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

In the Matter of the Accusation Against: Mark Stephen Wagner, M.D. Physician's and Surgeon's Certificate No. G 42267 Respondent.	Case No. 800-2017-030868

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 November 13, 2020.

IT IS SO ORDERED: October 14, 2020.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

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Attorney General of California
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARK STEPHEN WAGNER, M.D. 515 Cabrillo Park Drive, Suite 120 Santa Ana, California 92701-5016 Physician's and Surgeon's Certificate No. G 42267, Respondent.	Case No. 800-2017-030868 OAH No. 2020040153 **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. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Mark Stephen Wagner, M.D. ("Respondent") is represented in this proceeding by attorney William A. Elliott, whose address is 13522 Newport Avenue, Suite 201, Tustin, California 92780.

3. On or about July 1, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42267 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-030868, and will expire on April 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030868 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 March 13, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-030868 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030868. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-030868, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-030868, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G 42267 to disciplinary action.

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

CONTINGENCY

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

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-030868 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 42267 issued to Respondent MARK STEPHEN WAGNER, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions:

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

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

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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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

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

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

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (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.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations ("CCR") 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 Continuing Medical Education ("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 fifteen (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.

5. MONITORING - PRACTICE. Within thirty (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(s) and Accusation(s), and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands

the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within sixty (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.

If Respondent fails to obtain approval of a monitor within sixty (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, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (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 fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (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.

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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.

6. 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 fifteen (15) calendar days.

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

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

8. 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 ten (10) calendar days after the end of the preceding quarter.

9. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such

addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

10. 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.

11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (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 forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in

an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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

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

Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (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.

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

16. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-030868 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

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ACCEPTANCE

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

DATED: 7/30/20

MARK STEPHEN WAGNER, M.D.
Respondent

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

DATED: 7/30/2020

WILLIAM A. ELLIOTT
Attorney for Respondent

ENDORSEMENT

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

DATED: 8/3/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030868

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

In the Matter of the Accusation Against: MARK STEPHEN WAGNER, M.D. 515 Cabrillo Park Drive, Suite 120 Santa Ana, California, 92701-5016 Physician's and Surgeon's Certificate No. G 42267, Respondent.	Case No. 800-2017-030868 **ACCUSATION**

PARTIES

1. Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about July 1, 1980, the Medical Board issued Physician's and Surgeon's Certificate Number G 42267 to Mark Stephen Wagner, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2022, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California 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.

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

6. 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 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.

7. Section 2242 of the Code states:

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

unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

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

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of 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.

8. 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.

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.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

10. Code section 4021 states:

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

11. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

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

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

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

FACTUAL ALLEGATIONS

12. Respondent is the owner and director of OC Comprehensive Care, an outpatient clinic in Santa Ana. From November 9, 2011 through July 21, 2018, Patient 1[1] received care and treatment from Respondent and his staff at OC Comprehensive Care for post-traumatic stress

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[1] For privacy purposes, the patient in this Accusation is referred to as Patient 1.

disorder ("PTSD") and panic disorder. Patient 1 developed a dependence upon benzodiazepines during his care and treatment at Respondent's clinic.

13. Patient 1 initially presented to Respondent's clinic on November 11, 2011, at which time he was seen by Dr. T.P. and diagnosed with PTSD and anxiety. Patient 1 received a medical cannabis certificate.[2] Dr. T.P. prescribed 90 tablets of Xanax,[3] 1 mg, with instructions to take one tablet three times a day. Dr. T.P. next saw Patient 1 on December 7, 2011, at which time he prescribed 120 tablets of Xanax, 1 mg, with instructions for Patient 1 to take one tablet three times a day.

14. Respondent first saw Patient 1 on January 5, 2012, at which time Respondent noted that Patient 1's chief complaints were anxiety, PTSD and panic disorder. Respondent documented that Patient 1 reported having less frequent and less severe panic attacks with the attacks occurring about two times a day rather than three times a day. On a "Physical Finding/s" template, Respondent checked off that the patient's examination was within normal limits in all respects. No other assessment was noted. Respondent's impression was PTSD and panic disorder. Respondent prescribed 150 tablets of Xanax, 1 mg, with instructions for Patient 1 to take five tablets daily, twice a day and one additional tablet as needed for breakthrough panic. Respondent instructed the patient to return in one month.

15. Patient 1 returned to Respondent's clinic on February 4, 2012, at which time Respondent noted that Patient 1's chief complaint was anxiety. Respondent documented that Patient 1 reported that he experienced a couple panic attacks daily which would last about 15 minutes, that the medication was helpful and that he preferred taking two tablets three times a day. Respondent prescribed 180 tablets of Xanax, 1 mg, with instructions for Patient 1 to take two tablets three times a day.

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[2] Patient 1 received medical cannabis certificates for the following time periods during his care and treatment at Respondent's clinic: November 9, 2011 through November 8, 2012; January 11, 2014 through January 10, 2015; February 10, 2015 through February 9, 2016; and September 16, 2016 through September 16, 2017.

[3] Xanax, the brand name for alprazolam, is a Schedule IV Controlled Substance and a dangerous drug.

16. For the next 10 months, Patient 1 was seen monthly at Respondent's clinic by Respondent or his staff. At each monthly visit, Patient 1 was prescribed 180 tablets of Xanax, 1 mg, with instructions to take two tablets three times a day. After the March 2, 2012 visit, PTSD was dropped as a diagnosis, without explanation. Thereafter, the health care providers, including Respondent noted an impression of "anxiety" and occasionally, the additional impression of "panic disorder". Other than checking off boxes on a "Physical Findings/s" templates, no other physical assessments or evaluations for that 10-month time period were charted. Patient history taking was likewise limited to checking off boxes. Other than one notation by Respondent on April 2, 2012, that he "re-advised patient regarding tolerance, dependence, and withdrawal symptoms," there was no documentation of obtaining informed consent regarding the risks of taking Xanax.[4]

17. On January 23, 2013, Patient 1 was seen at Respondent's clinic by staff physician, Dr. A.P. At that time, Dr. A.P. noted that the patient's chief complaint was anxiety, that the anxiety was stable as expected and that the patient had no side effects or new complaints. Dr. A.P. noted that the patient had no panic attacks and that his anxiety was well controlled. Dr. A.P.'s impression was anxiety. He prescribed 180 tablets of Xanax, 1 mg, with instructions for Patient 1 to take two tablets three times a day. In addition, he prescribed 30 tablets of Lexapro,[5] 10 mg, with instructions for Patient 1 to take once a day. There was no documentation setting forth the reason for prescribing Lexapro and no documentation of any discussion of the risks and benefits associated with taking Lexapro. Patient 1 was also instructed to return to the clinic in one month.

18. On February 22, 2013, Patient 1 was seen by Respondent at which time the patient reported that the Lexapro was not effective and that Xanax works better. Respondent's impression was anxiety/panic disorder. He prescribed 180 tablets of Xanax, 1 mg, two tablets to

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[4] Only on July 27, 2012 and August 29, 2012, Patient 1 executed a document entitled Controlled Substance Informed Consent Form. These two forms do not document the risks associated with taking controlled substances.

[5] Lexapro is a selective serotonin reuptake inhibitor (SSRI). It is used as a treatment for major depressive disorder.

be taken three times a day and 30 tablets of Lexapro, 10 mg, to be taken once a day. The patient was instructed to return in a month.

19. For the remainder of 2013 through April 4, 2014, Patient 1 was seen monthly at Respondent's clinic by Respondent or his staff for a chief complaint of anxiety. At each monthly visit, Patient 1 was prescribed 180 tablets of Xanax, 1 mg, two tablets to be taken three times a day and 30 tablets of Lexapro, 10 mg, to be taken once a day. For each visit, the physical examination documentation consisted of checking off boxes on "Physical Finding/s" templates and the health care provider's impression was always "anxiety" with the occasional additional impression of panic disorder. There was no documentation of any discussions with Patient 1 regarding the risks of taking Xanax and Lexapro.

20. On May 2, 2014, Patient 1 was seen at Respondent's clinic by Dr. A.P. The patient's chief complaint was anxiety follow-up. Dr. A.P. noted that the patient felt that his anxiety was better controlled when he took 20 mg of Lexapro. On a "Physical Finding/s" template, Dr. A.P. checked off that the examination was within normal limits in all respects. No other assessment was noted. Dr. A.P.'s impression was anxiety. Dr. A.P. increased the patient's Lexapro to 30 tablets at 20 mg. Other than the patient's indication that his anxiety was better controlled when he took 20 mg of Lexapro, no further reason or explanation for the increase in dose was noted. Likewise, there was no documentation of any discussions with Patient 1 regarding the risks of increasing the dosage. Dr. A.P. also prescribed 180 tablets of Xanax, 1 mg, to be taken three times a day. The patient was instructed to return in 1 month.

21. Patient 1 returned to Respondent's clinic on May 31, 2014, and was again seen by Dr. A.P. The patient's chief complaint was anxiety follow-up. Dr. A.P. noted that the 20 mg of Lexapro was working well, the patient's anxiety was managed and he had no panic attacks. Dr. A.P. checked off that the patient's physical examination was within normal limits in all respects. No other assessment was noted other than a urine drug test positive for benzodiazepines. Dr. A.P.'s impression was anxiety. He prescribed 30 tablets of Lexapro, 20 mg, and 180 tablets of Xanax, 1 mg, to be taken three times a day. The patient was instructed to return in 1 month.

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22. On June 27, 2014, Patient 1 was seen by Respondent who noted the patient's chief complaint was anxiety follow-up. He further noted that the patient was taking Lexapro 20 mg and it was "working better." Respondent noted that the patient was not undergoing therapy, counseling or group sessions. Respondent checked off that the patient's physical examination was within normal limits. Respondent's impression was anxiety/panic disorder. He prescribed 30 tablets of Lexapro, 20 mg, with two refills, as well as 180 tablets of Xanax, 1 mg, to be taken three times a day. In addition, Respondent noted that he recommended therapy. The patient was instructed to return in 1 month.

23. For the remainder of 2014, Patient 1 continued to present on a monthly basis to Respondent's clinic for medications for his "anxiety/panic disorder." On July 25, 2014, Respondent added an additional diagnosis of depression. Other than when Patient 1 reported that he lost his medications, his panic attacks were documented to be under control.[6] During this timeframe, Patient 1's medical records from the clinic reflected normal examinations, with occasional urine drug testing reflecting that the patient was positive for benzodiazepines. On September 15, 2014, Respondent noted that Patient 1's CURES report reflected that in addition to the Xanax prescribed at Respondent's clinic, Patient 1 was receiving Valium.[7] Respondent further documented that the patient reported that Valium had "no effect." In addition to the monthly prescriptions for Lexapro and Xanax, Respondent added a prescription for 30 tablets of Valium 10 mg, one tablet to be taken at bedtime. The dose and dosage of these medications were adjusted at various visits without documented explanation.

24. Patient 1 continued to present to Respondent's clinic on a monthly basis in 2015 for treatment of his "anxiety/panic disorder." Every month, Patient 1 was noted to have had a normal examination. Lexapro was discontinued in August 2015, at which time Respondent noted that the patient was "not taking or acquiring Lexapro as prescribed." Every month, Patient 1 continued to

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[6] In September and October 2014, Patient 1 reported that he lost his medications and on both occasions, Respondent gave him new prescriptions.

[7] Valium, the brand name for diazepam, is a Schedule IV Controlled Substance, a benzodiazepine, and a dangerous drug.

be prescribed Xanax and Valium, with varying doses and dosages.[8] Respondent recommended grief counseling in August 2015. Respondent noted in October 2015 that grief counseling was to be arranged and in November 2015, that the patient had not yet seen a therapist. Also of significance, at the time of Patient 1's September 21, 2015 visit, Respondent noted that it would be the patient's last visit of receiving 120 tablets each of Xanax and Valium and that the patient must have a psychological support evaluation. Respondent further documented "[p]atient very demanding and I suspect diversion."

25. Patient 1 continued to present to Respondent's clinic on a monthly basis in 2016 for treatment of his "anxiety/panic disorder." In September and October 2016, Patient 1's visits were by video conference and in December 2016, Patient 1's visit was by audio conference. The examinations of Patient 1 were essentially documented to be "normal" with the exception of July 2016 at which time Respondent documented tenderness of the left 5th, 6th and 7th costochondral junctions following an accident the patient had in his garage 2 weeks prior. Three urine drug screens performed in 2016 reflected that the patient was positive for benzodiazepines and opioids. The only visit that the positive opioid was discussed was on November 12, 2016, at which time the patient reported that he had "left-over" Tylenol with Codeine[9] from when he broke his sternum and had taken it because he had an upper respiratory infection with cough that had since resolved. In 2016, Patient 1 was prescribed 120 tablets of Xanax, 2 mg, and 120 tablets of Valium, 10 mg. At the time of Patient 1's October 15, 2016 video conference, Respondent documented that the patient claimed to have no problems at the pharmacy despite the high dose of benzodiazepines. With respect to therapy, the patient reported that he was considering therapy in February 2016. In March 2016, the patient reported that his girlfriend was better than a therapist and in May 2016, the patient reported that he was seeing a church therapist. In June and August 2016, the patient reported that he benefited little from psychological therapy. In June 2016,

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[8] In August 2015, Patient 1 reported that he lost his medications and in response, Respondent gave him a new prescription.

[9] Tylenol with Codeine, the brand name for acetaminophen and codeine, is a Schedule IV Controlled Substance and a dangerous drug.

Patient 1 reported that he tried cannabis but that it was not helpful. Notwithstanding, his medical cannabis certification was renewed for anxiety, panic disorder, headaches and low back pain.

26. On January 7, 2017, Patient 1 was seen by Respondent for anxiety follow-up.[10] At that time, Respondent noted that the patient's anxiety was well controlled with medication and very difficult to wean. There was no indication when, if at all, an attempt to wean occurred. He also noted that the patient reported that therapy was not effective in the past. Respondent documented a normal examination. Respondent's impression was chronic and acute anxiety. Respondent prescribed 120 tablets of Xanax, 2 mg, and 120 tablets of Valium, 10 mg. With respect to his plan, Respondent noted that the patient has been on this therapy for "years" and in the patient's own words, he was "functioning normal" and "productive."

27. Patient 1 was next seen by Respondent on February 4, 2017, with a chief complaint of anxiety follow-up. Respondent noted that the patient claimed that he required "high dose" therapy for persistent anxiety/panic. He further noted that the patient "pleads for meds at all visits." Respondent documented a normal examination and noted that the patient's urine drug test was positive for benzodiazepines, morphine[11] and THC.[12] Respondent's assessment was chronic anxiety/panic disorder and benzodiazepine dependence. He instructed the patient to follow-up with a psychiatrist or psychologist for evaluation. Respondent noted that he will gradually decrease the patient's prescriptions starting with Xanax. Respondent further noted that the patient returned about an hour after his visit with a bottle of Tylenol with Codeine prescribed by Kaiser physician, Dr. B.N. on July 11, 2016, for a sternal fracture.

28. On February 7, 2017, Respondent noted in Patient 1's chart that he spoke with Kaiser psychiatrist, Dr. B.B. who reported that Patient 1 presented to the Kaiser Baldwin Park emergency room with thoughts of overdosing on Xanax/Valium. Dr. B.B. reported that Patient 1 was admitted voluntarily for detoxification and counseling.

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[10] This visit appears to be incorrectly dated in Patient 1's medical records as January 7, 2016.

[11] Morphine is a Schedule II Controlled Substance and a dangerous drug.

[12] THC (tetrahydrocannabinol) is a Schedule I Controlled Substance and is a dangerous drug.

29. On February 7, 2017, Patient 1 was admitted to Kaiser's psychiatric in-patient unit for three days for depression and suicidal ideation. Thereafter, Patient 1 was referred to a Kaiser multidisciplinary intensive outpatient substance abuse and detoxification program overseen by Kaiser physician, Dr. M.K. A benzodiazepine dependence treatment plan was established for Patient 1. He underwent a detoxification and agreed that he would remain benzodiazepine free indefinitely and any emergence of anxiety would be treated with non-benzodiazepines.[13] Over a two-month period from February 7, 2017 to April 10, 2017, Patient 1 successfully completed Valium and Xanax detoxification.

30. Patient 1 returned to Respondent's clinic on May 30, 2017, at which time he was seen by Nurse Practitioner I.B. for anxiety follow-up. He was noted to have had a normal examination. Nurse Practitioner's impression was anxiety. She prescribed 120 tablets of Xanax, 2 mg, and 120 tablets of Valium, 10 mg and noted that the patient stated that he has been taking this medication for two years and denied medication side effects. Patient 1 was instructed to return in 1 month. There was no reference to the patient's recent detoxification.

31. On June 24, 2017, Respondent documented that he had a videoconference with Patient 1 at which time the patient reported that everything was okay. There was a further note that the patient had "paid $408.00 and charged twice for anxiety as per medical director." Again, there was no reference to the patient's recent detoxification.

32. On July 22, 2017, Respondent documented that he had a videoconference with Patient 1 at which time the patient reported that he was stable as expected with medications and worsened without medications. Respondent noted that the patient had chronic anxiety and panic and that the patient admitted abuse and overuse of Valium and Xanax. Respondent documented that the patient was "pleading" and reported that things were good as long as he was medicated. Respondent advised Patient 1 to see a therapist or psychiatrist. He prescribed the patient 60

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[13] It was anticipated by Dr. M.K. that Patient 1 would likely experience reemergence of anxiety in the process of being tapered off benzodiazepines (using long-acting clonazepam to taper Patient 1 off the Valium and Xanax) and that if he experienced anxiety at a level requiring pharmacologic intervention, non-benzodiazepines would be used.

tablets of Xanax, 2 mg, and 60 tablets of Valium, 10 mg. He noted that with the medication reduction, the patient may need to follow-up in 2 weeks.

33. On August 19, 2017, Respondent documented that he had a videoconference with Patient 1. The patient reported that he saw a therapist in July and would see a therapist in Respondent's office on Tuesdays. The patient requested an increase to 90 tablets of Xanax and Valium. Respondent prescribed 60 tablets of Xanax, 2 mg, and 60 tablets of Valium, 10 mg.

34. On September 16, 2017, Respondent documented that he had a videoconference with Patient 1. The patient was noted to be stable as expected and improved. The patient reported that he attended a therapy session. He requested a change in his medication with an increase in Xanax tablets and reduction of Valium. Respondent agreed and prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of Valium, 10 mg. Respondent noted that the patient would be seen in person for the following visit.

35. Patient 1 was seen by Respondent on October 14, 2017 at which time Respondent noted that the patient was doing well and was less anxious with therapy sessions. Respondent documented a normal examination and noted an impression of anxiety/panic disorder. Respondent prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of Valium, 10 mg. Patient 1 was instructed to return in one month.

36. Patient 1 continued to present to Respondent's clinic on a monthly basis for treatment of his "anxiety/panic disorder" and was prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of Valium, 10 mg from November 2017 through May 2018. It was noted that Patient 1 participated in therapy at Respondent's clinic. Urine drug screen performed on November 11, 2017 and March 3, 2018 were positive for benzodiazepines and opioids. Patient 1 reported taking left over Tylenol with Codeine on both occasions. On March 21, 2018, Respondent noted that he "discussed issues of patient safety with patient."

37. On June 28, 2018, Patient 1 was seen by Respondent in follow-up for anxiety. Patient 1 reported that his chest felt like it was collapsing and his anxiety felt awful when he wakes up but that it would be better within 10 minutes of taking Xanax 2 mg. The patient reported that he also took Xanax at around 11:00 a.m. to 1:00 p.m. and around 5:00 p.m. to 6:00 p.m. and took

Valium at bedtime. Respondent documented that Patient 1 stated that he was not supplementing with other drugs and he denied selling drugs in the past. Respondent also documented that Patient 1 admitted to taking left over Tylenol with Codeine. Patient 1 reported that he stopped attending group meetings because he moved. Respondent's impression was anxiety and panic disorder. Respondent documented that Patient 1 inquired as to clonazepam/Klonopin[14] after a review on YouTube. Respondent prescribed 90 tablets of Xanax, 2 mg, and 30 tablets of clonazepam 1 mg. Patient 1 was instructed to follow-up in 1-2 weeks for a response to clonazepam. Patient 1 was also instructed to participate in group therapy and was advised to avoid narcotics, muscle relaxers and other sedating drugs.

38. A telephonic follow-up with Patient 1 took place on July 5, 2018, at which time the patient stated that the clonazepam was more effective than Xanax. That same day, Patient 1 was seen by Respondent for his anxiety/panic disorder. Respondent documented that the patient stated that clonazepam 1 mg did not give the same effect as Valium 10 mg when substituted while continuing Xanax 2 mg three times a day. He tried clonazepam 2 mg three times a day without Valium and did well. He also reported that he was not in therapy but had seen a psychiatrist in Norwalk two times in the past. Respondent encouraged the patient to participate in group therapy and see the psychiatrist in Norwalk or find a new one if the psychiatrist in Norwalk is no longer available. Respondent noted that he planned to contact the patient's prior psychiatrist to discuss Patient 1's case. Respondent prescribed 90 tablets of clonazepam, 1 mg, and instructed the patient to take one to two tablets, maximum, three times a day but to try to take only one tablet three times a day.

39. Patient 1 was last seen by Respondent for anxiety follow-up on July 21, 2018. At that time, Respondent documented that the patient reported taking two tablets of Xanax, 2 mg and 4 tablets of clonazepam, 1 mg, daily. The patient stated that he had no chest pain, palpitations, shortness of breath, lightheadedness, syncope, psychosis, suicidal thoughts, headaches, nausea, or vomiting and was not drinking alcohol. Respondent noted a normal examination and his

[14] Klonopin, the brand name for clonazepam, is a Schedule IV Controlled Substance, a benzodiazepine, and a dangerous drug.

impression was anxiety and panic disorder. Respondent prescribed 60 tablets of Xanax, 2 mg, and 120 tablets of clonazepam, 1 mg. He instructed the patient to return in a month and to bring his medication bottles in for a pill count.

STANDARD OF CARE

40. When prescribing benzodiazepines, the standard of care requires that the physician take a complete patient history, including the nature and extent of symptoms over time and document the history in the patient's medical records.

41. When prescribing benzodiazepines, the standard of care requires that the physician perform a mental status examination and document the findings of the mental status examination in the patient's medical records. A mental status examination includes a description of the patient's affect; speech pattern; thought organization; the presence or absence of symptoms of depression; the presence or absence of psychotic symptoms; the presence or absence of cognitive deficits; and the presence or absence of suicidal or homicidal ideation.

42. When a physician diagnoses a patient with a psychiatric diagnosis, such as PTSD or panic disorder, the standard of care requires that there be a sufficient history to justify a diagnosis. When a chronic psychiatric disorder is no longer a working diagnosis, the physician must document the reasoning as to why the diagnosis has been dropped, especially when the same pharmacologic treatment is continued. When amending a diagnosis and making a diagnosis of depression, the standard of care requires that the physician take a detailed history to support the diagnosis and document the findings in the patient's medical records.

43. When a physician provides care and treatment for diagnoses of PTSD, anxiety disorder and panic disorder, the standard of care requires the physician perform a physical examination and order of routine laboratory studies, including a complete blood count, chemical pain and thyroid function tests.

44. When a physician prescribes medications to a patient, the standard of care requires that the physician obtain informed consent and document the assessment of the indications, benefits, risks alternatives (and offer of alternatives), adverse effects, effectiveness, and/or precautions regarding safe prescribing of medications.

45. When prescribing benzodiazepines, the standard of care requires that the physician obtain informed consent and document that informed consent was obtained. Informed consent for benzodiazepines includes but is not limited to (1) the risk of dependence and tolerance; (2) the risk of withdrawal, including the potential for worsening anxiety, panic attacks, life-threatening seizures and delirium; (3) risk of sedation, including an increased risk for motor vehicle accidents; (4) risk of cognitive impairment; (5) increased risk for falls; and (5) risk of respiratory depression if combined with alcohol or opioids.

46. When prescribing benzodiazepines, the standard of care requires that the physician attempt to stabilize the patient on a single benzodiazepine and document the rationale should the physician prescribe two benzodiazepines to be used concurrently.

47. When the dose or dosage of benzodiazepines is changed, the standard of care requires that the physician clearly document the rationale for the change in the patient's medical records.

48. When treating PTSD and/or panic disorder, the standard of care is to prescribe a trial of an SSRI and try to keep treatment with benzodiazepines to a minimum. When the patient has a positive response to an SSRI, the standard of care requires that the physician attempt to decrease the dose of benzodiazepine to determine if the patient can be managed on a lower benzodiazepine dose with the ultimate goal to taper the patient off benzodiazepines all together. When the trial of an SSRI is complete, the standard of care requires that the physician document the reasoning for continuing or discontinuing it.

49. When a physician suspects that a patient is abusing, is dependent on, and/or is diverting drugs with a high abuse potential, the standard of care requires that the prescribing physician refer the patient to a psychiatrist or substance abuse-treatment program for an evaluation and treatment.

50. When a patient is in need of a psychiatric evaluation refuses to obtain one, the standard of care requires that the physician treating the patient require that the psychiatric evaluation be a condition of treatment rather than merely recommending one and accepting the patient's refusal to undergo one.

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51. When a physician prescribes benzodiazepines to a patient for treatment of a psychiatric disorder such as PTSD or panic disorder, the standard of care requires that the physician request the patient's past medical and psychiatric records. Further, when a patient is admitted to a hospital and receives treatment for a chemical dependence, the standard of care requires that the patient's physician obtain a copy of those records.

52. When a physician resumes the prescribing of benzodiazepines to a patient following the patient's detoxification and treatment for substance abuse, the standard of care requires that the prescribing physician confer with the patient's treating substance abuse physician.

53. The standard of care requires that a physician maintain accurate and adequate medical records that clearly reflect the patient's history, physical examination, assessment and treatment plan. When medications are prescribed, the method of filling the prescriptions (i.e., dispensed at the clinic versus filled at a pharmacy) should be clearly denoted.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

54. Respondent is subject to disciplinary action under Code Section 2234, subdivision (b), in that he engaged in gross negligence in his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 53, above, as though fully set forth herein. The circumstances are as follows:

55. Respondent failed to take a complete patient history of Patient 1 prior to and during the 6 ½ year period of Respondent prescribing benzodiazepines to Patient 1 and document the same.

56. Respondent failed to perform and document a mental status examination of Patient 1 prior to and during the 6 ½ year period of Respondent prescribing benzodiazepines to Patient 1, other than a limited checklist review of systems.

57. Respondent failed to obtain a sufficient history to justify a diagnosis of PTSD in Patient 1 with no documentation in his initial patient encounters as to the causes of Patient 1's purported PTSD. Without explanation, after March 2, 2012, PTSD was no longer referenced in Patient 1's medical records at Respondent's clinic, despite Patient 1's continued monthly

medication regimen. On July 25, 2014, Respondent, without explanation, noted an additional diagnosis of depression; however, there was no change in the patient's medication regime and no additional treatment recommendations made.

58. Respondent failed to perform complete and thorough physical examinations and failed to order routine laboratory studies during Patient 1's care and treatment at Respondent's clinic.

59. Respondent failed to obtain informed consent before prescribing Xanax, Valium and Klonopin to Patient 1. Respondent's notation on April 2, 2012 that he "re-advised patient regarding tolerance, dependence, and withdrawal symptoms" was insufficient to fully inform Patient 1 of the risks associated with taking Xanax.

60. Respondent failed to attempt to stabilize Patient 1 on a single benzodiazepine and inappropriately began prescribing two benzodiazepines concurrently without documenting the rationale for prescribing two benzodiazepines concurrently.

61. Respondent inappropriately changed the doses and dosages of Patient 1's Xanax and Valium during the course of Patient 1's care and treatment at Respondent's clinic without documenting the rational for the changes in Patient 1's medical records.

62. Respondent failed to obtain and document informed consent for the SSRI trial of Lexapro prescribed to Patient 1 from January 23, 2013 through August 2015.

63. Respondent attempted an SSRI trial of Lexapro with Patient 1 from January 23, 2013 through August 2015 without any attempt to decrease and taper Patient 1's Xanax use. Other than noting that Patient 1 was "not taking or acquiring Lexapro as prescribed," Respondent failed to document the rationale for discontinuing Lexapro and prescribing two benzodiazepines, Xanax and Valium. Further, there was no documentation as to why the trial of SSRI was not initiated sooner than January 23, 2013.

64. Respondent failed to refer the patient to a psychiatrist or substance abuse treatment program when he suspected that Patient 1 was diverting medications and when he suspected that Patient 1 was dependent on the medications that Respondent was prescribing

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65. Respondent failed to require that a psychiatric evaluation be a condition of Patient 1's treatment despite "recommending" that the patient see a psychiatrist or therapist.

66. Respondent failed to request Patient 1's past medical and psychiatric records during his care and treatment of Patient 1. Despite being aware that Patient 1 underwent care and treatment for his dependence on the benzodiazepines that Respondent prescribed, he failed to obtain the hospital records relating to the treatment of Patient 1's dependence on benzodiazepines.

67. Respondent resumed prescribing benzodiazepines to Patient 1 following Patient 1's detoxification and treatment for dependence on benzodiazepines without conferring with Patient 1's treating substance abuse physician.

68. Respondent failed to maintain accurate and medical records clearly reflecting Patient 1's history, physical examination, assessment and treatment plan. Respondent further failed to document the occasions he dispensed medications to Patient 1 at his clinic versus prescribing medications to Patient 1 to be filled a pharmacy.

69. Respondent's acts and/or omissions as set forth in paragraphs 12 through 68, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

70. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 69, above, as though fully set forth herein.

71. Respondent's acts and/or omissions as set forth in paragraphs 12 through 70, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs Without Examination)

72. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patient 1 without an appropriate prior examination or medical indication therefor. Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 69, above, as though fully set forth herein.

73. Respondent's acts and/or omissions as set forth in paragraphs 12 through 69, above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to section 2242, subdivision (a), of the Code. Therefore cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

74. Respondent is subject to disciplinary action under Code section 725, in that he excessively prescribed dangerous drugs to Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 69, above, as though fully set forth herein.

75. Respondent's acts and/or omissions as set forth in paragraphs 12 through 69, above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to section 725. Therefore cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

76. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of Patient 1. Complainant refers to and, by this reference, incorporates herein, paragraphs 12 through 42, 44 through 48, 53, 55 through 57, 59 through 63, and 68, above, as though fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 42267, issued to Mark Stephen Wagner, M.D.;

2. Revoking, suspending or denying approval of Mark Stephen Wagner, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mark Stephen Wagner, 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: MAR 13 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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