruction of vascular lesion procedures were not performed on patient T.M. on these dates.

O. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on September 7 and 14, 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, destruction of vascular lesion procedures were not performed on patient T.M. on these dates.

P. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. September 28, 2006, as destruction of fifteen (15) premalignant lesions under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 15 lesions on her face on this visit or at any time during the period of treatment.

Q. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. October 5, 19 and 26, 2006, as destruction of fifteen (15) premalignant lesions, for each visit under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 15 lesions on her face at any time during the period of treatment.

R. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. November 9, 2006, as destruction of sixteen (16) premalignant lesions under CPT Code 17004. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, patient T.M. did not have 16 lesions on her face during this visit or at any time during the period of treatment.

S. Respondent billed and/or caused to be billed, the dermatologic services provided to patient T.M. on December 9, 2006, as "destruction of proliferated vascular lesions" under CPT Code 17108. This represents false and fraudulent insurance billing and an inappropriate "upcoding" of procedures, in that, a destruction vascular lesion procedure was not performed on patient T.M. on this date.

T. Respondent failed to obtain patient T.M.'s informed consent for the medical treatments proposed during the patient's visits in that the written informed consent documents were written in "medical jargon" and not in "lay" terms.

U. Respondent failed to generate appropriate charts notes of the medical services provided to patient T.M., in that, the chart notes do not include the name and credential of the provider of medical services on each of the patient's visit.

SECOND CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty and Corruption)

14. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that Respondent committed acts involving dishonesty or corruption substantially related to the qualifications, functions, or duties of a physician and surgeon, as more particularly alleged hereinafter:

A. Respondent repeatedly created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew would be utilized by CD to bill insurance companies for dermatologic services that were not actually rendered; repeatedly billed and/or caused to be billed insurance companies and patients for dermatologic services not rendered; and repeatedly engaged in fraudulent and inappropriate "upcoding" of procedures, as more particularly alleged in paragraphs 12(A) through 12(CC), and 13, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

B. Respondent made false, fraudulent, or misleading statements, and presented or caused to be presented false, fraudulent, or misleading statements, to insurance companies in support of a claim or claims for disability insurance benefits, as more particularly alleged in paragraph 18, below, which is incorporated herein by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Knowingly Making or Creating a False Medical Record)

15. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2261 of the Code, in that respondent created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew would be utilized by CD to bill insurance companies for dermatologic services that were not actually rendered; repeatedly billed and/or caused to be billed insurance companies for dermatologic services not rendered; and repeatedly engaged in fraudulent and inappropriate "upcoding" of procedures, as

more particularly alleged in paragraphs 12(A) through 12(CC), and 13, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Creation of False Medical Records with Fraudulent Intent)

16. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2262, of the Code, in that Respondent created false medical records with fraudulent intent in that, respondent created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew would be utilized by CD to bill insurance companies for dermatologic services that were not actually rendered; repeatedly billed and/or caused to be billed insurance companies for dermatologic services not rendered; and repeatedly engaged in fraudulent and inappropriate "upcoding" of procedures, as more particularly alleged in paragraphs 12(A) through 12(CC), and 13, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

17. Respondent is further subject 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 of the dermatologic services provided to patients R.P-Z. as more particularly alleged in paragraphs 12(A) through 12(CC), and 13, above, which are incorporated by reference as though fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Insurance Fraud)

18. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 810, subdivision (a)(1), in that he knowingly presented or caused to be presented a false or fraudulent claim or claims for payment of a loss under a contract of insurance, and/or by section 810, subdivision (a)(2), in that he knowingly prepared, made, or subscribed a writing or writings, with the intent to present or use the same, or allowed the writing or writings to be presented or used in support of a false or fraudulent claim or claims, and/or by

section 810, subdivision (b), in that he engaged in conduct prohibited by Penal Code section 550, subdivisions (a)(1), (a)(5), (a)(6), (b)(1), (b)(2), and (b)(3), as more particularly alleged hereinafter:

A. Respondent created, or assisted the creation of, or aided and abetted the creation of false medical records which respondent knew would be utilized by CD to bill insurance companies for dermatologic services that were not actually rendered; repeatedly billed and/or caused to be billed insurance companies for dermatologic services not rendered; and repeatedly engaged in fraudulent and inappropriate "upcoding" of procedures, as more particularly alleged in paragraphs 12(A) through 12(CC), and 13, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

B. In or about March 1994, respondent applied for a Disability Income Protection Plan with Unum life Insurance Company (Unum). On or about March 5, 1994, Unum granted respondent individual Disability Insurance Policy #LA280696. Also, in or about May 1994, respondent's Professional Corporation (CD) applied for Long Term Disability coverage as well as Life and Accidental Death & Dismemberment Insurance with Paul Revere Life Insurance Company (Paul Revere). On or about May 1, 1994, Paul Revere granted respondent group Disability Insurance Policy # G-57346. On or about March 27, 1997, Paul Revere became a wholly owned subsidiary of Provident Companies, Inc. On or about July 1, 1999, Unum and Provident Companies Inc. merged to the UnumProvident Corporation. On or about March 2, 2007, UnumProvident Corporation became the Unum Group.

C. On or about October 9, 1997, respondent submitted disability claims to Unum and Provident Companies (Unum Group) claiming total disability due to an illness that restricted his ability to perform the material and substantial duties of his profession as a physician. Unum Group commenced payment on the disability claims. Thereafter, respondent submitted annual disability status update claim forms (claim forms) to Unum Group. Among others, respondent submitted claim forms for payment on or about December 16, 2008, December 23, 2009 and January 28, 2010. On each claim form, respondent indicated he was unable to perform any of the duties of his profession. He also indicated on each claim form that he had not engaged in any

other occupation. These statements are false in that respondent has been practicing medicine as the Medical Director for CD since about October 2008.

D. Respondent engaged in insurance fraud in that he repeatedly submitted disability claim forms for payment to the Unum Group, in which he represented that he was totally disabled and unable to perform his duties as a physician and that he was not engaged in any other occupation when, in truth and fact, respondent has been practicing medicine as the medical director for CD since about October 2008.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

19. Respondent is further subject to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particular alleged in paragraphs 12-18, above, which are hereby incorporated by reference and reallged as if though fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

20. Respondent is further subject to disciplinary action under section 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that he violated, or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate, a provision of the Medical Practice Act, as more particularly alleged in paragraphs 12-19, above, which are hereby incorporated by reference and realleged as if full set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 44761, issued to respondent Glenn N. Ledesma, M.D.;

2. Revoking, suspending or denying approval of respondent Glenn N. Ledesma, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering respondent Glenn N. Ledesma, M.D. to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

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

DATED: November 13, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2011801651