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

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	
STEVEN KEITH MANGAR, M.D.	Case No. 800-2014-007649
Physician's and Surgeon's Certificate No. A 65476	
Respondent	

DECISION

The attached Stipulated Surrender of Certificate 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 September 20, 2016

IT IS SO ORDERED September 13, 2016.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

KAMALA D. HARRIS
Attorney General of California
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Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **STEVEN MANGAR, M.D.** P.O. Box 1530 Salinas, CA 93902 Physician's and Surgeon's Certificate No. A65476 Respondent.	Case No. 800-2014-007649 (D1) OAH No. 2015080625 **STIPULATED SURRENDER OF CERTIFICATE**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above entitled proceedings, that the following matters are true:

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California, Department of Consumer Affairs, who brought this action solely in her official capacity. She is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Lawrence Mercer, Deputy Attorney General.

2. Steven Mangar, M.D. ("Respondent") is represented in this matter by his attorneys William J. Murray and Belzer & Murray, whose offices are located at 3650 Mount Diablo Blvd., Suite 130, Lafayette, CA 94549.

3. On June 5, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A 65476 to Steven Mangar, 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. Said certificate is renewed and current with an expiration date of May 31, 2018. Said certificate is currently on probation to the Board and is further subject to a partial restriction order issued by the Monterey Superior Court on July 19, 2016.

JURISDICTION

4. On November 6, 2014, Accusation and Petition to Revoke Probation, MBC No. 800-2014-007649 (D1) (hereinafter "Accusation") was filed before the Board. Said Accusation was amended on January 7, 2016 and is currently pending against Respondent. The Accusation, together with all other statutorily required documents, was duly served on Respondent at his address of record. A copy of Accusation No. 800-2014-007649 (D1) is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read and understands the charges and allegations in Accusation No. 800-2014-007649 (D1). Respondent has also carefully read and understands the effects of this Stipulation for Surrender of Certificate.

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

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

ACKNOWLEDGMENTS

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2014-007649 (D1), if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate. Respondent hereby gives up his right to contest these charges and he agrees that his Physician's and Surgeon's Certificate is subject to discipline pursuant to Business and Professions Code section 2234.

9. Respondent is willing to and hereby agrees to surrender his Physician's and Surgeon's Certificate for the Board's formal acceptance, thereby giving up his right to practice medicine in the State of California.

CONTINGENCY

10. This Stipulation shall be subject to the approval of the Board. Respondent understands and agrees that Board staff and counsel for Complainant may communicate directly with the Board regarding this Stipulation, without notice to or participation by Respondent or his attorney. If the Board fails to adopt this Stipulation as its Order in this matter, the Stipulation shall be of no force or effect; it shall be inadmissible in any legal action between the parties; and the Board shall not be disqualified from further action in this matter by virtue of its consideration of this Stipulation.

11. The parties understand and agree that facsimile and electronic format copies of this Stipulation for Surrender of Certificate, including facsimile and electronic format signatures thereto, shall have the same force and effect as the originals.

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STIPULATION AND ORDER

IT IS THEREFORE STIPULATED AND ORDERED as follows:

1. **SURRENDER** Respondent hereby agrees that the Board may issue its order accepting the surrender of his license without further process and that he will surrender his wall and wallet Physician's and Surgeon's Certificates and all other indicia of his right to practice medicine in the State of California to the Board or its representative on or before the 45th day following the effective date of this decision. In the interim period between the effective date of the decision and the 45th day thereafter, Respondent understands and agrees that he shall not prescribe, furnish or administer any prescription medication, as defined by Business & Professions Code §4022, to any person. Respondent understands and agrees that as of the 45th day after the effective date of the decision accepting his license surrender, he will no longer be permitted to practice as a physician in California.

2. **REINSTATEMENT** Respondent fully understands and agrees that if he ever files an application for re-licensure or reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time any petition is filed, and he understands and agrees that all of the allegations and causes for discipline contained in Accusation No. 800-2014-007649 (D1) will be deemed by the Board to be true, correct and admitted for purposes of the Board's determination whether to grant or deny the petition. Respondent agrees that he will not petition for reinstatement for at least two (2) years following the effective date of this decision. Respondent hereby waives any time-based defense he might otherwise have to the charges contained in Accusation No. 800-2014-007649 (D1) including, but not limited to, the equitable defense of laches.

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ACCEPTANCE

I, STEVEN MANGAR, M.D., have carefully read the above Stipulation for Surrender of Certificate, and enter into it freely and voluntarily and with full knowledge of its force and effect. I do hereby agree to surrender my Physician's and Surgeon's Certificate no. A 65476 to the Medical Board of California for its formal acceptance. By signing this Stipulation to surrender my license, I recognize that as of the 45th day after the effective date of this Decision, I will lose all rights and privileges as a physician and surgeon in the State of California and, if I have not already done so, I also will cause to be delivered to the Board both my license and wallet certificates on that date. I further understand and agree that between the effective date of this decision and the 45th day thereafter, I shall not prescribe, furnish or administer any prescription medication.

Dated: 9.1.2016

STEVEN MANGAR, M.D.
Respondent

I have read and fully discussed with Respondent STEVEN MANGAR, M.D., the terms and conditions and other matters contained in the Stipulation for Surrender of Certificate. I approve its form and content.

Dated: 9.1.2016

BEZNER & MURRAY

WILLIAM J. MURRAY
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulation for Surrender of Certificate is respectfully submitted for consideration by the Medical Board of California, Department of Consumer Affairs.

Dated: ~~August 31,~~ 2016
9-2-2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

LAWRENCE MERCER
Deputy Attorney General
Attorneys for Complainant

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

FIRST AMENDED In the Matter of the Accusation/Petition to Revoke Probation Against: **STEVEN KEITH MANGAR, M.D.** P.O. Box 1530 Salinas, CA 93902 Physician's and Surgeon's Certificate No. A65476 Respondent.	Case No. 800-2014-007649(D1) OAH No. 2015080625 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

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

2. On June 5, 1998, the Medical Board of California issued Physician's and Surgeon's Certificate Number A65476 to Steven K. Mangar, M.D. (Respondent). At all relevant times, said certificate was current and valid and, unless renewed, it will expire on May 31, 2016.

3. In a disciplinary action entitled "In the Matter of the Accusation Against Steven K. Mangar, M.D.," Case No. 03-2010-209330, the Board issued a decision, effective October 5, 2012, in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the

revocation was stayed and Respondent's Physician's and Surgeon's Certificate was placed on probation for a period of three (3) years with certain terms and conditions, including a prescribing practices course and a medical record keeping course. A copy of that decision is attached as Exhibit A and is incorporated by reference. On November 6, 2014, the Board filed the Accusation and Petition to Revoke Probation in this disciplinary action. Pursuant to the terms of the 2012 stipulated Decision, the Board retained jurisdiction by reason of that action and Respondent's Physician's and Surgeon's Certificate will remain on probationary status until a final decision on this First Amended Accusation and Petition to Revoke Probation.

JURISDICTION

4. This First Amended Accusation and Petition to Revoke Probation is brought before the Medical Board of California (Board) under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2004 of the Code provides, pertinent part, that the Medical Board shall have responsibility for:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board. . ."

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

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7. Section 2228 of the Code provides that a probation imposed by the Board may include, but is not limited to the following:

"(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge."

"(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice."

"(c) Restricting or limiting the extend, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate."

8. Section 2234 of the Code provides:

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

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

"(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."

9. Section 2241.5 provides that a physician and surgeon may prescribe for a person under his care for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing intractable pain. However, nothing in that section affects the power of the board to take any action described in Section 2227 of the Code, including, but not limited to, Sections 2234, subsections (b), (c) and (d), and/or Section 2242.

10. Section 2241.6 of the Code authorized the board, in conjunction with professional peer organizations in the field of pain management, to develop standards for review of cases concerning the management of a patient's pain. In 2007, the board revised its 1994 Guidelines for Prescribing Controlled Substances for Pain, which guidelines were disseminated to all California-licensed physicians and surgeons. Those guidelines recommend that physicians follow the standard of care in managing pain patients, including a history, appropriate examination, treatment plan with objectives, informed consent, periodic review of the treatment, consultation where warranted and accurate and complete medical records.

11. Section 2242(a) of the Code provides:

"Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

12. Section 2261 of the Code provides:

"Knowingly making or signing any certificate or other documentation 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."

13. Section 2266 of the Code provides:

"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."

FIRST CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient R.M.[1])

14. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or (d) and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in his patient care and treatment, and Respondent failed to maintain adequate and accurate medical records, including but not limited to the following:

A. At all relevant times, Respondent was a physician and surgeon with a specialization in pain management.

B. On or about April 21, 2008, Patient R.M., who was then a 40 year old male, came under Respondent's care and treatment for chronic pain management. R.M. was referred to Respondent by a Colorado physician and had a history significant for chronic low back pain resulting from a ruptured disc and degenerative disc disease. The patient reported a past laminectomy and discectomy in 1993. He also stated that his medications included Oxycontin, 80 mg[2], TID, Oxycontin, 40 mg, TID, Oxycodone, 15 mg, 8/day, Ritalin, 20 mg[3], BID, Testosterone IM injections, Valium, 10 mg[4], QD. In brief annotations to the patient's intake questionnaire, Respondent entered diagnoses of Failed Back Surgery Syndrome, Low Back Pain, Lumbar Radiculopathy and Chronic Pain Syndrome. Other than vital signs consisting of a blood pressure reading and pulse, no objective findings were obtained or stated. No additional history beyond

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[1] Patient's names are abbreviated to protect privacy.

[2] Oxycodone is a narcotic analgesic with multiple actions similar to those of morphine. Oxycodone is a schedule II controlled substance. It is available in combination with other drugs or alone. When Oxycodone is available by itself, it is Oxycontin. Oxycodone can produce drug dependence and, therefore, has the potential for being abused. Oxycontin is indicated for the management of moderate to severe pain, and is a commonly abused or diverted drug.

[3] Ritalin (methylphenidate) is a central nervous stimulant. It is a schedule II controlled substance. Ritalin is potentially addictive and presents a likelihood for abuse.

[4] Valium (diazepam) is a psychotropic drug used for the treatment of anxiety disorders. It is a schedule IV controlled substance which can produce psychological and physical dependence.

that provided by the patient was recorded, a physical examination was either not performed or not documented and the treatment plan was limited to a notation that the patient's reported medications would be refilled.

C. Between 2007 and 2011, Respondent's record of patient encounters consisted of the patient's completed questionnaire, with vital signs noted by a medical assistant and only brief remarks handwritten by Respondent. Between 2011 and 2013, Respondent utilized an electronic medical record system. Respondent's handwritten and electronic medical records were frequently incomplete, stating only "see questionnaire" under review of systems and "unchanged" for history of present illness. Some records clearly state that the patient was seen only by a medical assistant, while others suggest that no face-to-face encounter took place based upon the lack of a documented examination and/or vital signs.

D. During the course of his treatment with Respondent, Patient R.M. experienced little improvement in his functioning and quality of life. Patient R.M. also suffered significant adverse side effects related to his opioid regimen, including hypogonadism and opioid induced somnolence. Nevertheless, Respondent maintained him on high dose opioid therapy, initially consisting of the Oxycontin/Oxycodone therapy described in Paragraph B above, and later replacing Oxycontin with high dose Morphine Sulfate but also continuing to utilize Oxycodone. Despite the patient's lack of improvement on high dose opioids, Respondent failed to consider alternatives to medication or to seek a consultation from an endocrinologist or addiction medicine specialist.

E. The patient frequently complained of problems staying awake and requested an increased dosage of Ritalin. Respondent initially noted that the patient was already receiving the maximum dosage of 80 mg/day, but later did increase the dosage to Ritalin, 20 mg, TID, or 120 mg/day, and also added another stimulant, Adderall, to the patient's medications. When Respondent was interviewed by the Board's investigator regarding Patient R.M., he initially stated that the patient was receiving stimulants for a diagnosis of narcolepsy, but when the absence of that diagnosis in his records was pointed out to him, he stated that the stimulants were prescribed for opioid induced somnolence.

15. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent failed to obtain a complete history and to perform an appropriate examination before prescribing high dose opioid therapy;

B. Respondent failed to develop a treatment plan with objectives, to periodically review the effectiveness of the prescribed treatment or to consider alternatives when the patient failed to improve;

C. Respondent failed to obtain appropriate consultations;

D. Respondent failed to maintain adequate and accurate records.

SECOND CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient K.B.)

16. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or (d) and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in his patient care and treatment, and Respondent failed to maintain adequate and accurate medical records, including but not limited to the following:

A. In or before 2010, Patient K.B., a 43 year old female, came under Respondent's care and treatment for probable rheumatoid arthritis and joint pain in the ankles, knees, hips and wrists as well as the cervical spine. The patient's initial evaluation is not in Respondent's chart and, due to the chart's incompleteness, the extent of the initial history and examination is uncertain. Respondent's subsequent records reveal that the patient had a history of psychological issues, including Major Depression and anxiety, and that she was non-compliant with her medications. The lack of documented medical response to evidence that the patient was not benefitting from the treatment, was abusing some medications and likely diverting others, gives rise to concern that Respondent was not in fact having face-to-face encounters with the patient.

B. Patient K.B. was initially treated with Hydrocodone, 10/325 mg[5], #300, in a regimen which, as of January 2014, was expanded to include Hydrocodone, 10/325, up to 6/day, Ambien, 10 mg, 1-2 HS, Valium, 10 mg, BID, Oxycodone, 30 mg, QD, Dilaudid, 8 mg[6], and Dilaudid, 4 mg. A clear treatment plan is absent from Respondent's records.

C. Respondent's periodic review of the effectiveness of the patient's medication regimen is difficult to follow in that he attempted to taper the patient's medications at some points and at others increased her medication without a documented rationale. The earliest record in Respondent's chart states that she "returns early due to last month only received Norco #180." No patient encounter is documented, but the patient received a new prescription for Norco #300. The patient resisted attempts to taper her medication and, in a letter dated February 4, 2011, complained about her prescribed medications being cut in half: "I am financially strapped but can afford a fee for a script."

D. The medication regimen prescribed by Respondent never achieved its presumed goal of pain control and, in fact, appears to have exacerbated the patient's underlying depression and suicidal ideation. While she was on the above-described regimen of benzodiazepines and opioids, Patient K.B. underwent four psychiatric hospitalizations for opiate dependence and depression in 2011-2012. In January, 2012, the patient was brought to the hospital on a 5150 after she was found in a parking lot cutting her wrist. In March 2012, K.B. returned to the hospital, stating that she had suicidal thoughts and did not feel safe. The record of that admission states that the patient was having problems managing her pain medications. An inquiry to the patient's pharmacy revealed that the patient was "always asking for her medications early, for any various reasons such as going out of town or going to a funeral in Hawaii." Despite this and other evidence that K.B.'s chronic use of opiates and benzodiazepines was not benefitting her, but was exacerbating her underlying psychiatric condition and increasing the potential for harm due to increasing suicidal ideation, Respondent neither withdrew the patient's medications nor did he

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[5] Hydrocodone bipartrate (including the trade name products Vicodin and Norco) is a schedule III controlled substance.

[6] Dilaudid (hydromorphone hydrochloride) is a potent opioid agonist and a schedule II controlled substance.

refer the patient for alternative pain management, such as interventional treatment. Moreover, in Respondent's record of several years of treatment there is no record indicating that he was communicating with the patient's psychiatrist regarding her status.

E. In addition to many indications that K.B. was abusing some of her medications, available laboratory test results beginning in September 2012 show that she also repeatedly tested negative on urine toxicology screens for her prescribed medications (including Oxycodone) and positive for controlled substances (including Suboxone, Klonopin, Cocaine and Methadone) which Respondent was not prescribing. These repeated inconsistent results required Respondent's immediate action to stop the apparent drug diversion and substance abuse. Nevertheless, and despite repeated threats of termination, he continued to prescribe for K.B. until finally discharging her from his practice in January 2014.

17. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent failed to develop a treatment plan with objectives, to periodically review the effectiveness of the prescribed treatment or to consider alternatives when the patient failed to improve;

B. Respondent failed to respond to evidence that the patient's condition was not benefitting and was actually worsening on the prescribed treatment by weaning and withdrawing her from the treatment;

C. Respondent failed to obtain appropriate addiction medicine consultations despite signs that the patient was abusing some medications while apparently diverting others;

D. Respondent failed to maintain adequate and accurate records.

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THIRD CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient B.M.)

18. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or 2261 and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts in his patient care and treatment, and Respondent failed to maintain bona fide, adequate and accurate medical records, including but not limited to the following:

A. On June 26, 2013, the Medical Board received a complaint from Patient B.M., who reported that Respondent had discharged him after approximately 10 years of care. B.M. stated that during that time he picked up his prescriptions from Respondent's office every thirty days, but actually had face-to-face meetings with, and examination by, Respondent on approximately three visits per year. The patient also complained that Respondent's medical records were inaccurate and that many were missing.

B. On May 6, 2002, Patient B.M. was referred to Respondent by his neurosurgeon for a pain management consultation. B.M. reported that he had been disabled by chronic back pain since two industrial accidents that occurred in 1999 and had undergone multiple surgeries and procedures without relief. Respondent diagnosed B.M. with Failed Back Surgery Syndrome and recommended a regimen of pain medications, injections and physical therapy. B.M. was placed on Oxycontin, 10 mg, TID, Trazodone HS, Valium and Baclofen. Respondent stated that if the patient's pain was refractory to medications and injections, consideration of a spinal cord stimulator would be made in the future.

C. Respondent continued to prescribe for Patient B.M. through 2012, at which time B.M. was receiving prescriptions for Fentanyl, 50 mcg[7], 1 Q 48 hrs, and Hydrocodone, 7.5/500, #180. Although Respondent's initial notes are detailed, usually in the form of reports to Patient B.M.'s workers' compensation carrier and his referring neurosurgeon, the chart produced by him in

[7] Fentanyl is a schedule II opioid agonist that is delivered via transdermal patch.

response to B.M.'s medical release is disorganized, missing records for large periods of B.M.'s treatment, and consists mainly of B.M.'s questionnaires, with only sparse notes by Respondent. Electronic medical records replace the patient's questionnaire in or about 2010, but they are of doubtful accuracy -- often lacking vital signs or other indicia that the patient was actually seen and examined by Respondent. On August 24, 2012, Respondent discharged Patient B.M. from his practice after the patient had an angry confrontation with his staff. In that record, Respondent states: "He was informed that the doctor was not in, and his prescription was not ready and that staff was contacting me because [Patient B.M.] has not been seen since March 27, 2012." However, Respondent's chart contains monthly notes for each of the intervening four months, each of which states that the patient was seen for 20 minutes. Moreover, these notes correspond with the dates on which Patient B.M. filled prescriptions for pain medications, indicating that the patient was receiving prescriptions for controlled substances from the office staff, without a medical examination.

19. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2234(d) and/or 2261 and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts and/or was incompetent in the practice of medicine, including but not limited to the following:

A. Respondent prescribed controlled substances to a patient without an appropriate medical examination;

B. Respondent created medical records which stated that the patient was seen by him, when in fact there was no face-to-face encounter;

C. Respondent failed to maintain adequate and accurate medical records.

FOURTH CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient A.H.)

20. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts in his

patient care and treatment, and Respondent failed to maintain adequate and accurate medical records, including but not limited to the following:

A. Patient A.H., a 33 year old male, came under Respondent's care on January 17, 2012, for management of chronic pain. The patient stated that his chief complaint was low back pain, which was the result of a work injury. Respondent's records for A.H. include a note dated October 10, 2011, which was prepared by another physician and which references an L5-S1 disc protrusion and annular tear. This information is included in Respondent's handwritten history of the present illness. Respondent also noted that the patient was receiving social security disability and relates this disability to the patient's diagnosis of Bipolar Mood Disorder. Although Respondent's electronic note indicates that the patient denied use of alcohol or recreational drugs, the questionnaire filled out by the patient reported a past DUI arrest, next to which comment Respondent added "2" -- apparently referring to the patient's admission on the SOAPP questionnaire that he had "sometimes" had legal problems or been arrested. The patient also reported on that questionnaire that he was using marijuana, which use he justified in an additional explanation. Patient A.H. reported current medications including Ambien, 12.5 mg, HS, Gabapentin, 800 mg, TID, and Oxycodone. 30 mg, 5/day.

B. Respondent's limited physical examination included a finding of decreased lumbar lordosis, but was generally within normal limits. Respondent diagnosed A.H. with low back pain, chronic pain syndrome and degenerative disc disease, as well as Bipolar Mood Disorder to be followed by another physician. He assigned the patient a SOAPP[8] score of 3.

C. Respondent prescribed Methadone[9], 10 mg, BID, and Norco[10], 10/325, not to exceed 8/day.

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[8] The Screener and Opioid Assessment for Patients in Pain (SOAPP) is a clinical tool used to predict which patients, being considered for long-term opioid therapy, may exhibit aberrant medications behaviors in the future. A score of ≥ 4 is considered positive.

[9] Methadone hydrochloride is a Schedule II opioid indicated for the treatment of pain severe enough to require around-the-clock longterm opioid treatment and for which alternative treatments have failed. Methadone exposes users to the risks of opioid addiction, misuse and abuse, which can lead to overdose and death.

[10] See fn. 4 above.

D. On January 22, 2012, Patient A.H. was taken by his parents to the local hospital emergency room for altered mental status, respirations < 10 and cyanotic appearance. The patient's parents reported that he had a history of substance abuse and depression. The patient admitted to having taken Norco the previous day, but denied any opiate medications on that day; however, when given Narcan he regained respirations and consciousness. He was discharged the same day with instructions to consult with his treating psychiatrist and Respondent the next day and not to take any more Methadone until he had talked with his physicians.

E. On January 23, 2012, A.H. was found deceased in his bed. A postmortem examination was performed and a forensic pathologist determined that A.H. had died as a result of Methadone and Hydrocodone intoxication. A.H.'s parents stated that he had an addiction to alcohol and methamphetamine, for which he had received treatment in the past, and that he had also used heroin and marijuana.

21. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts in the practice of medicine, including but not limited to the following:

A. Respondent inappropriately and/or excessively prescribed Methadone to A.H., despite his history of Bipolar Disorder and depression;

B. Respondent failed to perform, or performed an inadequate, risk evaluation and mitigation strategy in a patient who presented with indications of past substance abuse;

C. Respondent failed to maintain adequate and accurate records, including a documented and complete history and appropriate physical examination.

FIFTH CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient D.R.)

22. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts in his

patient care and treatment, and Respondent failed to maintain adequate and accurate medical records, including but not limited to the following:

A. Patient D.R., a 48 year old female, came under Respondent's care and treatment on or about March 13, 2012. She had previously been under the care of another physician, from whom she had been receiving high dose opioid medications, including Oxycontin, 80 mg, QID, and Oxycodone IR, 30 mg, up to 6/day, Xanax, 1 mg, TID, and Soma, 350 mg, QID. The records of that course of treatment are included in Respondent's records and are notable for the patient's multiple arrests and/or citations for driving under the influence of her medications between 2009 and 2011, as well as her lack of apparent significant improvement in functionality despite the high dose opioid therapy.

B. Prior to her first visit with Respondent, Patient D.R. submitted a written request that Respondent refill her prescriptions, which she stated had been spilled on the street and lost in a hit and run accident. The record of the patient's initial examination utilizes an electronic template, incorrectly identifies the patient as African American and is at places unintelligible.[11] The note documents the presence of back pain, neck pain and stiffness of the legs, but does not otherwise describe the patient's condition. Respondent diagnosed Patient D.R. with Headache/Facial Pain, Low Back Pain, Chronic Pain Syndrome and Disc Disorder Lumbar. Respondent continued the patient on the regimen of opiates, benzodiazepines and sensorium altering muscle relaxants, despite the fact that the latter two types of medications have negative interactions with opioids.

C. Patient D.R. continued under Respondent's care until her death by accidental overdose on October 24, 2014. During this time, collateral medical records show that the patient went to local emergency rooms after an accidental overdose, a fall in her home and two

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[11] The HPI, for example states: "It[the pain] becomes worse with bearing weight bending to the sides carrying, climbing stairs and cold, coughing, descending stairs, doing excessive work exercise, extension grasping and gripping, head tilting lifting 2-5 pounds, lying down, lying on the affected side movement of the injured part, overhead movement, overhead use and overhead work, prolonged standing or walking, pulling a load and rising, shaking and turning over twisting, walking and work but denies any activity or movement and brace but denies breathing casing mail and driving, flexion handling mail, heat, keyboard typing or using a mouse and medication, pregnancy pushing heavy object, reaching repetitive pinching or grasping, rest, sitting and squatting and straining tonic postures, typing, using parking brake and Valsalva."

automobile accidents where she ran off the road and hit an embankment and a tree. Respondent's records lack any documentation of an appropriate risk evaluation and mitigation strategy for this patient. At no point was there any decision-making documented by him regarding alternative treatment modalities. All of the diagnoses, when made very sporadically, were nonspecific discussing headache and back pain, but no consideration was evident that the headaches might have represented opioid-induced hyperalgesia.

D. Respondent often prescribed powerful narcotic medications for the patient without a face-to-face encounter. Respondent's employee was interviewed by the Board and stated that Respondent would collect a fee of $187.50 for an in-person visit with him, but that if the patient simply arrived at the office to collect a prescription, and would only see a member of the office clerical staff, the fee would be $62.50. Patient D.R.'s billing records reflect many periods where a payment of $50.00 or $62.50 was collected for several consecutive "visits." Even for dates when the patient apparently paid the higher fee, there is often not a documented physical examination.

E. Patient D.R.'s last visit with Respondent was on October 14, 2014. Her medications included Morphine Sulfate[12] ER, 100 mg, 2 PO Q8 hours, Morphine Sulfate IR, 30 mg, 1-2 PO, Q 6 hours, Xanax, 2 mg, BID, Soma, 350 mg, TID, and Lunesta, 3 mg, QHS. Respondent's handwritten notes reflect a recent hospitalization and surgery to address multiple fractures, but does not state the cause of the fractures. In fact, the patient had been involved in an automobile accident, in which she drove her car off the highway and into a tree, and which may have been medication-related.

F. On October 24, 2014, Patient D.R. was found deceased on the floor of her home. A postmortem examination was performed and a forensic pathologist determined that D.R. had died

[12] Morphine Sulfate is a Schedule II controlled substance and a potent opioid intended for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Morphine sulfate extended-release tablets exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death. Serious, life-threatening, or fatal respiratory depression may occur with use of morphine sulfate extended-release tablets.

as a result of Acute Mixed Drug Intoxication. Significant levels of benzodiazepines and opiates were detected by toxicology studies.

23. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts in the practice of medicine, including but not limited to the following:

A. Respondent failed to develop a treatment plan with objectives, to periodically review the effectiveness of the prescribed treatment or to consider alternatives when the patient failed to improve;

B. Respondent failed to respond to evidence that the patient's condition was not benefitting and was actually worsening on the prescribed treatment by weaning and withdrawing her from the treatment;

C. Respondent failed to perform face-to-face evaluations and appropriate physical examinations while prescribing high dose opioids;

D. Respondent failed to obtain appropriate addiction medicine consultations despite signs that the patient was abusing some medications;

E. Respondent failed to maintain adequate and accurate records.

SIXTH CAUSE FOR DISCIPLINARY ACTION

(Gross Negligence/Repeated Negligent Acts)

(Patient A.C.)

24. Respondent's license is subject to discipline and Respondent is guilty of unprofessional conduct in violation of Business and Professions Code § 2234(b) and/or (c) and/or 2266 in that Respondent was grossly negligent and/or committed repeated negligent acts in his patient care and treatment, and Respondent failed to maintain adequate and accurate medical records, including but not limited to the following:

A. Patient A.C., a 40 year old woman, came under Respondent's care on or about June 23, 2011. The patient had previously been under the care of another physician, whose records are included in Respondent's chart for Patient A.C. and which disclose that the patient was advised

on March 16, 2011 that she would be discharged from care after she presented an altered triplicate to the pharmacy. That physician then began a taper to wean Patient A.C. from her pain medications. As of April 27, 2011, the patient was receiving Oxycontin, 40 mg, 2 q6h, Phenergan (to address withdrawal related nausea), 25 mg, 1-2 QID prn.

B. Respondent's record for the first patient encounter on June 23, 2011 consists of the patient's questionnaire with scant notes by Respondent. There is no documented physical examination or charted diagnosis. Respondent continued the patient on Oxycontin, 80 mg, 2 BID, and added Soma 350 mg, TID, and Norco (Oxycodone), 10/325 mg, 1-2 q4-6 hours without a documented rationale or treatment plan.

C. Respondent's records for Patient A.C. indicate that during her approximately 16 months of treatment with Respondent, she made repeated requests for early refills and requested additional medications. Respondent's chart also includes a CURES report showing that A.C. was receiving prescriptions for benzodiazepines and opiates from multiple providers. Although Respondent warned A.C. that she would be terminated as a patient for non-compliance he continued to prescribe controlled substances to her -- and in fact increased the dosage of opiates substantially -- until her death by accidental overdose on November 10, 2012. On November 6, 2012, he gave the patient an early refill of Oxycontin, 80 mg, #32. He then refilled her Oxycontin, 80 mg, #240, at her next appointment on November 9, 2012. Respondent's records do not document consideration of referral to a subspecialist to address the patient's addiction to her medications.

D. Billing records in Respondent's chart indicate that the patient was not seen by Respondent on many occasions, but paid a fee to receive her prescription from his office staff. On occasions when the patient was seen in a face-to-face encounter, a physical examination is not documented. Also absent is a documented rationale for increasing doses of opiates prescribed by him, which is especially significant given the patient's lack of positive response in terms of daily functioning.

E. On November 10, 2012, Patient A.C. was found choking at her home. Emergency medical personnel found her deceased upon arrival. A postmortem examination was performed

and a forensic pathologist determined that A.C. had died of Oxycodone and Hydrocodone intoxication.

25. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b) and/or 2234(c) and/or 2266 of the Code in that Respondent was grossly negligent and/or committed repeated negligent acts in the practice of medicine, including but not limited to the following:

A. Respondent failed to develop a treatment plan with objectives, to periodically review the effectiveness of the prescribed treatment or to consider alternatives when the patient failed to improve;

B. Respondent failed to respond to evidence that the patient's condition was not benefitting and was actually worsening on the prescribed treatment by weaning and withdrawing her from the treatment;

C. Respondent failed to perform face-to-face evaluations and physical examinations while prescribing high dose opioids.

D. Respondent failed to obtain appropriate addiction medicine consultations despite signs that the patient was abusing her medications;

E. Respondent failed to maintain adequate and accurate records.

CAUSE FOR REVOCATION OF PROBATION

26. As stated above, an Accusation was filed before the Board, in which it was alleged that Respondent had engaged in multiple departures from the standard of care, including prescribing controlled substances without an appropriate examination, in violation of the above-recited provisions of the Medical Practice Act. The Board and Respondent thereafter entered into a stipulated settlement, by which Respondent agreed that his certificate would be placed on probation to the Board with terms and conditions. The stipulated settlement specifically provided that failure to fully comply with any term or condition of probation, including the requirement that Respondent obey all laws, would be a violation of his settlement agreement with the Board and would authorize the Board to take action to carry out the disciplinary order that was stayed. The Stipulation further provided that, should the Board file a Petition to Revoke Probation,

Respondent's probation would continue until such time as a final decision on the Petition was rendered. A copy of the Decision is attached to this First Amended Accusation and Petition to Revoke Probation as Exhibit A and is incorporated in this Petition by reference, as though fully set out herein.

A. Respondent is guilty of unprofessional conduct and his probation is subject to revocation based upon his violations of the Medical Practice Act, as set forth in the above Causes for Disciplinary Action.

PRAYER

WHEREFORE, complainant prays that a hearing be held and that the Board issue an order:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A65476, issued to Steven Mangar, M.D.;

2. Revoking Respondent Steven Mangar, M.D.'s current probation and carrying out the disciplinary order that was stayed, a revocation of Respondent's license;

3. Revoking, suspending or denying approval of Steven Mangar, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. Ordering Steven Mangar, M.D., if placed on probation, to pay the Medical Board the costs of probation monitoring;

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

DATED: January 7, 2016

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

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