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

In the Matter of the Accusation Against: Steven Arnold Tenenbaum, M.D. Physician's and Surgeon's Certificate No. A 73555 Respondent.	Case No. 800-2017-030830

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 March 18, 2021.

IT IS SO ORDERED: February 16, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEVEN ARNOLD TENENBAUM, M.D.** **1000 Newbury Road, # 210** **Thousand Oaks, CA 91320** **Physician's and Surgeon's Certificate No. A 73555,** Respondent.	Case No. 800-2017-030830 OAH No. 2020070864 **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 Edward Kim, Deputy Attorney General.

2. Respondent Steven Arnold Tenenbaum, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., whose address is: 355 South Grand Avenue, Suite 1750, Los Angeles, CA 90071-1562.

3. On or about November 30, 2000, the Board issued Physician's and Surgeon's Certificate No. A 73555 to 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. 800-2017-030830, and will expire on July 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030830 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 February 20, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-030830 is attached hereto 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. 800-2017-030830. 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. 800-2017-030830, 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 contained in Accusation

No. 800-2017-030830 (except as to any allegation that Patient A suffered any harm as a result of the prescribing of any drugs by Respondent) and Respondent gives up his right to contest those charges and has subjected his license 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. 800-2017-030830 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, provided that such admission shall not include any admission that Patient A suffered any harm as a result of the prescribing of any drugs by Respondent.

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.

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 the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 73555 issued to Respondent STEVEN ARNOLD TENENBAUM, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

1. 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.

2. 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 educational program(s) or course(s) which shall not be less than 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 40 hours were in satisfaction of this condition.

3. 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 Continuing Medical Education (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.

4. 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 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 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. 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 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 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.

6. MONITORING – PRACTICE (PEP). Within 30 calendar days of the effective date of this Decision, Respondent shall participate in a professional enhancement program (PEP) 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's participation in an approved PEP shall serve as practice monitoring hereunder. Respondent shall provide to the Board or its designee the name and qualifications of a PEP monitor(s) for approval. The PEP's practice monitor(s) to be approved by the Board or its designee shall be licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. Each PEP practice 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/participation costs during the term of probation. Respondent shall participate in PEP monitoring during the term of probation, or until the Board or its designee determines that further participation and/or monitoring is no longer necessary.

The Board or its designee shall provide the approved PEP monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the PEP 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 PEP monitor disagrees with the proposed monitoring plan, the PEP 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 PEP 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 PEP 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 PEP monitor is approved to provide monitoring responsibility.

The PEP monitor(s) 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 PEP 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 PEP 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.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the 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.

8. 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.

9. 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.

10. 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 30 calendar days prior to the dates of departure and return.

11. 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.

12. 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 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 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.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, 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.

14. 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.

15. 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 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.

16. 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.

17. 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. 800-2017-030830 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, provided that such admission shall not include any admission that Patient A suffered any harm as a result of the prescribing of any drugs by Respondent.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. 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: 12-30-2020

STEVEN ARNOLD TENENBAUM, M.D.
Respondent

I have read and fully discussed with Respondent Steven Arnold Tenenbaum, 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: 1/2/2020

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

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

DATED: 1-4-21

Respectfully submitted,

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

EDWARD KIM
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030830

XAVIER BECERRA
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Supervising Deputy Attorney General
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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: **STEVEN ARNOLD TENENBAUM, M.D.** **1000 Newbury Road # 210** **Thousand Oaks, CA, CA 91320** **Physician's and Surgeon's Certificate No. A 73555,** Respondent.	Case No. 800-2017-030830 **A C C U S A T I O N**

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 November 30, 2000, the Medical Board issued Physician's and Surgeon's Certificate Number A 73555 to Steven Arnold Tenenbaum, 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 July 31, 2020, 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.

STATUTORY PROVISIONS

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

5. 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 that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that 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.

6. Section 2238 of the Code states:

> A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

7. 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.

8. 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.

9. Section 2242.1 of the Code states:

(a) No person or entity may prescribe, dispense, or furnish, or cause to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices, as defined in Section 4022, on the Internet for delivery to any person in this state, without an appropriate prior examination and medical indication, except as authorized by Section 2242.

(b) Notwithstanding any other provision of law, a violation of this section may subject the person or entity that has committed the violation to either a fine of up to twenty-five thousand dollars ($25,000) per occurrence pursuant to a citation issued by the board or a civil penalty of twenty-five thousand dollars ($25,000) per occurrence.

(c) The Attorney General may bring an action to enforce this section and to collect the fines or civil penalties authorized by subdivision (b).

(d) For notifications made on and after January 1, 2002, the Franchise Tax Board, upon notification by the Attorney General or the board of a final judgment in an action brought under this section, shall subtract the amount of the fine or awarded civil penalties from any tax refunds or lottery winnings due to the person who is a defendant in the action using the offset authority under Section 12419.5 of the Government Code, as delegated by the Controller, and the processes as established by

the Franchise Tax Board for this purpose. That amount shall be forwarded to the board for deposit in the Contingent Fund of the Medical Board of California.

(e) If the person or entity that is the subject of an action brought pursuant to this section is not a resident of this state, a violation of this section shall, if applicable, be reported to the person's or entity's appropriate professional licensing authority.

(f) Nothing in this section shall prohibit the board from commencing a disciplinary action against a physician and surgeon pursuant to Section 2242 or 2525.3.

10. Section 2261 of the Code states:

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

11. Section 2262 of the Code states:

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

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

12. 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.

13. 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.

14. Section 11190 of the Health and Safety Code states:

(a) Every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II shall make a record that, as to the transaction, shows all of the following:

(1) The name and address of the patient.

(2) The date.

(3) The character, including the name and strength, and quantity of controlled substances involved.

(b) The prescriber's record shall show the pathology and purpose for which the controlled substance was administered or prescribed.

(c) (1) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to Section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.

(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(C) NDC (National Drug Code) number of the controlled substance dispensed.

(D) Quantity of the controlled substance dispensed.

(E) ICD-9 (diagnosis code), if available.

(F) Number of refills ordered.

(G) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(H) Date of origin of the prescription.

(2) (A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation.

(B) The reporting requirement in this section shall not apply to the direct administration of a controlled substance to the body of an ultimate user.

(d) This section shall become operative on January 1, 2005.

(e) The reporting requirement in this section for Schedule IV controlled substances shall not apply to any of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

(f) Notwithstanding paragraph (2) of subdivision (c), the reporting requirement of the information required by this section for a Schedule II or Schedule III controlled substance, in a format set by the Department of Justice pursuant to regulation, shall be on a monthly basis for all of the following:

(1) The dispensing of a controlled substance in a quantity limited to an amount adequate to treat the ultimate user involved for 48 hours or less.

(2) The administration or dispensing of a controlled substance in accordance with any other exclusion identified by the United States Health and Human Service Secretary for the National All Schedules Prescription Electronic Reporting Act of 2005.

15. Section 11200 of the Health and Safety Code states:

(a) No person shall dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) No prescription for a Schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

(c) No prescription for a Schedule II substance may be refilled.

16. Section 829, subdivision (a) of Title 21 of the United States Code states, in pertinent part:

. . . No prescription for a controlled substance in schedule II may be refilled.

17. Section 1306.05, subdivision (a) of Title 21 of the Code of Federal Regulations states:

Manner of issuance of prescriptions. (a) All prescriptions for controlled substances shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use, and the name, address and registration number of the practitioner.

DEFINITIONS

18. As used herein, the terms below will have the following meanings:

"Adderall" is the brand name for a drug formulation combining amphetamine and dextroamphetamine. It is generally used to treat attention deficit hyperactivity disorder, but also has a high potential for abuse. It is defined in Health and Safety Code section 11055, subdivision (d)(1) as a Schedule II controlled substance. It is a dangerous drug as defined in Business and Professions Code section 4022.

"Alprazolam" is a benzodiazepine drug used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Alprazolam has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestions of alcohol and other central nervous system depressant drugs during treatment with it. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence. Its usual starting dose of is 0.25 to 0.5 mg three times per day (max 1.5 mg/day). It is also sold under various brand names including, alprazolam Intensol, Xanax, and Xanax XR. It is a schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(1), and a dangerous drug as defined in Business and Professions code section 4022. It is also a Schedule IV controlled substance as defined by the Code of Federal Regulations Title 21, section 1308.14 (c).

"Benzodiazepines" are a class of drugs that produce central nervous system depression. They are used therapeutically to produce sedation, induce sleep, relieve anxiety and muscle spasms, and to prevent seizures. They are most commonly used to treat insomnia and anxiety. There is the potential for dependence on and abuse of benzodiazepines particularly by individuals with a history of multi-substance abuse. Alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), clonazepam (e.g., Klonopin), diazepam (e.g., Valium), and temazepam (e.g., Restoril) are the five most prescribed, as well as the most frequently encountered benzodiazepines on the illicit market. In general, benzodiazepines act as hypnotics in high doses, anxiolytics in moderate doses, and sedatives in low doses.

"CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III and IV controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from all Schedule II, III and IV controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of Schedule II, III and IV drugs. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice.

"Divalproex" sodium is an anticonvulsant mood stabilizer that can be used to treat bipolar disorder and seizures. It can also help prevent migraine headaches. It is sold under the brand name of "Depakote," which is a prescription drug (generic name valproic acid).

"including" means, including, without limitation.

"Klonopin" is a brand name for clonazepam, which is a medication used to prevent and treat seizures, panic disorder, and the movement disorder known as akathisia. Clonazepam is a benzodiazepine-based sedative. It is generally used to control seizures and panic disorder. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug as defined in Business and Professions Code section 4022.

"Tramadol" is a synthetic pain medication used to treat moderate to moderately severe pain. The extended-release or long-acting tablets are used for chronic ongoing pain. Tramadol is sold under various brand names, including, Ultram. It is a Schedule IV controlled substance pursuant to federal Controlled Substances Act, and a dangerous drug pursuant to Business and Professions Code section 4022.

"Seroquel" (quetiapine) is used to treat the symptoms of schizophrenia and bipolar disorder. It is a dangerous drug pursuant to Business and Professions code section 4022.

"Vyvanse" is a brand name for lisdexamfetamine. It is a stimulant used as part of a treatment program to control symptoms of attention deficit hyperactivity disorder (ADHD; more difficulty focusing, controlling actions, and remaining still or quiet than other people who are the same age) in adults and children. It is a psychostimulant prodrug of the phenethylamine and amphetamine chemical classes. It is a dangerous drug as defined in Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

19. The Board received a complaint, that Respondent had inappropriately prescribed controlled substances to Patient A,[1] a middle aged woman with a history of alcohol abuse (with multiple driving under the influence convictions), from a long-time acquaintance of Patient A. According to the complaint, a friend of Patient A brought her to see Respondent and he prescribed Klonopin to her. It further alleged that Patient A would take "2 or 3 of those pills, then 2 or 3 of the Tramadol" and then drink either "Vodka or Wine until she is passed out."

20. On or about October 29, 2019, Respondent was interviewed ("Subject Interview") by an investigator and medical consultant with the Department of Consumer Affairs' Division of Investigation's Health Quality Investigations Unit ("HQIU") on behalf of the Board. During his Subject Interview, Respondent admitted that he does not always document every patient interaction he has into the patient chart. He stated that,

> "Sometimes we're so busy, I don't document. I don't document every interaction with the patient. It's just too much -- too much work, and there's just too much stuff going on. . . . I don't always document everything that's going on in the office. That's a lot of interactions. They'd be also on the way when they ask a question. Okay. Hold on. Go back, document that, and then, they ask another question when they're leaving. Go back and document. That's too -- it can be -- um -- burdensome, because I -- I already need to take care of the next patient."

A majority of Respondent's patient chart notes in this matter were illegible and lacking in content (including, an absence of any or an adequate history, review of systems, physical exam,

[1] The patients are designated by letters to address privacy concerns. The identity of the patients are known to Respondent.

assessment and/or plan).

21. The standard of care applicable to Respondent during his treatment of the patients in this matter required, among other things, that he conduct an adequate evaluation of his patients, including taking a medical history and performing an examination of each patient; establish a diagnosis and medical necessity for any controlled and/or dangerous drugs he prescribed for each patient; and maintain adequate and accurate medical records regarding the medical services he provided to each patient; including documenting the foregoing evaluation, medical history taking and physical examination, and other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rational for change in treatment plans or medications, agreements with the patient and periodic reviews of the treatment plan. Furthermore, Respondent failed to formulate and/or document his rationale for writing prescriptions for dangerous drugs for each of the prescriptions he wrote for his patients. Respondent wrote prescriptions for dangerous drugs, including refills, without corresponding patient visits.

Factual Allegations re Patient A

22. Respondent's records for Patient A for 2016 were very minimal and difficult to read. At his Subject Interview, Respondent alleged that Patient A was referred to him by another patient of his who was a retired Sheriff's deputy. He also stated that she had "mental health issues." He stated that she had a recurring issue with alcohol, and that, "either she's going to drink like crazy, or she's going to take a Klonipin." He stated that he preferred that the patient use a benzodiazepine as opposed to suffering through alcohol withdrawal. He also stated that he believed she was in jail "right now for DUIs." Respondent also read and interpreted his illegible notes and stated that the patient had chronic anxiety.

23. A CURES report generated for the period from on or about March 14, 2014, to on or about March 14, 2017 (2014-17 CURES Report), shows that Respondent prescribed Klonopin (clonazopin) to Patient A from on or about April 28, 2014, to on or about December 15, 2016, on fifteen separate occasions.

24. An information sheet for Patient A included the following data: patient was referred by [Patient X]; under "past medical history," it states, "not too good and not too happy;" under

"family medical history," it states "father – ETOH," "sibling – scisafrenia (sic);[2] under her personal "alcohol history," it states "yes," under "drinks per week," it states "a lot;" under "prescription medications," it stated "depacot (sic) or lithium, colonopin (sic) and Prozac." It also listed the phone numbers for CVS and "Costco Simi." An undated medications list in his medical records referred to clonazepam, 1 mg and divalproex 5000 mb "d/c'd."

25. On or about January 28, 2016, Respondent saw Patient A, a 51-year-old patient. His notes for this visit were very brief and mostly illegible, but he did read and interpret them at his Subject Interview as follows: Under "S,"[3] he wrote that the patient had meds that were stolen by roommate. There was nothing under "O," except for the patient's weight and blood pressure. Under "A," he used abbreviations which he translated to mean, chronic anxiety. And, his notes under "P," were not legible - he interpreted his notes for his plan at his Subject Interview, which included Klonopin, 1 mg, p.o., q8 hour p.r.n. (95) with one refill.

26. On or about June 27, 2016, Respondent saw Patient A, but his chart notes were mostly illegible. He did not include any information under "S" for subjective. At his subject interview, he said that while he did perform an examination, he "didn't document it." Under "P" for plan there appears to be a prescription for two medications. At his Subject Interview, he interpreted his records as "under Assessment -- anxiety." Under Plan, "I wrote Topamax 25 mg, one to four p.o. q.h.s." And further that if "Topamax wasn't going to be helpful, I wrote arrow to

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[2] Possibly schizophrenia?

[3] Presumably, he used these letters to mean, subject, objective, assessment and plan. A SOAP note is an acronym for a method of documentation widely used by healthcare providers.

Subjective. This section documents the patient's "subjective" experiences and information. It includes the chief complaint (CC) or presenting problem and history of present illness reported by the patient. It may include symptoms, conditions, previous diagnoses or other short statement that describes why the patient is presenting. Helpful information also includes, onset, location, duration, characterization, alleviating and aggravating factors and severity of the CC. Relevant history (medical, surgical, family, social, medications, etc.) of the patient should also be discussed. A review of systems (inventory of body systems, i.e., questions arranged by organ system, designed to uncover dysfunction and disease) should be included.

Objective. This section documents the objective data from the patient visit. This includes: vital signs; physical exam findings; laboratory, imaging, or other diagnostic data; and review of records by other clinicians.

Assessment. This section documents the synthesis of "subjective" and "objective" evidence to arrive at a diagnosis. A differential diagnosis may list different possible diagnosis, from most to least likely, and include the practitioner's rationale.

Plan. This section includes the plan for how the doctor will treat the patient's illness after taking into account all subjective and objective information.

Neurontin, because I was going to prescribe her Neurontin in case," and a "Klonopin refill."

27. On or about August 28, 2016, a request for a refill of the Klonopin prescription originally written by Respondent on June 27, 2016, for Patient A (and last filled on August 4, 2016) was made to Respondent and filled on August 29, 2016. There is no corresponding patient visit for this prescription.

28. On or about December 15, 2016, a request for a refill of the Klonopin prescription originally written by Respondent on August 29, 2016, for Patient A (and last filled on November 14, 2016) was made to Respondent, and filled on December 15, 2016. There is no corresponding patient visit for this prescription.

29. A note dated December 20, 2016, by a different provider at Respondent's office in more legible handwriting documented that the patient's friend advised emergency room as needed or patient to call office or to follow up; that the patient was advised to go to an addiction specialist; saw Dr. Thomas five years ago; and there is also mention of going to Tarzana Treatment Center and Simi Valley Drug Center.

30. A note dated December 21, 2016, by a different provider at Respondent's office in more legible handwriting documented that the patient's last drink was last evening; she had three glasses of wine per day; she is scared she will (1) have alcohol withdrawal, (2) have opiate and benzo withdrawal; and in the plan section the following was documented: (1) a prescription for Klonopin 1mg, 1 tablet twice daily, number 60, (2) keep taking Klonopin, go straight to ER or call 911, (3) patient and friend, K. refusing for me to call ER/911 or to go to, (4) they are requesting to go home and call 911 so patient will go to closest facility ER which is Simi Valley, and (5) call office tomorrow with update; and finally in the top right corner of the note it states tramadol, Klonopin, and alcohol.

31. Patient A suffered harm, including, legal interactions, criminal investigations for driving under the influence due to her addiction to alcohol and drugs, including the controlled substances prescribed by Respondent to Patient A. Patient A also suffered emergency room visits, including in Simi Valley several times due to her abuse of alcohol and drugs.

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Factual Allegations re Patient B

32. At his Subject Interview, Respondent stated that he knew Patient B very well because her mother was also a patient of Respondent. He also stated that he spoke to Patient B and her mother frequently about being evaluated by a psychiatrist, but he stated that psychiatrists were "heavy handed" with their anti-dopaminergic[4] (antipsychotic) medications which rendered the patient non-functional.

33. Respondent's chart notes for Patient B were inadequate, mostly illegible and often lacked necessary content (no history, review of systems, physical exam, scant and/or illegible plan). Respondent provided chart notes for his care of Patient B from March 27, 2014 to February 28, 2017, which contained seven chart notes by Respondent and additional chart notes either by other providers or unsigned but dated.

34. On or about June 14, 2014, a nurse practitioner saw Patient B at Respondent's office. The notes were very short and included, "1) Anxiety, 2) Insomnia, 3) Depression Mood Swings," and "Seroquel, 50 mg." The rest of the note was the plan, which stated, "1) Seroquel, 100 mg, p.o.q., 2) alprazolam, 1 mg, 1/2-1 – 11/2 tab, PRN Anxiety #30, 3) RTO in 1 month."

35. On or about March 11, 2015, Respondent saw Patient B, a 20-year-old woman for a follow up appointment. The note appeared to contain the handwriting of two different people. The handwriting of the other person (not Respondent) was legible and stated that Patient B reported interest in changing medications and felt Seroquel was no longer completely effective and that she still experienced mood swings and low energy. There was no documented physical exam (other than weight and blood pressure) and the remainder of the note was in Respondent's largely illegible handwriting (seems to state the patient is experiencing mood swings; was fine, then crying, then anxiety and the diagnosis appears to be bipolar). At his Subject Interview, Respondent was asked to read his handwriting. He stated, "Low energy, hard to wake up in the morning. Feels depressed. Less mood swings. Fine, then crying, then anxiety, then can get manic. Spend money. Xanax -- uh -- takes away the intensity. And I wrote, Assessment --

[4] A dopamine antagonist (anti-dopaminergic) is a type of drug which blocks dopamine receptors by receptor antagonism.

bipolar. And then -- oh, and then, I had asked her some other questions here. But where it said -- uh – didn't read well, and then, I wrote something about putting her on an anti-seizure medicine daily. She didn't try the lithium. And then, I wrote niacin 500, 9 mg, two a day. And then, in her Plan I wrote, Methyl, B12 twice a day, and then I wrote, (inaudible). This is a vitamin. Uh -- can try Adderall when feeling low -- just for the day, and then follow up one month." He also admitted that he failed to document his physical exam of the patient at this visit, but that he usually performed a physical exam at the end of the visit.

36. On or about May 6, 2015, Respondent saw Patient B, but his documentation for that day is mostly illegible. The patient's weight is documented as 110 pounds, but there is no blood pressure or other vital signs taken, but there are several check marks. The assessment appears to state bipolar and contains two additional diagnoses that are illegible. The plan was also illegible. At his Subject Interview, Respondent stated, that this patient had bipolar disease and was extremely complicated. He stated that when she becomes depressed, she would "stay in her room for like a week, and not shower, and be suicidal, and feel miserable." Thus, according to Respondent, controlled substances used in the past could help her "get out of the hole" and become functional. He stated that Patient B could not get out of bed, but acknowledged that he did not document this lack of function by the patient. Respondent further stated at his Subject Interview that he wrote three prescriptions for Adderall at this patient visit on or about May 6, 2015, but stated that he postdated two of those prescriptions by writing June 3, 2015, and July 1, 2015 on the prescriptions. However, the scripts did not contain the address of the patient. Respondent also stated at his Subject Interview that Patient B was "a patient who she cares about her mental health [and that her] parents are extremely involved in her, like, life on a daily basis." Respondent also stated, "where is the medicine going if I'm giving her 30 pills a month?" And, "It's not like, you know, she's taking 150 pills a month, and who takes five Adderall a day?"

37. Respondent's medical records for Patient B included a controlled substance refill request notification, dated June 3, 2015, regarding a prescription (#4439975) written on March 31, 2015 (and last filled on May 4, 2015) for Xanax, 1 mg, 60 pills, and filled for alprazolam, 1 mg, 60 pills. There was no corresponding office visits for this prescription. Respondent's

record failed to show the pathology and purpose for which the controlled substance was administered or prescribed as required by Health and Safety Code section 11190, subdivision (b).

38. On or about September 4, 2015, Respondent saw Patient B, but his documentation for that day is mostly illegible. It did appear to note that Patient B was using Xanax as needed. The physical examination included the patient's weight, blood pressure and heart rate. The assessment appeared to state anxiety, ADD and mood instability. The plan though mostly, illegible, appeared to include B12.

39. Prescriptions for Xanax and Adderall to Patient B were each signed by Respondent and dated September 4, 2015, but did not include the patient's address.

40. On or about December 4, 2015, Respondent saw Patient B, but his documentation for that day is mostly illegible. It did appear to note that Patient was using Xanax and Seroquel. The plan appeared to indicate a prescription for Vyvanse. At his Subject Interview, Respondent admitted to changing Patient B's prescription for Adderall to Vyvanse, however, he did not document his rationale for such change.

41. A prescription for Vyvanse was signed by Respondent and dated December 4, 2015, but did not include the patient's address.

42. On or about January 5, 2016, Respondent saw Patient B, but his documentation for that day is mostly illegible. The note appeared to contain the handwriting of two different people. The handwriting of the other person (not Respondent) was legible. Patient B presented to discuss "nature thyroid dose," B12 injections, laboratory tests, and for wart removal. The physical exam documentation was limited to the Patient's weight and blood pressure. At his subject interview, Respondent explained that his portion of the record stated that he wrote "Vyvanse is "way better than Adderall." He then stated, "why would I increase anyone's dose of Vyvanse from 40 to 50?" Respondent also could not explain his rationale even after reviewing his chart note, which appeared to increase the dose of Vyvanse to 50 mg,[5] although he did state that he had "wiggle room." He translated his last note in the record as, "increased Neurontin to 100 mg, one to three

[5] This corresponded with a prescription by Respondent for Patient B for Vyvanse for 50 mg, dated January 5, 2016, which appeared in his records.

p.o. t.i.d." When asked why he prescribed the Neurontin, Respondent stated that it was for anxiety.

43. A prescriptions for Vyvanse was signed by Respondent and dated January 5, 2016. but did not include the patient's address.

44. On or about March 18, 2016, Respondent saw Patient B, but his documentation for that day is mostly illegible and unsigned. At his Subject Interview, Respondent explained that he wrote, bipolar, anxiety and OCD. The note appeared to indicate that the patient had "run out of Vyvanse," and it appears that Seroquel and Xanax are listed.

45. On or about May 13, 2016, Respondent saw Patient B. The note appeared to contain the handwriting of two different people. The handwriting of the other person (not Respondent) was legible and stated that the chief complaint was a follow up visit, a need for laboratory testing and concerns regarding taking lithium. No physical examination was performed at this visit. The note by Respondent appear to mention Xanax and Seroquel. The notation does not appear to have a subjective section. The plan was completely illegible. The note is also unsigned.

46. A CURES report indicated that Respondent had been prescribing Patient B controlled substances while she was also being prescribed drugs from other providers, during the period from August 25, 2016 through July 8, 2019. A CURES report reflected that Respondent prescribed hundreds of alprazolam 1 mg tablets to Patient B. He also prescribed 90 tablets of phentermine 37.5 mg and 120 tablets of Sandoz (a stimulant weight loss medication). During this period Patient B received opioid prescriptions form other providers as well.

Factual Allegations re Patient C

47. Respondent's notes for this patient were mostly illegible and inadequately lacking in content (e.g., missing any history, review of systems, physical exam, and a scant or illegible plan). Respondent also admitted at his Subject Interview that he allowed his physician assistant to write and post date prescriptions for Adderall for Patient C. He stated that the patient was very responsible and that every three months was "a reasonable thing."

48. A signed prescription for Adderall dated April 18, 2014, does not include an address for the patient, but states that it is to be filled after May 15, 2014. There is no corresponding

patient visit for a May 15, 2014 fill date.

49. A signed prescription for Adderall dated July 31, 2014, does not include an address for the patient. There is no corresponding patient visit for this prescription.

50. Each of three signed prescriptions for Adderall is dated October 23, 2014, and does not include an address for the patient. In addition, two of them also state that they are to be filled after November 18, 2014 and December 13, 2014, respectively. There is no corresponding patient visit for either a November 18, 2014, or a December 13, 2014 fill date.

51. Each of three signed prescriptions for Adderall is dated June 8, 2015, and does not include an address for the patient. In addition, two of them also state that they are to be filled after July 3, 2015 and July 29, 2015, respectively. There is no corresponding patient visit for either a July 3, 2015, or a July 29, 2015 fill date.

52. At his Subject Interview, Respondent was asked if he spoke to his physician assistant regarding the medications prescribed at the patient visit on or about June 8, 2015. Respondent replied, "No, I don't think I saw him during that visit."

53. On or about December 2, 2015, Respondent saw Patient C, and his records are mostly illegible. His subjective chart note is blank. His chart note for this visit failed to include any history, no review of systems or physical exam (except for certain vitals). The assessment section listed ADD and two illegible items (which he stated at his subject interview read, "anxiety and IBS"). His plan stated Adderall 20 mg, 60 tablets and there were two additional illegible items. At his Subject Interview, Respondent stated, he gave Clomid to "bump up" the patient's testosterone. The note also stated at the bottom: Epi-pen x2 and illegible items. At his Subject Interview, Respondent stated, "he must have requested EpiPen," but he did not remember why he prescribed the EpiPen. He further admitted that he did not "usually get into the whole detailed thing of why" he prescribed EpiPen for a patient.

54. On or about February 2, 2016, Respondent saw Patient C. The note appeared to contain the handwriting of two different people. The handwriting of the other person (not Respondent) was legible and the chief complaint section listed this visit as a follow up appointment for prescription refills. The subjective section appeared to discuss Xanax, but was

not legible. Only certain vitals are listed for the physical exam. The note failed to have an assessment for the patient. His plan appeared to list two prescriptions, Adderall, 20 mg, 60 tablets, and what appears to be "Xan."[6]

55. On or about July 19, 2016, Respondent saw Patient C, and the brief notes were mostly illegible. His record for this visit included a subjective note that seemed to state that Adderall was helpful. His physical exam was limited to a weight reading. His assessment was anxiety; his plan included, "Xan;" and the remainder of his note was illegible.

Factual Allegations re Patient D

56. On or about June 27, 2014, Respondent saw Patient D, a 19-year-old woman. The chart note was very brief and illegible and there is no physical exam except for weight and blood pressure. At his Subject Interview, he interpreted his writing, stating that he wrote her weight and blood pressure that her chief complaint was back pain, and that midway through the page, he wrote, L4 over L5 "she had some disc pain when I was 8 pressing," and then that "she has a history of ADD," but that "wasn't diagnosed on this day." He also explained that the note also included a plan including "Pilates, x-ray of L-spine, NuvaRing refill, 16 and then, the Xanax and the Adderall were refills."

57. On or about April 14, 2015, Respondent saw Patient D, however, the chart note is mostly illegible. The physical exam is limited to the patient's weight. He listed fatigue, but failed to provide any details regarding what he meant. His plan including prescribing Adderall with a dosage of 20 mg.

58. On or about May 11, 2015, Respondent saw Patient D, but his chart notes for this visit were also mostly illegible. However, his plan referred to B12.

59. On or about July 29, 2015, Respondent saw Patient D, but his chart notes for this visit were mostly illegible.

60. On or about April 27, 2016, Respondent saw Patient D, but his chart notes for this visit were mostly illegible. His assessment was ADD.

61. A chart note dated February 20, 2017 by another provider, LCL referred to prior

[6] Possibly Xanax.

treatment of Patient D with Vyvanse prescribed by Respondent (initially in or around April, 2016).

62. According to a CURES report, Respondent prescribed the following drugs to Patient D on the following dates: on June 27, 2014, amphetamine 20 mg (60 pills) and alprazolam 1 mg (30 pills); on September 13, 2014, alprazolam 1 mg (30 pills); on December 17, 2014, alprazolam 1 mg (30 pills); on January 2, 2015, alprazolam 1 mg (30 pills); on February 10, 2015, alprazolam 1 mg (30 pills); on April 18, 2015, amphetamine 20 mg (60 pills); and on April 28, 2016 Vyvanse, 70 mg (30 pills).

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

63. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in connection with the care and treatment of Patients A, B, C, and D. The circumstances are as follows: Paragraphs 19 through 62, inclusive, are incorporated herein by reference as if fully set forth. In addition the following grossly negligent acts are alleged:

Patient A.

64. On or about January 1, 2016 and thereafter, Respondent committed the following acts of gross negligence in connection with Patient A:

A. Respondent failed to adequately assess, evaluate, re-assess/re-evaluate, and/or engage the differential diagnosis process and/or establish a medical necessity, and/or document his actions in respect of his treatment of Patient A, in light of her long-term use of controlled substances, including benzodiazepines,[7] and its concomitant potential risks, including the possibility of adverse effects on Patient A's cognitive function, physical health, and mental health (e.g., addiction, dependence, motor impairment and cognitive impairment, impaired motor skills with concern for activities such as driving and the risk of misuse, dependence, addiction and overdose). Respondent's records failed to include a diagnosis of medical necessity. Respondent provided no evidence to support the patient's controlled substances therapy, including Klonopin.

[7] Ten weeks or more of benzodiazepine use is considered long-term use.

He also failed to perform and/or document an adequate medical history taking, physical examination and/or psychological evaluation and/or use screening tools (e.g., PHQ-9,[8] GAD-7[9] or any obvious clinical assessment). He further failed to identify for the patient the potential benefits and risks of prescribing dangerous drugs, including Klonopin. After Patient A initiated her controlled substance therapy, Respondent failed to adequately re-evaluate and re-assess the patient's drug therapy in light of, her progress or lack thereof, toward functional goals (including level of function), the absence or presence (and nature) of, side effects, mental health status (e.g., her behavior and/or or mood), and/or evidence of patient misuse, abuse or diversion.

B. Respondent failed to adequately classify Patient A's risks from long-term use of controlled substances. Respondent failed to undertake any risk assessment of the patient in light of his long term prescribing of controlled substances, and lack of adequate screening. He failed to adequately perform and/or document any risk benefit analysis and/or rationale for prescribing dangerous drugs to Patient A. He also failed to consider the patient's symptoms, diagnosis, alternatives to treatment, goals of treatment and a consideration of the substance abuse history of the patient, as well as other known risk factors including pertinent medical conditions and/or social history and alcohol use

C. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient A. Respondent failed to specify measurable goals and objectives (e.g., addressing associated symptoms such as sleep disturbance and depression/anxiety; avoidance of excessive use of medications; and creating an exit strategy, if applicable) to evaluate the progress of his treatment of Patient A. His documentation failed to address Patient A's progress and were devoid of any discussion of improvement or worsening.

D. Respondent failed to adequately perform and/or document the informed consent process with Patient A. Respondent failed to discuss any potential risks and/or side effects from long-term benzodiazepine use, and/or benefits of his treatment plan with the patient. He failed to

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[8] The PHQ-9 is a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression. It is the 9-question depression scale from the Patient Health Questionnaire

[9] General Anxiety Disorder (GAD-7) is a screening tool for generalized anxiety.

advised Patient A about non-drug therapies such as counseling. He also failed to counsel the patient about safe ways to store and dispose of unused controlled substances or dangerous drugs.

E. Respondent failed to adequately monitor Patient A for compliance regarding the controlled substances she was using. Respondent failed to adequately investigate Patient A's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate).

F. Respondent failed to enter into and/or amend or revise, any controlled substance agreement[10] with Patient A.

G Respondent failed to have adequate and/or accurate medical records. His medical records were useless (i.e., illegible, inadequate). As discussed in footnote 3 above, Respondent's medical records for Patient A should have included more information such as her medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rational for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

H. Respondent prescribed benzodiazepines to Patient A while she chronically consumed alcohol. This combination of substances is contraindicated and created a dangerous risk of harm.

Patient B.

65. On or about March 27, 2014 and thereafter, Respondent committed the following acts of gross negligence in connection with Patient B:

A. Respondent failed to adequately assess, evaluate, re-assess/re-evaluate, and/or engage the differential diagnosis process and/or establish a medical necessity, and/or document his actions in respect of his treatment of Patient B, in light of her long-term use of controlled

[10] This contract should include the doctor's policies and expectations regarding the number and frequency of refills of prescriptions and replacement of lost or stolen medications; specific reasons why drug therapy may be changed or discontinued; the patient's responsibility for safe use; the patient's agreement to share information with family or close contacts about addressing overdose, only obtain the drugs from the contracting doctor, and to undergo drug testing; and the doctor's agreement to have a covering medical professional.

substances, including benzodiazepines, and its concomitant potential risks, including the possibility of adverse effects on Patient B's cognitive function, physical health, and mental health (e.g., addiction, dependence, motor impairment and cognitive impairment, impaired motor skills with concern for activities such as driving and the risk of misuse, dependence, addiction and overdose). Respondent's records failed to include a diagnosis of medical necessity. Respondent provided inadequate evidence to support the patient's controlled substances therapy, including alprazolam. He also failed to perform and/or document an adequate medical history taking, physical examination and/or psychological evaluation and/or use screening tools (e.g., PHQ-9, GAD-7, Mood Disorder Questionnaire, or any obvious clinical assessment). He further failed to identify for the patient, the potential benefits and risks of prescribing dangerous drugs, including alprazolam. Respondent failed to adequately re-evaluate and re-assess the patient's drug therapy in light of, her progress or lack thereof, toward functional goals (including level of function), the absence or presence (and nature) of, side effects, mental health status (e.g., her behavior and/or or mood), and/or evidence of patient misuse, abuse or diversion.

B. Respondent failed to adequately classify Patient B's risks from long-term use of controlled substances. Respondent failed to undertake any risk assessment of the patient in light of his long-term prescribing of controlled substances, and lack of adequate screening. He failed to adequately perform and/or document any risk benefit analysis and/or rationale for prescribing dangerous drugs to Patient B, including alprazolam. He also failed to consider the patient's symptoms, diagnosis, alternatives to treatment, goals of treatment and a consideration of the substance abuse history of the patient, as well as other known risk factors including pertinent medical conditions and/or social history and alcohol use.

C. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient B. Respondent failed to specify measurable goals and objectives (e.g., addressing associated symptoms such as sleep disturbance and depression/anxiety; avoidance of excessive use of medications; and creating an exit strategy, if applicable) to evaluate the progress of his treatment of Patient B. His documentation failed to adequately address Patient B's progress, or lack thereof.

D. Respondent failed to adequately perform and/or document the informed consent process with Patient B. Respondent failed to discuss any potential risks and/or side effects from long-term benzodiazepine use, and/or benefits of his treatment plan with the patient. He failed to advise Patient B about non-drug therapies such as counseling. He also failed to counsel the patient about safe ways to store and dispose of unused controlled substances or dangerous drugs.

E. Respondent failed to adequately monitor Patient B for compliance regarding the controlled substances she was using. Respondent failed to adequately investigate Patient B's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate).

F. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient B.

G Respondent failed to have adequate and/or accurate medical records. His medical records were useless (i.e., illegible, inadequate). As discussed in footnote 3 above, Respondent's medical records for Patient B should have included more information such as her medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rational for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

Patient C.

66. On or about March 1, 2014 and thereafter, Respondent committed the following acts of gross negligence.

A. Respondent failed to adequately classify Patient C's risks from long-term use of controlled substances. Respondent failed to undertake any risk assessment of the patient in light of his long term prescribing of controlled substances, and lack of adequate screening. He failed to adequately perform and/or document any risk benefit analysis and/or rationale for prescribing dangerous drugs to Patient C, including alprazolam. He also failed to consider the patient's symptoms, diagnosis, alternatives to treatment, goals of treatment and a consideration of the substance abuse history of the patient, as well as other known risk factors including pertinent

medical conditions and/or social history and alcohol use.

B. Respondent failed to formulate an adequate treatment plan and/or objectives for Patient C. Respondent failed to specify measurable goals and objectives (e.g., addressing associated symptoms such as sleep disturbance and depression/anxiety; avoidance of excessive use of medications; and creating an exit strategy, if applicable) to evaluate the progress of his treatment of Patient C. His documentation failed to adequately address Patient C's progress, or lack thereof.

C. Respondent failed to adequately perform and/or document the informed consent process with Patient C. Respondent failed to discuss any potential risks and/or side effects from long-term benzodiazepine use, and/or benefits of his treatment plan with the patient. He failed to advise Patient C about non-drug therapies such as counseling. He also failed to counsel the patient about safe ways to store and dispose of unused controlled substances or dangerous drugs.

D. Respondent failed to adequately monitor Patient C for compliance regarding the controlled substances she was using. Respondent failed to adequately investigate Patient C's drug use (e.g., drug testing, review of CURES Reports and/or conducting pill counting, as appropriate).

E. Respondent failed to adequately re-assess/re-evaluate, and/or engage the differential diagnosis process and/or establish a medical necessity, and/or document his actions in respect of his treatment of Patient C, in light of her long-term use of controlled substances, including benzodiazepines, and its concomitant potential risks, including the possibility of adverse effects on Patient C's cognitive function, physical health, and mental health (e.g., addiction, dependence, motor impairment and cognitive impairment, impaired motor skills with concern for activities such as driving and the risk of misuse, dependence, addiction and overdose). Respondent's records failed to include a diagnosis of medical necessity. Respondent provided inadequate evidence to support the patient's controlled substances therapy, including alprazolam. He also failed to perform and/or document an adequate medical history taking, physical examination and/or psychological evaluation and/or use screening tools (e.g., PHQ-9, GAD-7, Mood Disorder Questionnaire, or any obvious clinical assessment). He further failed to

identify for the patient, the potential benefits and risks of prescribing dangerous drugs, including Xanax. Respondent failed to adequately re-evaluate and re-assess the patient's drug therapy in light of, her progress or lack thereof, toward functional goals (including level of function), the absence or presence (and nature) of, side effects, mental health status (e.g., her behavior and/or or mood), and/or evidence of patient misuse, abuse or diversion.

F. Respondent failed to enter into and/or amend or revise, any controlled substance agreement with Patient C.

G Respondent failed to have adequate and/or accurate medical records. His medical records were useless (i.e., illegible, inadequate). As discussed in footnote 3 above, Respondent's medical records for Patient C should have included more information such as her medical history, physical examination, review of systems, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rational for change in treatment plans or medications, agreements with Respondent and Respondent's periodic reviews of the treatment plan.

Patient D.

67. Respondent committed gross negligence when he failed to perform an adequate assessment of Patient D and/or adequately document his interactions with the patient, in connection with each visit of Patient D as discussed above. Respondent's records were illegible inaccurate and/or inadequate.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

69. The allegations of the First Cause for Discipline are incorporated herein by reference as if fully set forth, and represent repeated negligent acts.

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THIRD CAUSE FOR DISCIPLINE

(Record Keeping)

70. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to patients. The circumstances are as follows:

71. The allegations of the First and Second Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing)

72. Respondent is subject to disciplinary action under section 725 of the Code in that Respondent clearly excessively prescribed narcotic medications to patients. The circumstances are as follows:

73. The allegations of the First through Third Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

74. Respondent is subject to disciplinary action under section 2242 of the Code, in that Respondent prescribed drugs to each of the patients above, without appropriate prior examinations and/or medical indications. The circumstances are as follows:

75. The allegations of the First through Fourth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Violation of Drug Statute; Dishonest, Corrupt Acts)

76. Respondent is subject to disciplinary action under section 2238 and 2234, subdivision (e) of the Code and sections 11190 and 11200 of the Health and Safety Code and section 829 of Title 21 of the United States Code, section 1306.05, subdivision (a) of Title 21 of the Code of Federal Regulations in that Respondent failed to issue correct prescriptions and/or make a correct record of his prescriptions to his patients for controlled substances and/or post-dated his

prescriptions and failed to include the actual date of his prescriptions, and this constituted dishonest and/or corrupt acts in an attempt to circumvent the proscriptions against refills of Schedule II controlled substances. The circumstances are as follows:

77. The allegations of the First through Fifth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth.

SEVENTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

78. Respondent is subject to disciplinary action under section 2234 of the Code in that Respondent has engaged in unprofessional conduct, generally. The circumstances are as follows:

79. The allegations of the First through Sixth Causes for Discipline, inclusive, are incorporated herein by reference as if fully set forth, and represent unprofessional conduct.

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 73555, issued to Steven Arnold Tenenbaum, M.D.;

2. Revoking, suspending or denying approval of Steven Arnold Tenenbaum, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Steven Arnold Tenenbaum, 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: FEB 20 2020

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

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