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

In the Matter of the Accusation Against Edgar Corrales Banez, M.D. Physician's and Surgeon's License No. A52430 Respondent.	Case No. 800-2016-021809

DECISION

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

This Decision shall become effective at 5:00 p.m. on July 17, 2020.

IT IS SO ORDERED: June 19, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General
JOSHUA M. TEMPLET
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **EDGAR CORRALES BANEZ, M.D.** **4867 Eagle Rock Blvd., Suite 1** **Los Angeles, CA 90041** **Physician's and Surgeon's Certificate No. A 52430** Respondent.	Case No. 800-2016-021809 OAH No. 2019090483 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, via Joshua M. Templet, Deputy Attorney General.

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2. Respondent Edgar Corrales Banez, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, Doyle, Schafer, McMahon, LLP, 5440 Trabuco Road, Irvine, CA 92620.

3. On October 14, 1993, the Board issued Physician's and Surgeon's Certificate No. A 52430 to Edgar Corrales Banez, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-021809, and it will expire on August 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-021809 (Accusation) was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent, on April 4, 2019. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of the Accusation is attached as **Exhibit A** and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the Accusation. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in the Accusation, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

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

CONTINGENCY

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

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 52430, issued to Respondent EDGAR CORRALES BANEZ, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years with the following terms and conditions:

1. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Until and unless Respondent successfully completes the Clinical Competence Assessment Program referenced in Condition No. 7, Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Until and unless Respondent successfully completes the Clinical Competence Assessment Program referenced in Condition No. 7, Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

Until and unless Respondent successfully completes the Clinical Competence Assessment Program referenced in Condition No. 7, if Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical

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purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval an educational program or courses which shall not be less than 40 hours per year, for each year of probation. The educational program or courses shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program or courses shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the CME requirements for renewal of licensure.

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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7. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence, as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms, interview, Decision, Accusation, and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment

program has been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

8. PRACTICE MONITORING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering; shall be in Respondent's field of practice; and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine,

including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. OBEY ALL LAWS. Respondent shall obey all federal, state, and local laws; all rules governing the practice of medicine in California; and remain in full compliance with any court ordered criminal probation, payments, and other orders.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, e-mail address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside of California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California that lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing, 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program that has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or federal jurisdiction while on probation with the

medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines " prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (*e.g.*, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in

determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Board and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and I agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 03/10/2020

EDGAR CORRALES BANEZ, M.D.
Respondent

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

DATED: March 11, 2020

RAYMOND J. MCMAHON
Attorney for Respondent

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ENDORSEMENT

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

DATED: 3/11/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

JOSHUA M. TEMPLET
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2016-021809

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

In the Matter of the Accusation Against: EDGAR CORRALES BANEZ, M.D. 4867 Eagle Rock Blvd., Suite 1 Los Angeles, CA 90041 Physician's and Surgeon's Certificate No. A 52430, Respondent.	Case No. 800-2016-021809 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On October 14, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number A 52430 to Edgar Corrales Banez, 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 August 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(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.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2220 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

"(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

"(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative

total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

"(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon."

7. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption 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.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the

proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to 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 564, 575.)

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 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5."

11. Section 2242 of the Code states:

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

"(b) No licensee shall be found to have committed unprofessional conduct within the

meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

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

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

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

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

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

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

12. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by

imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of patients. The circumstances are as follows:

Patient 1

14. In or around March 2013, Patient 1 presented to Respondent. Patient 1 was seen on numerous occasions between 2013 and 2016, including the office visits set forth below. During this period, Respondent provided Patient 1 with 31 prescriptions of oxycodone for a total of 2,790 tablets, 9 prescriptions of clonazepam for a total of 270 tablets, 2 prescriptions of hydrocodone for a total of 180 tablets, and 2 prescriptions of hydromorphone for a total of 120 tablets. The patient also had a history of coronary artery disease that had required multiple stent procedures.

15. On or about March 8, 2013, Respondent saw Patient 1, noting a chief complaint of "[status post] lumbar surgery" with two illegible words. Patient 1's weight was noted to be 134 pounds. There is no information about how the patient was doing, what symptoms he had or whether he was responding favorably to his multiple medications. Respondent did not document any patient concerns. For the physical examination, Respondent only checked a box indicating lungs were clear; no other physical exam is noted. Specifically, there was no documented exam of the patient's back nor a neurologic exam of the lower extremities to address the chief complaint. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not

adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

16. On or about November 26, 2013, Respondent saw Patient 1 for "follow up." The patient's weight was charted as 126 pounds. There is no evidence in the chart notes that Respondent noted the weight loss, nor did he attempt to address it by obtaining a thorough history, review of systems, and physical examination. Respondent also did not perform an appropriate work-up of the weight loss, such as with laboratory tests or imaging studies. He did not document how the patient was feeling, any health concerns or how the medications were working. There was no documentation of a chief complaint, allergies, review of systems or past medical history and no documented exam of the patient's back. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, utilizing a pain management contract, evaluating for aberrant behaviors, or documenting a review of the CURES database.

17. On or about May 5, 2014, Respondent saw Patient 1. The patient's blood pressure was on the low end of normal at 100/60 mm Hg, a range that could cause lightheadedness. Respondent did not document asking the patient about this nor adjust the patient's blood pressure medications (Tenormin, Isordil and Zestril). The note appears to indicate the patient's wife had a

concern but the note is otherwise illegible. There was no documentation of how the patient was feeling. Also absent is any documentation of an interval history, allergies or any physical examination. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database. The chart indicated that the patient was taking Plavix, a blood thinner. Respondent ordered labs for Patient 1.

18. On or about May 6, 2014, laboratory results ordered by Respondent indicated that Patient 1 had anemia with a hemoglobin of 10.8 g/dL, which is low. There is no indication in the chart that Respondent ordered an appropriate work-up to evaluate the patient's anemia.

19. On or about June 9, 2014, Patient 1 was seen by Respondent. Only seven illegible words are documented in the history of present illness. The chart does not appear to address the patient's anemia and appears to have a notation that "labs are essentially normal." Respondent did not document a chief complaint, allergies, review of systems or past medical history. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

20. On or about June 19, 2014, Patient 1 was seen by Respondent. His blood pressure was lower, at 90/50 mm Hg. The chart notes that he was only taking Isordil for blood pressure but Respondent did not document whether the patient was having symptoms related to low blood pressure, did not adjust his medications and did not attempt to determine why the blood pressure was low.

21. On or about April 27, 2015, Respondent stated in a hospital admission note that Patient 1 had a "history of liver surgery for tumor, which was apparently benign."

22. On or about April 30, 2015, a gastroenterology consultation for Patient 1 stated that "the chronicity of the patient's liver problem certainly indicates a nonaggressive pattern of liver disease."

23. On or about May 4, 2015, a nuclear medicine scan of the liver was performed and did not demonstrate evidence of liver cancer.

24. On or about June 10, 2015, Patient 1 presented to Respondent who only documented that the patient had had lumbar surgery. The patient's weight was noted to be 118 pounds. The chart does not appear to address the issue of anemia. There is no evidence in the chart notes that Respondent noted the weight loss, nor did he attempt to address it by obtaining a thorough history, review of systems, and physical examination. Respondent also did not perform an appropriate work-up of the weight loss, such as with laboratory tests or imaging studies. Respondent did not document information about how the patient was doing or whether the medications were helping. The patient's blood pressure was low at 100/40 mm Hg. Respondent did not ask the patient about symptoms nor adjust his blood pressure medication. He did not document an interval history. There are only a few illegible words documenting a physical exam of the back. Respondent diagnosed the patient with coronary artery disease, hypertension, and some other words that are illegible. Respondent did not document information about how the patient was feeling and whether he was having chest pain or lightheadedness. There was no documentation of a cardiac and pulmonary exam to support his diagnoses. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain,

did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

25. On or about September 18, 2015, in a hospital admission note, Respondent state that Patient 1 was "status post excision of liver tumor, which was benign" and included on the discharge summary for the same hospital stay as a diagnosis, "History of liver tumor, benign."

26. On or about October 5, 2015, Respondent saw Patient 1 but only documented "follow up" in the history of present illness. The patient's weight was not documented. The patient's blood pressure was at the low end of normal at 102/60 mm Hg; this was not addressed with the patient nor were medications adjusted. Respondent did not document a chief complaint, allergies, review of systems, or past medical history. His seven diagnoses are not supported by the documentation in the note. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

27. On or about January 18, 2016, Patient 1 was seen by Respondent for follow up; just a few words are documented in the history of present illness. The patient's weight was not documented. The patient's heart rate was 109, which is elevated, and was higher than the heart rate on previous office visits. Respondent did not document a history or review of systems to try

to determine the cause of the rapid heart rate (tachycardia). Pulse oximetry was not documented. Tachycardia is not noted in Respondent's assessment. The patient's blood pressure was at the low end of normal, at 100/60 mm Hg. Respondent did not address this or adjust the patient's medications. There is no real indication of how the patient was feeling or doing. Respondent did not document a chief complaint, allergies, review of systems or past medical history. At least four diagnoses were made by Respondent; they are not supported by the documentation in the note. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database. Labs were ordered.

28. On or about January 19, 2016, laboratory results ordered by Respondent indicated that Patient 1 had anemia with a hemoglobin of 10.7 g/dL, which is low. There is no indication in the chart that Respondent ordered an appropriate work-up to evaluate the patient's anemia. The labs showed a very low cholesterol level, which can be a sign of conditions such as malnutrition or anemia.

29. On or about March 17, 2016, Respondent saw Patient 1 for follow up and documented just four words in the history of present illness. The patient's weight was not documented. With respect to the issue of anemia, Respondent's chart appears to indicate "labs normal." There is no indication in the chart that Respondent ordered an appropriate work-up to evaluate the patient's anemia. The patient's heart rate was tachycardic at 105. Respondent did not address the tachycardia in his assessment or plan. He did not document how the patient was doing nor did he document a chief complaint, allergies, review of systems or past medical history. He made five diagnoses which are not supported by the documentation in the note. With respect

to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

30. On or about August 4, 2016, Patient 1 was seen by Respondent, who did not document an interval history. The patient's weight was not documented. In the section for patient concerns, Respondent wrote some words which seem to indicate that the patient had been seen by another physician. There was no information about that evaluation nor about how the patient was feeling. No physical exam was documented. The assessment and plan is generally unclear but includes hypertension and coronary artery disease. The documentation in the medical record is inadequate and does not support the diagnoses. With respect to prescribing controlled substances to Patient 1 for pain and anxiety, Respondent did not document an appropriate history regarding Patient 1's pain or anxiety, did not adequately assess the pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records did not document the presence of a medical indication for the use of controlled substances. Again, Respondent did not attempt to minimize the possibility of drug abuse or diversion by performing a toxicology screen, by utilizing a pain management contract, by evaluating for aberrant behaviors, or by documenting a review of the CURES database.

31. On or about September 7, 2016, Respondent saw Patient 1. Respondent certified on a Physician Certification/Recertification of Terminal Illness form that Patient 1 was terminally ill with a hospice diagnosis of "Liver Cancer with metastasis to colon and spine." Respondent's

clinic notes and hospital notes do not provide radiographic and biopsy evidence to support this diagnosis and contradicts the diagnosis in several respects. For example, the autopsy report on Patient 1 noted a firm mass in the liver but stated that "no gross evidence of cancer in the intestinal tract is identified" and "no gross evidence of cancer in the spine or vertebrae." The microscopic examination of tissue showed that "no definitive evidence of metastatic cancer is identified" in the large intestine, and the intervertebral disc showed "no evidence of metastatic cancer." The summary of the autopsy report stated that the cause of death was pneumonia with "complications of metastatic liver cancer (by history) and liver cirrhosis." It was noted that "microscopic examination of the liver shows micronodular cirrhosis." In summary, the autopsy report identified a liver mass but did not find evidence of liver cancer or any metastatic disease.

Patient 2

32. In or around April 2013, Patient 2 presented to Respondent. Patient 2 was seen on numerous occasions between 2013 and 2018, including the office visits set forth below. From April 1, 2013, to December 13, 2018, Respondent saw Patient 2 in the office multiple times and failed to maintain adequate medical records regarding the patient's medical care as set forth below. During this time, Respondent provided Patient 2 with 33 prescriptions of oxycodone for a total of 4,050 tablets, 34 prescriptions of clonazepam for a total of 1,020 tablets, 1 prescription of alprazolam for 90 tablets, and 1 prescription of zolpidem for 30 tablets. During this time, Respondent did not document an appropriate history regarding Patient 2's pain or anxiety. Respondent did not adequately assess her pain, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting the patient's physical and psychological functioning. The medical records that Respondent maintained did not even document the presence of a medical indication for the use of these controlled substances. Respondent never attempted to minimize the possibility of drug abuse or diversion by performing toxicology screens, by utilizing pain management contracts, by evaluating for aberrant behaviors, or by documenting a review of the CURES database. During this time, Respondent managed Patient 2's diabetes and routinely included diabetes as a diagnosis in his assessments. However, there is no evidence that he ever

referred her for screening for diabetic retinopathy; examined her feet for nerve damage or poor blood flow or sent her to a podiatrist; or measured her urine microalbumin levels to monitor for diabetic nephropathy.

33. On or about April 1, 2013, Respondent saw Patient 2. He documented just a few words under patient concerns and did not document any physical examination at all.

34. On or about July 11, 2013 Respondent saw Patient 2 for follow up. He did not document a chief complaint, documented only three words in the history of present illness, did not document a past medical history or review of systems and did not document allergies. Respondent added zolpidem to Patient 2's regimen of oxycodone and clonazepam without documenting the reason for doing so. It is a potentially dangerous combination to add a sedating sleep medication to a benzodiazepine and an opioid pain medication, all of which can alter mental status and suppress respiratory drive.

35. On or about August 2, 2013, Respondent saw Patient 2 for follow up of hypertension and chronic low back pain. He documented only a few words in the history of present illness. He did not document a past medical history, review of systems, or allergies.

36. On or about September 4, 2013, Respondent apparently saw Patient 2. Respondent doubled the quantity of oxycodone from 120 tablets to 240 tablets without documenting the rationale for doing so. In fact, there is no office visit around this date and there is no note at all explaining why this increase in a potentially addictive controlled substance occurred.

37. On or about November 4, 2013, Respondent saw Patient 2 for follow up. He wrote only "seen by rheumatology" and did not document any information about that visit or how the patient was doing. He did not document a past medical history, review of systems, or allergies.

38. On or about May 5, 2014, Respondent saw Patient 2 and wrote just a few words under patient concerns. He did not document any physical examination. Respondent ordered labs.

39. On or about May 6, 2014, laboratory results ordered by Respondent indicated that Patient 2 had anemia with a hemoglobin of 9.9 g/dL, which is low.

40. On or about June 9, 2014, Respondent saw Patient 2 and in the history of present illness wrote only "follow up" without documenting any information about how the patient was

doing or even why she was there. He did not document a chief complaint, review of systems, or medication allergies. Respondent's chart note on June 9, 2014 appears to indicate "labs essentially normal." Respondent did not include anemia among the list of diagnoses for that visit.

41. On or about January 8, 2015, Respondent saw Patient 2 and did not document anything under patient concerns, so it is unclear what for the reason was for the visit or how she was doing. Respondent did not document a physical examination. Respondent ordered labs.

42. On or about January 12, 2015, another lab result again shows that Patient 2 had anemia with a hemoglobin of 10.7 g/dL, which is low. There is no indication in the chart that Respondent addressed this.

43. On or about March 17, 2016, Respondent saw Patient 2 and did not document a reason for the visit, an interval history, patient concerns, information about how she was doing, or a physical examination. There is no indication in the chart that Respondent addressed the patient's anemia documented in the January 2015 lab report.

44. On or about August 4, 2016, Respondent saw Patient 2 and did not document a chief complaint, history of present illness, review of systems, past medical history, or allergies. It is unclear why the patient was there that day or how she was doing.

45. On or about August 29, 2016, Respondent saw Patient 2 for follow up and only wrote two illegible words in the history of present illness. He did not document a chief complaint, how the patient was doing, allergies, review of systems, or past medical history.

46. On or about November 29, 2016, Respondent saw Patient 2 for follow up and wrote just a few words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

47. On or about March 30, 2017, Respondent saw Patient 2 and did not document a reason for the visit, interval history, patient concerns, or any physical examination.

48. On or about August 21, 2017, Respondent saw Patient 2 for follow up and wrote only three words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history. The patient's blood pressure was 260/80 which was significantly and dangerously elevated. Respondent did not document that he asked Patient 2

about symptoms related to this elevated blood pressure such as headache, chest pain, shortness of breath, or visual changes. Respondent added amlodipine 10 mg to her regimen to try to lower the blood pressure. He did not require her to return soon for a follow up on this issue. At this visit, Respondent diagnosed Patient 2 with dementia. Respondent did not document any history related to this diagnosis, did not perform any memory testing, did not perform a neurologic examination, did not order any laboratory tests to evaluate for underlying medical causes of memory loss, and did not order imaging of the brain. Respondent did not make any reasonable attempt to determine the cause of memory loss. This is particularly concerning in an elderly patient who was receiving prescriptions from Respondent for Percocet and Klonopin, both of which can cause alterations in mental status and memory. Health and Safety Code section 103900 mandates as a public safety measure that physicians report to the Department of Motor Vehicles patients with Alzheimer's disease or related disorders so that potentially unsafe drivers are not operating motor vehicles. There is no documentation in the medical record that Respondent made the required report to the Department of Motor Vehicles.

49. On or about September 28, 2017, Respondent saw Patient 2 for follow up and wrote only three words in the history of present illness. Respondent did not document a blood pressure on this visit so there is no way to tell if the amlodipine helped bring the patient's blood pressure down. Respondent also did not document that he asked if the patient was measuring her blood pressure at home or if she was having any symptoms related to elevated blood pressure. He also did not document a chief complaint, allergies, review of systems, or past medical history. Respondent did not make any mention of dementia or memory loss in this note.

50. On or about May 17, 2018, Respondent saw Patient 2 and did not document a reason for the visit, interval history, or patient concerns. There are just a few illegible words written in the physical examination section.

51. On or about July 16, 2018, Respondent saw Patient 2 for follow up and wrote only three words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

52. On or about October 4, 2018, Respondent saw Patient 2 for follow up and wrote only

three words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

53. On or about December 3, 2018, Respondent saw Patient 2. The history of present illness is very brief and illegible. He did not document a chief complaint, allergies, review of systems, or past medical history.

54. On or about December 13, 2018, Respondent saw Patient 2 for follow up and wrote only a few words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

Patient 3

55. On or about April 1, 2013, Respondent saw patient Patient 3 and wrote only three words under patient concerns. The patient complained of blood in her urine and Respondent documented in the patient concerns that "UA has blood," where UA means urinalysis. Respondent did not obtain any additional information from the patient such as whether she could see blood in the urine, how long this had been going on, whether she was having any pain with urination, whether she had any back or abdominal pain, or whether she had any fevers or weight loss. Respondent did not document a physical examination for this issue as would be expected. Even though blood in the urine can be a sign of a serious underlying medical issue such as a cancer, and the blood in the urine was the stated reason for the office visit, Respondent did not include hematuria in his list of diagnoses, did not order any studies to evaluate the hematuria and did not refer the patient to a urologist. During this visit, Respondent did not otherwise document a physical examination. Under the treatment plan, he wrote just three illegible words, so it is not clear what the treatment plan was for the patient. As outlined in detail below, from April 1, 2013, to May 10, 2018, Respondent saw Patient 3 in the office multiple times and failed to maintain adequate medical records regarding her care. During this time, Respondent provided Patient 3 with 52 prescriptions of lorazepam for a total of 3,360 tablets (which were prescribed on approximately monthly intervals) and 9 prescriptions of alprazolam for a total of 930 tablets. During this time, Respondent never documented an appropriate history regarding Patient 3's anxiety. Respondent did not adequately assess the anxiety, did not document a substance abuse

history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting her physical and psychological functioning. Respondent never attempted to minimize the possibility of drug abuse or diversion by performing toxicology screens, utilizing pain management contracts, evaluating for aberrant behaviors, or documenting a review of the CURES database. Lorazepam 1 mg was included in the medication list for this office visit. However, it is not clear from this note, whether Patient 3 had been on the medication prior to this or if Respondent first prescribed it on this date.

56. On or about April 19, 2013, Respondent saw Patient 3 and documented just a few words about pain in the foot. He documented just seven words in the physical examination section.

57. On or about April 22, 2014, Respondent saw Patient 3 but did not document an interval history, patient concerns, history, or physical examination. Respondent added alprazolam (Xanax) while also continuing to prescribe lorazepam. On the date that the alprazolam was added, there is no interval history, no patient concerns, and no physical examination was documented, so it is unclear why a second benzodiazepine was added. From this date forward, Respondent continued to prescribe both lorazepam and alprazolam at approximately monthly intervals.

58. On or about June 26, 2014, Respondent saw Patient 3 and documented only "follow up" in the history of present illness. There is no information documented about the reason for the visit or how she was doing.

59. On or about December 2, 2014, Respondent saw Patient 3 and documented just a few words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

60. On or about December 12, 2014, Respondent saw Patient 3 for "follow up" and indicated that she was there for elevated blood pressure. He did not document any information about how she was doing or the symptoms she was having.

61. On or about February 16, 2015, Respondent doubled the dose of alprazolam. There is no progress note in the medical record to explain why the dose was increased, and the patient had not been seen in the office since on or about December 12, 2014. From this date forward,

Respondent continued to prescribe the higher dose of alprazolam at approximately monthly intervals, and the last prescription for lorazepam was filled on or about March 4, 2015.

62. On or about June 9, 2015, Respondent saw Patient 3. He did not document an interval history, patient concerns, or physical examination.

63. On or about March 29, 2016, Respondent saw Patient 3 for follow up. He documented just five words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history.

64. On or about June 7, 2016, Respondent saw Patient 3 for follow up and wrote only "back pain." He did not document any additional information about how her back pain was doing, any associated symptoms, or a review of systems. Essentially, he did not evaluate her back pain. For example, Respondent did not document any additional information about the back pain such as how long it had been going on, where the pain was located, the severity of the pain, whether the pain radiated into the legs, or any other information that would be expected. Respondent did not document a review of systems such as asking about fever, weight loss, abdominal pain, or blood in the urine to evaluate for serious underlying medical conditions. Respondent documented a basic back examination but did not document a neurologic examination such as strength, sensation, and reflexes to make sure that there was not a more serious problem such as a nerve compression. In the assessment, Respondent did not document any information about the potential causes of the back pain, as would be expected.

65. On or about July 21, 2016, Respondent saw Patient 3 and did not document a chief complaint, interval history, patient concerns, allergies, review of systems, past medical history, or physical examination. Without this information, documenting an assessment and plan simply does not make sense because there is no context to support it.

66. On or about September 6, 2016, Respondent saw patient Patient 3. He did not document a chief complaint, allergies, review of systems, or past medical history. He only wrote "follow up no urinary s/s [signs and symptoms]."

67. On or about November 15, 2016, Respondent saw Patient 3 for follow up with just a few illegible words about the ER. He did not document a chief complaint, allergies, review of

systems, or past medical history.

68. On or about December 22, 2016, Respondent saw Patient 3 for follow up and wrote only three words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history. Despite writing only three words, he diagnosed her with five different problems including TIA (a transient ischemic attack which is temporary stroke symptoms), hypertension, cerebral atrophy, and two words that are illegible.

69. On or about June 23, 2017, Respondent evaluated Patient 3 for back pain. He did not document any information about the back pain. He did not document a review of systems to evaluate for fever, blood in the urine, or any other systemic symptoms to make sure the back pain was not being caused by a serious underlying problem.

70. On or about July 21, 2017, Respondent saw Patient 3 and diagnosed her with hypertension, TIA, dysphagia (difficulty swallowing), and low back pain. However, he did not document a chief complaint, history of present illness, allergies, review of systems, past medical history, or physical examination which would support the diagnoses he made and capably describe what was going on with the patient.

71. On or about August 8, 2017, Respondent saw Patient 3 and wrote only "still with LBP," where LBP means low back pain. He did not document any other information that would be expected such as the pain level, what treatment had been tried, or how the pain was affecting her daily functioning. He did not document a review of systems to make sure the back pain was not being caused by a serious underlying medical condition such as an infection or a cancer.

72. On or about December 18, 2017, Respondent saw Patient 3 and again wrote just a few words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history, yet he again diagnosed her with low back pain. His documentation does not provide adequate information about what was going on with her back pain.

73. On or about March 27, 2018, Respondent saw Patient 3 and diagnosed her with low back pain, this time with radiculopathy, which means pain that goes down the leg. However, he documented just a few words in the history of present illness and did not document a chief

complaint, allergies, review of systems, or past medical history. He did not perform a neurologic examination that would support a diagnosis of radiculopathy.

74. On or about May 10, 2018, Respondent saw Patient 3 and wrote just a few words in the history of present illness but did not document a chief complaint, allergies, review of systems, or past medical history that would provide adequate information about the four diagnoses that he wrote on the note.

Patient 4

75. In or around April 2005, Respondent began treating Patient 4. He also treated her at various times between 2010 and 2012. Between at least May 21, 2012, and March 16, 2018, Respondent saw Patient 4 in the office multiple times as set forth below and failed to maintain adequate medical records regarding this care. Between June 13, 2013, and May 11, 2016, Respondent provided Patient 4 with 33 prescriptions of alprazolam for a total of 2,970 tablets, 16 prescriptions of zolpidem for a total of 480 tablets, and 13 prescriptions of aspirin-butalbital-caffeine for a total of 390 tablets. Respondent was prescribing both alprazolam (a benzodiazepine) and zolpidem (a nonbenzodiazepine sedative) at the same time. This combination could cause changes in mental status and could also cause respiratory depression, especially when combined with the aspirin/butalbital/caffeine that Respondent was also prescribing at the same time. Between June 13, 2013, and May 11, 2016, Respondent never documented an appropriate history regarding Patient 4's anxiety or headaches. Respondent did not adequately assess the anxiety and headaches, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting her physical and psychological functioning. Respondent never attempted to minimize the possibility of drug abuse or diversion by performing toxicology screens, utilizing pain management contracts, evaluating for aberrant behaviors, or documenting a review of the CURES database.

76. On or about May 21, 2012, Respondent saw Patient 4 for follow up and documented only two words in the history of present illness. He did not document a chief complaint, allergies, review of systems, or past medical history. Patient 4's TSH was elevated, so Respondent

appropriately increased her dose of thyroid hormone. However, he did not address her TSH test again until it appeared on a progress note six months later, on January 17, 2013, at which point the TSH was suppressed, indicating that Patient 4 had been taking too high a dose of thyroid hormone for the previous 8 months without appropriate monitoring.

77. On or about January 17, 2013, Respondent saw Patient 4. He did not document a chief complaint, any information in the history of present illness to explain how she was feeling, allergies, review of systems, or past medical history. Respondent decreased the dose of thyroid hormone at this time.

78. On or about July 29, 2013, Respondent ordered a TSH test.

79. On or about July 30, 2013, Respondent saw Patient 4. He did not document a chief complaint, any information in the history of present illness to explain how she was feeling, allergies, review of systems, or past medical history. Despite this lack of documentation, he diagnosed the patient with hypertension, hypothyroidism, insomnia, and two other diagnoses that are illegible. From the July 29, 2013, test, the TSH level was suppressed, indicating that the patient had been taking too high a dose of thyroid hormone for the past six months. It is not clear from the progress note if Respondent changed the dose of thyroid hormone on this visit.

80. On or about May 9, 2014, Respondent saw Patient 4 for "follow up." He did not document a chief complaint, any information in the history of present illness to explain how she was feeling, allergies, review of systems, or past medical history. Despite this lack of documentation, Dr. Banez made multiple diagnoses that are illegible.

81. On or about May 29, 2014, a lab test disclosed that Patient 4's TSH was again suppressed, meaning the patient had been taking too high a dose of thyroid hormone for another 10 months without appropriate monitoring.

82. On or about December 1, 2014, Respondent saw Patient 4 for "follow up." He did not document a chief complaint, any information in the history of present illness to explain how she was feeling, allergies, review of systems, or past medical history. Despite this lack of documentation, Respondent made multiple diagnoses that are illegible. The treatment plan consists of five words that are illegible. Respondent decreased the dose of thyroid hormone at

this office visit but there is no TSH test available on this date.

83. On or about June 4, 2015, Respondent saw Patient 4 for "follow up." He did not document a chief complaint, any information in the history of present illness to explain how she was feeling, allergies, review of systems, or past medical history.

84. On or about June 5, 2015, a lab test disclosed that Patient 4's TSH was high, indicating the patient's dose of thyroid hormone was too low. This means that the TSH had not been checked in approximately 13 months even though Respondent was having difficulty determining the right dose of thyroid hormone for this patient. Respondent increased the dose of thyroid hormone on this date.

85. On or about October 29, 2015, Respondent saw Patient 4 for "follow up" with only two words in the history present illness, so it is not documented how the patient was feeling. He did not document a chief complaint, allergies, review of systems, or past medical history. A repeat TSH test was not performed on Patient 4 on this office visit.

86. On or about February 5, 2016, lab results for Patient 4 demonstrated elevated transaminase levels (the ALT and AST tests) as well as an elevated alkaline phosphatase. This should have prompted additional lab tests and an ultrasound of the liver to evaluate the potential causes of these abnormal liver function tests. Respondent did not include any notes with these lab results and did not address the abnormal lab values at the next office visit on March 4, 2016. Respondent did not order additional lab tests or an ultrasound of the liver to evaluate these abnormal results. The next set of labs were performed on July 2, 2017, approximately 17 months later. The lab test results also indicated the TSH was suppressed on this date, indicating the dose of thyroid hormone was too high and had not been monitored for approximately 8 months.

87. On or abut March 4, 2016, Respondent saw Patient 4 for "follow up" but did not document anything else in the history. He did not document a chief complaint, allergies, review of systems, past medical history, or physical examination. Respondent made multiple diagnoses despite not documenting any information or an exam to support his diagnoses. Respondent did not address the abnormal lab values from February 5, 2016.

88. On or about January 5, 2017, Respondent saw Patient 4 for "follow up" and only

wrote "seen by Dermatology" in the history. He did not document anything else in the history. He did not document a chief complaint, allergies, review of systems, past medical history, or physical examination. Respondent made three diagnoses despite not documenting any information or an exam to support these diagnoses.

89. On or about July 2, 2017, Patient 4's TSH was again suppressed, meaning that the patient had been on the wrong dose of thyroid hormone for another 5 months. Respondent decreased the dose of thyroid hormone at the next visit on July 11, 2017, but had not checked the TSH test again as of the last progress note on March 16, 2018, as set forth below.

90. On or about July 11, 2017, Respondent saw Patient 4. He did not document a chief complaint, history of present illness, allergies, review of systems, or past medical history. Respondent made multiple diagnoses despite not documenting anything about why the patient was there or what was going on with her.

91. On or about February 22, 2018, Respondent saw Patient 4 for "follow up" and documented only "chronic cough." Respondent did not document any additional information about this cough that might help determine the cause such as how long it had been going on, whether she was coughing up phlegm, whether she had fever, whether she had lost weight, whether she had a smoking history, or what treatments she had tried. Respondent did not document allergies, review of systems, or past medical history. Despite this lack of important information, Respondent made at least four diagnoses that are not supported by the documentation.

92. On or about March 16, 2018, Respondent saw Patient 4 and only documented "follow up" without including any additional information about the visit, why she was there, or how she was feeling. Despite the lack of documentation, Respondent made four diagnoses that are not supported by his chart.

Patient 5

93. In or around August 2010, Respondent began treating Patient 5. He also treated him at various times between 2010 and 2012. Between at least May 3, 2012, and September 17, 2018, Respondent saw Patient 5 in the office multiple times as set forth below and failed to maintain

adequate medical records regarding this care. The CURES report reveals that between June 13, 2013, to June 2, 2016, Respondent provided Patient 5 with 21 prescriptions of alprazolam for a total of 1,787 tablets, 11 prescriptions of lorazepam for a total of 760 tablets, 14 prescriptions of diazepam for a total of 1,630 tablets, 4 prescriptions of amphetamine salts for a total of 180 tablets, and 1 prescription of methylphenidate for 90 tablets. During this time, Respondent never documented an appropriate history regarding Patient 5's anxiety or establish a diagnosis that would support the decision to prescribe amphetamines or methylphenidate. Respondent did not adequately assess the anxiety, did not document a substance abuse history, and did not document prior treatments. Respondent did not document how the medications were helping or adversely affecting his physical and psychological functioning. The medical records that Respondent maintained did not even document the presence of a medical indication for the use of these controlled substances. Respondent never attempted to minimize the possibility of drug abuse or diversion by performing toxicology screens, utilizing pain management contracts, evaluating for aberrant behaviors, or documenting a review of the CURES database. Respondent also managed Patient 5's diabetes and routinely included diabetes as a diagnosis in his assessments. The period of time included in the available medical records is from at least May 3, 2012, to September 17, 2018. However, there is no evidence that over the course of that period Respondent ever referred the patient to an ophthalmologist for screening for diabetic retinopathy or examined his feet for nerve damage or poor blood flow or sent him to a podiatrist. Respondent only measured the urine microalbumin twice, on October 27, 2017, and September 7, 2018 when it should have been measured annually. These urine microalbumin measurements occurred at the end of this date range, so Respondent failed to measure the urine microalbumin for Patient 5 for at least approximately six years.

94. On or about May 3, 2012, Respondent saw Patient 5 for follow up and documented "too much stress" and about six other illegible words. He did not document any additional information about what was going on with the patient, a chief complaint, allergies, review of systems, or past medical history. Respondent made three diagnoses but did not document a treatment plan.

95. On or about June 1, 2012, Respondent saw Patient 5 for follow up and only documented that he had been seen by another doctor. Respondent did not document a chief complaint, any information about how the patient was doing, allergies, review of systems, past medical history, or a physical examination. Respondent made diagnoses of anxiety, type II diabetes, and Crohn's disease despite a complete lack of information in the note. Respondent failed to document a treatment plan.

96. On or about June 18, 2012, Respondent saw Patient 5 for follow up and documented about ten illegible words in the history of present illness. He did not document a chief complaint, allergies, or review of systems. Respondent made diagnoses of pain in the knee, Crohn's disease, type II diabetes, and one other illegible diagnosis. The treatment plan notes only x-rays of the knee but does not outline a plan for any of the other medical problems.

97. On or about September 6, 2012, Respondent saw Patient 5 for follow up and documented just a few words in the history of present illness. Respondent did not document a chief complaint, allergies, review of systems, or past medical history.

98. On or about November 1, 2012, Respondent saw Patient 5 and only documented "follow up" in the history of present illness. He failed to document the chief complaint, no information about how the patient was doing, allergies, review of systems, or past medical history.

99. On or about December 3, 2012, Respondent saw Patient 5 and only documented "follow up" in the history of present illness. There was no chief complaint, no information about how the patient was doing, and no allergies, review of systems, or past medical history documented. Respondent made multiple diagnoses that are not supported by the documentation in the medical record.

100. On or about July 16, 2013, Respondent saw Patient 5 for follow up and only documented that the patient had been seen by a GI (gastroenterologist). Respondent did not document the outcome of that visit or any information about how the patient was doing. He did not document a chief complaint, allergies, review of systems, or past medical history.

101. On or about December 2, 2013, Respondent saw Patient 5 for follow up. Respondent wrote only three illegible words in the history of present illness. There is no information about how the patient was doing. Respondent did not document a chief complaint, allergies, review of systems, or past medical history. Despite the lack of documentation about the patient's status, Respondent made five diagnoses. Respondent prescribed Adderall that Patient 5 first filled on December 23, 2013. As noted above, the chart includes only a three-word history that would not support a diagnosis of ADHD or narcolepsy. In the diagnoses, Respondent included schizoaffective disorder, but not ADHD or narcolepsy. Adderall is not an appropriate nor FDA-approved treatment for schizoaffective disorder. Respondent prescribed Adderall on three other occasions and then prescribed methylphenidate on June 2, 2016. There is no documentation in the medical records to support a diagnosis of ADHD or narcolepsy, nor is there any documented rationale for why these medications were prescribed. Methylphenidate (Ritalin) and amphetamines carry a "black box" warning because of the high potential for abuse and dependence. Their use by Respondent in this patient was inappropriate. In addition, Patient 5 had elevated blood pressure on multiple office visits. Methylphenidate and amphetamines can increase blood pressure and must be used with caution in patients with hypertension, making these prescriptions even more inappropriate. Patient 5's blood pressure was elevated at 160/100 mm Hg. Respondent did not document that he asked about symptoms such as headache, chest pain, shortness of breath, or visual changes. Respondent did not note the elevated blood pressure in his assessment and plan. Despite the significantly elevated blood pressure, Respondent prescribed Adderall which can increase blood pressure even more.

102. On or about January 16, 2014, Respondent saw Patient 5 for follow up and wrote just four illegible words in the history of present illness. Respondent did not document a chief complaint, allergies, review of systems, or past medical history. Respondent made five diagnoses that are not supported by the documentation in the note. At this visit, the blood pressure again was elevated at 140/100 mm Hg. Respondent noted the patient had a headache. At this visit, Respondent started Patient 5 on amlodipine to treat the elevated blood pressure but also refilled his Adderall without acknowledging that it can increase blood pressure. Respondent

did not document any additional information about the headache as would be expected. Respondent did not document a review of systems to evaluate for serious causes of headache such as meningitis, cancer, or bleeding inside the brain. Respondent did not document a mental status examination, funduscopic examination, or neurologic examination to evaluate this headache. Respondent did not include headache in his list of diagnoses or document his thoughts about the cause of the headache.

103. On or about January 28, 2014, Respondent saw Patient 5 for a blood pressure check. He did not document allergies, review of systems, or past medical history. The patient's blood pressure was elevated at 140/100 mm Hg. Respondent did not document information that would be expected, such as whether the patient was taking the blood pressure medication as prescribed, whether he was having any side effects, or whether he was having symptoms related to the elevated blood pressure such as headache, chest pain, shortness of breath, or visual changes. Respondent did not document any physical examination as would be expected during a blood pressure check. Respondent did not document whether the patient was checking his blood pressure at home. Respondent changed the amlodipine to a combination of amlodipine with olmesartan, another blood pressure medication. He did not document any information about the headache that that patient had been having, so it is unknown whether the headache had persisted, resolved, or worsened. Respondent did not document a review of systems or a physical examination. Respondent did not address the headache in his assessment and plan.

104. On or about April 14, 2014, Respondent saw Patient 5 for follow up and only wrote that the patient had a flare up of abdominal spasms. In a patient with Crohn's disease, Respondent would be expected to document additional information such as whether the patient was having fevers, diarrhea, blood in the stool, abdominal pain, or weight loss. Respondent did not document a chief complaint, allergies, review of systems, or past medical history. Despite the lack of appropriate documentation, Respondent made six diagnoses, including type 2 diabetes, hypertension, anxiety disorder, Crohn's disease, and two more that are illegible. Respondent did not document any information about most of the conditions that he diagnosed.

105. On or about August 28, 2014, Respondent saw Patient 5 and only documented

"follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Despite the lack of documentation, Respondent made three diagnoses that are not supported by the documentation in the progress note.

106. On or about November 25, 2014, Respondent saw Patient 5 for follow up and wrote only one word followed by two question marks. There is no information about why the patient was there or how he was doing. Respondent made diagnoses of type 2 diabetes, hypertension, and one other illegible diagnosis. None of these diagnoses are supported by the information documented in the note. Specifically, in the history of present illness Respondent wrote "Follow up—depressed??" Respondent did not document any other information about the patient's symptoms, did not document a review of systems, did not document a history of depression or previous treatments, and did not document that he asked the patient whether he was feeling suicidal. Respondent did not use a depression screening tool such as a PHQ-9 to help with the evaluation. Respondent did not order laboratory studies to evaluate for medical causes for the depression. Respondent did not refer the patient to a psychiatrist for evaluation or to a mental health practitioner for counseling. Respondent prescribed high doses of diazepam in addition to the alprazolam that the patient was already taking. Diazepam and alprazolam are both benzodiazepines which, because they are central nervous system depressants, can actually make depressive symptoms worse. Respondent did not outline a follow up plan for the patient. Respondent did not see the patient for follow up for approximately 11 months until October 1, 2015, and he did not address the depressive symptoms in this progress note even though he had continued to refill the benzodiazepines at regular intervals.

107. On or about October 1, 2015, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Despite the lack of documentation, Respondent made diagnoses of type 2 diabetes, hypertension, Crohn's disease, and one other illegible diagnosis. None of these diagnoses are supported by the documentation in the note.

108. On or about May 31, 2016, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Despite the lack of documentation, Respondent made four diagnoses, none of which are supported by the documentation in the note.

109. On or about September 13, 2016, Respondent saw Patient 5 for follow up, and it appears that the only history he documented was "out of Victoza" (a diabetes medication) and one other illegible word. Respondent did not document any information about the patient's health status or how he was doing. He did not document a chief complaint, allergies, review of systems, or past medical history. Respondent made four diagnoses which are not supported by the documentation in the note.

110. On or about October 11, 2016, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, past medical history, or any physical examination. Respondent made four diagnoses which are not supported because of the lack of documentation and lack of physical examination.

111. On or about June 5, 2017, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Respondent made five diagnoses including type 2 diabetes, hypertension, anxiety disorder, Crohn's disease, and one more illegible diagnosis. These diagnoses are not supported by the documentation in the note.

112. On or about November 27, 2017, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Respondent made five diagnoses including type 2 diabetes, hypertension, anxiety disorder, Crohn's disease, and dyslipidemia (an abnormal amount of lipids in the blood). These diagnoses are not supported by the documentation in the note.

113. On or about May 7, 2018, Respondent saw Patient 5 for follow up. Respondent only documented three words in the history. There is no indication how the patient was doing, no chief complaint, no allergies, no review of systems, and no past medical history. Respondent made five diagnoses including type 2 diabetes, hypertension, anxiety disorder, Crohn's disease, and dyslipidemia, which are not supported by the documentation in the note.

114. On or about September 17, 2018, Respondent saw Patient 5 and only documented "follow up." Respondent did not document any information about why the patient was there or how he was doing. He did not document allergies, review of systems, or past medical history. Respondent made the same five diagnoses without the required supporting documentation.

ALLEGATIONS OF GROSS NEGLIGENCE

Patient 1

115. During the whole course of Respondent's care and treatment of Patient 1, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

116. During the whole course of Respondent's care and treatment of Patient 1, Respondent was grossly negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

117. During the whole course of Respondent's care and treatment of Patient 1, Respondent was grossly negligent when he failed to adequately evaluate the patient's weight loss, which could have been the presenting symptoms of a serious underlying condition such as malignancy or infection or could have been the result of inadequate nutritional intake.

118. Between on or about May 6, 2014, and March 17, 2016, and thereafter, Respondent, with respect to Patient 1, was grossly negligent when he repeatedly failed to address and evaluate anemia in an elderly patient who was also losing weight.

119. Between on or about May 5, 2014, and January 18, 2016, and thereafter, Respondent, with respect to Patient 1, was grossly negligent by repeatedly failing to address low blood pressure in a patient with heart disease who was on blood pressure medication that could have

been causing the low blood pressure.

Patient 2

120. During the whole course of Respondent's care and treatment of Patient 2, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

121. During the whole course of Respondent's care and treatment of Patient 2, Respondent was grossly negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

122. Between on or about May 6, 2014, and January 12, 2015, and thereafter, Respondent, with respect to Patient 2, was grossly negligent when he repeatedly failed to address and evaluate anemia, which can be a sign of a serious underlying medical problem such as a cancer or bone marrow disorder.

123. On or about August 21, 2017, Respondent, with respect to Patient 2, was grossly negligent when he made a diagnosis of dementia without performing an appropriate evaluation.

124. On or about August 21, 2017, and thereafter, Respondent, with respect to Patient 2, was grossly negligent when he failed to make a report of his dementia diagnosis to the Department of Motor Vehicles as required by law.

125. On or about August 21, 2017, and thereafter, Respondent, with respect to Patient 2, was grossly negligent when he failed to adequately evaluate symptoms of an extremely elevated blood pressure, did not follow up an extremely elevated blood pressure in a timely manner, and did not even recheck a dangerously high blood pressure on a subsequent visit.

Patient 3

126. During the whole course of Respondent's care and treatment of Patient 3, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

127. During the whole course of Respondent's care and treatment of Patient 3, Respondent was grossly negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and

documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

128. During the whole course of Respondent's care and treatment of Patient 3, Respondent was grossly negligent when he prescribed multiple benzodiazepines at the same time without maintaining adequate documentation in the medical record.

129. On or about April 22, 2014, and thereafter, and on or about February 16, 2015, and thereafter, in the care and treatment of Patient 3, Respondent was grossly negligent when he increased the dose of a benzodiazepine without any documentation of the rationale for doing so.

130. On or about April 1, 2013, and thereafter, in the care and treatment of Patient 3, Respondent was grossly negligent when he failed to appropriately evaluate a patient complaint of blood in the urine.

Patient 4

131. Between on or about May 21, 2012, and May 16, 2018, in the care and treatment of Patient 4, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

132. Between on or about June 13, 2013, and May 11, 2016, in the care and treatment of Patient 4, Respondent was grossly negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

133. Between at least on or about May 21, 2012, and May 16, 2018, in the care and treatment of Patient 4, Respondent was grossly negligent when he repeatedly failed to appropriately monitor the patient's dose of thyroid hormone over a period of many years, exposing her to the health risks of not being on the appropriate dose of medication.

Patient 5

134. Between at least May 3, 2012, and September 17, 2018, in the care and treatment of Patient 5, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

135. Between at least June 13, 2013, to June 2, 2016, in the care and treatment of Patient 5, Respondent was grossly negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

136. Between on or about November 25, 2014, and October 1, 2015, in the care and treatment of Patient 5, Respondent was grossly negligent (1) when he failed to adequately evaluate depressive symptoms, (2) for failing to order laboratory studies to evaluate for other medical causes of depressive symptoms, (3) for inappropriately treating depressive symptoms with high doses of multiple benzodiazepines, and (4) for continuing to refill these benzodiazepines without following up on the patient's symptoms and response to treatment.

137. On or about November 25, 2014, and thereafter, in the care and treatment of Patient 5, Respondent was grossly negligent for prescribing multiple benzodiazepines to a patient at the same time without maintaining adequate documentation in the medical record, without seeing the patient at regular intervals, and without evaluating the patient's response to therapy.

138. On or about December 2, 2013, and thereafter, in the care and treatment of Patient 5, Respondent was grossly negligent for (1) prescribing Ritalin and Adderall without a medical indication for doing so; (2) not establishing a diagnosis of attention-deficit hyperactivity disorder or narcolepsy; and (3) not documenting that he had considered side effects such as worsening of the patient's anxiety and the impact of these medications on his elevated blood pressure.

139. On or about December 2, 2013, and thereafter, in the care and treatment of Patient 5, Respondent was grossly negligent for not adequately evaluating hypertension in a patient who was having headaches and for starting and continuing to prescribe Adderall at the same time, which can increase blood pressure.

140. On or about January 16, 2014, in the care and treatment of Patient 5, Respondent was grossly negligent for failing to obtain a history; obtain a review of systems; perform an appropriate examination; or address the potential causes of a patient's headache, especially in the setting of elevated blood pressure; and for failing to document any assessment of this headache

when he saw the patient in follow up less than two weeks later on January 28, 2014.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

141. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he engaged in repeated negligent acts in the care and treatment of patients. The circumstances are as follows:

Patient 1

142. The facts and circumstances alleged in paragraphs 14 through 31 above are incorporated here as if fully set forth.

143. During the whole course of Respondent's care and treatment of Patient 1, Respondent was negligent when he failed to maintain adequate and accurate medical records.

144. During the whole course of Respondent's care and treatment of Patient 1, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

145. During the whole course of Respondent's care and treatment of Patient 1, Respondent was negligent when he failed to adequately evaluate the patient's weight loss, which could have been the presenting symptoms of a serious underlying condition such as malignancy or infection or could have been the result of inadequate nutritional intake.

146. Between on or about May 6, 2014, and March 17, 2016, and thereafter, Respondent, with respect to Patient 1, was negligent when he repeatedly failed to address and evaluate anemia in an elderly patient who was also losing weight.

147. Between on or about January 18, 2016, and March 17, 2016, Respondent, with respect to Patient 1, was negligent when he failed to adequately evaluate tachycardia in a patient with serious underlying medical problems such as coronary artery disease.

148. Between on or about May 5, 2014, and January 18, 2016, and thereafter, Respondent, with respect to Patient 1, was negligent when repeatedly failing to address low blood pressure in a

patient with heart disease who was on blood pressure medication that could have been causing the low blood pressure.

149. On or about September 7, 2016, Respondent, with respect to Patient 1, was negligent when he provided an attestation of terminal illness for a patient without convincing evidence of the identified terminal illness and in contradiction to information available in the medical record.

Patient 2

150. The facts and circumstances alleged in paragraphs 32 through 54 above are incorporated here as if fully set forth.

151. During the whole course of Respondent's care and treatment of Patient 2, Respondent was grossly negligent when he failed to maintain adequate and accurate medical records.

152. During the whole course of Respondent's care and treatment of Patient 2, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

153. Between on or about May 6, 2014, and January 12, 2015, and thereafter, Respondent, with respect to Patient 2, was negligent when he repeatedly failed to address and evaluate anemia, which can be a sign of a serious underlying medical problem such as a cancer or bone marrow disorder.

154. On or about August 21, 2017, Respondent, with respect to Patient 2, was negligent when he made a diagnosis of dementia without performing an appropriate evaluation.

155. On or about August 21, 2017, and thereafter, Respondent, with respect to Patient 2, was negligent when he failed to make a report of his dementia diagnosis to the Department of Motor Vehicles as required by law.

156. On or about August 21, 2017, and thereafter, Respondent, with respect to Patient 2, was negligent when he failed to adequately evaluate symptoms of an extremely elevated blood pressure, did not follow up an extremely elevated blood pressure in a timely manner, and did not even recheck a dangerously high blood pressure on a subsequent visit.

157. During the whole course of Respondent's care and treatment of Patient 2, Respondent was negligent when he failed to appropriately manage a patient with diabetes by screening for complications of diabetes.

Patient 3

158. The facts and circumstances alleged in paragraphs 55 through 74 above are incorporated here as if fully set forth.

159. During the whole course of Respondent's care and treatment of Patient 3, Respondent was negligent when he failed to maintain adequate and accurate medical records.

160. During the whole course of Respondent's care and treatment of Patient 3, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

161. During the whole course of Respondent's care and treatment of Patient 3, Respondent was negligent when he prescribed multiple benzodiazepines at the same time without maintaining adequate documentation in the medical record.

162. On or about April 22, 2014, and thereafter, and on or about February 16, 2015, and thereafter, in the care and treatment of Patient 3, Respondent was negligent when he increased the dose of a benzodiazepine without any documentation of the rationale for doing so.

163. On or about June 7, 2016, Respondent was negligent when he failed to adequately evaluating Patient 3's complaint of back pain.

Patient 4

164. The facts and circumstances alleged in paragraphs 75 through 92 above are incorporated here as if fully set forth.

165. Between on or about May 21, 2012, and May 16, 2018, in the care and treatment of Patient 4, Respondent was negligent when he failed to maintain adequate and accurate medical records.

166. Between on or about June 13, 2013, and May 11, 2016, in the care and treatment of

Patient 3, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

167. On or about February 5, 2016, and March 4, 2016, and thereafter, in the care and treatment of Patient 3, Respondent was negligent when he failed to properly evaluate abnormal liver function tests.

168. Between on or about May 21, 2012, and May 16, 2018, in the care and treatment of Patient 4, Respondent was negligent when he failed to maintain adequate and accurate medical records.

169. Between on or about June 13, 2013, and May 11, 2016, in the care and treatment of Patient 3, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

170. Between at least on or about May 21, 2012, and May 16, 2018, in the care and treatment of Patient 4, Respondent was negligent when he repeatedly failed to appropriately monitor the patient's dose of thyroid hormone over a period of many years, exposing her to the health risks of not being on the appropriate dose of medication.

Patient 5

171. The facts and circumstances alleged in paragraphs 93 through 114 above are incorporated here as if fully set forth.

172. Between at least May 3, 2012, and September 17, 2018, in the care and treatment of Patient 5, Respondent was negligent when he failed to maintain adequate and accurate medical records.

173. Between at least June 13, 2013, to June 2, 2016, in the care and treatment of Patient 5, Respondent was negligent when (1) he prescribed large amounts of controlled substances over an extended period of time without an appropriate history, physical examination, workup, and

documentation in the medical record, and (2) failed to attempt to minimize the possibility of drug abuse or diversion.

174. Between on or about November 25, 2014, and October 1, 2015, in the care and treatment of Patient 5, Respondent was negligent (1) when he failed to adequately evaluate depressive symptoms, (2) failed to order laboratory studies to evaluate for other medical causes of depressive symptoms, (3) for inappropriately treating depressive symptoms with high doses of multiple benzodiazepines, and (4) for continuing to refill these benzodiazepines without following up on the patient's symptoms and response to treatment.

175. On or about November 25, 2014, and thereafter, in the care and treatment of Patient 5, Respondent was negligent for prescribing multiple benzodiazepines to a patient at the same time without maintaining adequate documentation in the medical record, without seeing the patient at regular intervals, and without evaluating the patient's response to therapy.

176. On or about December 2, 2013, and thereafter, in the care and treatment of Patient 5, Respondent was negligent for (1) prescribing Ritalin and Adderall without a medical indication for doing so; (2) not establishing a diagnosis of attention-deficit hyperactivity disorder or narcolepsy; and (3) not documenting that he had considered side effects such as worsening of the patient's anxiety and the impact of these medications on his elevated blood pressure.

177. On or about December 2, 2013, and thereafter, in the care and treatment of Patient 5, Respondent was negligent for not adequately evaluating hypertension in a patient who was having headaches and for starting and continuing to prescribe Adderall at the same time, which can increase blood pressure.

178. On or about January 16, 2014, in the care and treatment of Patient 5, Respondent was negligent for failing to obtain a history; obtain a review of systems; perform an appropriate examination; or address the potential causes of a patient's headache, especially in the setting of elevated blood pressure; and for failing to document any assessment of this headache when he saw the patient in follow up less than two weeks later on January 28, 2014.

179. Between on or about May 3, 2012, to September 17, 2018, in the care and treatment of Patient 5, Respondent was negligent for failing to appropriately manage a patient with diabetes

by screening for complications of diabetes.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

180. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records of the medical services he provided to patients. The circumstances are as follows:

181. The facts and circumstances alleged in paragraphs 14 through 114 above are incorporated here as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without a Good Faith Exam)

182. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2242 of the Code in that he prescribed, dispensed, or furnished dangerous drugs as defined in Section 4022 of the Code without an appropriate prior examination and a medical indication. The circumstances are as follows:

183. The facts and circumstances alleged in paragraphs 14 through 114 above are incorporated here as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

184. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 725 of the Code in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment. The circumstances are as follows:

185. The facts and circumstances alleged in paragraphs 14 through 114 above are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Incompetence)

186. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2234, subdivision (d), of the Code in that he was incompetent in the care and treatment of all five patients referenced above. The circumstances are as follows:

187. The facts and circumstances alleged in paragraphs 13 through 185 above are incorporated here as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

188. Respondent Edgar Corrales Banez, M.D. is subject to disciplinary action under section 2234 in that he engaged in general unprofessional conduct. The circumstances are as follows:

189. The facts and circumstances alleged in paragraphs 13 through 187 above are incorporated here as if fully set forth.

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 A 52430, issued to Edgar Corrales Banez, M.D.;

2. Revoking, suspending or denying approval of Edgar Corrales Banez, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Edgar Corrales Banez, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: April 4, 2019

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

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