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

In the Matter of the Accusation Against: Frances Dee Filgas, M.D. Physician's and Surgeon's Certificate No. G 42185 Respondent.	Case No.: 800-2018-040641

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 December 16, 2021.

IT IS SO ORDERED: November 16, 2021.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
GREG W. CHAMBERS
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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: **FRANCES DEE FILGAS, M.D.** **8733 Lakewood Dr. Ste. 100** **Windsor CA 95492-8675** **Physician's and Surgeon's Certificate No. G 42185** Respondent.	Case No. 800-2018-040641 OAH No. 2021060566 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

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 Rob Bonta, Attorney General of the State of California, by Greg W. Chambers, Deputy Attorney General.

2. Respondent Frances Dee Filgas, M.D. (Respondent) is represented in this proceeding by attorney Virgil F. Pryor, Esq., whose address is: 220 Montgomery Street, Suite 910, San Francisco, CA 94104-3440

3. On July 1, 1980, the Board issued Physician's and Surgeon's Certificate No. G 42185 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. 800-2018-040641, and will expire on January 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-040641 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 January 22, 2021. Respondent timely filed her Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-040641 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-040641. Respondent has also carefully read, fully discussed with her counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of her 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 her; the right to present evidence and to testify on her 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. 800-2018-040641, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

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

11. Respondent agrees that if she ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2018-040641, a true and correct copy of which is attached hereto as Exhibit A, shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

CONTINGENCY

13. 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 her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

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. G 42185 issued to Respondent FRANCES DEE FILGAS, 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. 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.

2. 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.

3. 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.

4. 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.

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

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

days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

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

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

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

to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

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

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

The monitor(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 monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

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

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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 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.

17. 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.

18. 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. 800-2018-040641 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.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Virgil F. Pryor, Esq. 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: 10/28/21

FRANCES DEE FILGAS, M.D.
Respondent

I have read and fully discussed with Respondent Frances Dee Filgas, 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: 10/29/21

VIRGIL F. PRYOR, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

GREG W. CHAMBERS
Deputy Attorney General
Attorneys for Complainant

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Virgil F. Pryor, Esq. 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: _____ _____
FRANCES DEE FILGAS, M.D.
Respondent

I have read and fully discussed with Respondent Frances Dee Filgas, 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: _____ _____
VIRGIL F. PRYOR, ESQ.
Attorney for Respondent

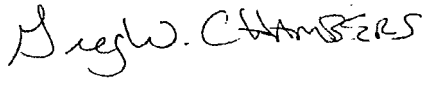
ENDORSEMENT

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

DATED: October 29, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General



GREG W. CHAMBERS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2018-040641

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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:	Case No. 800-2018-040641
Frances Dee Filgas, M.D. **8733 Lakewood Dr. Ste. 100** **Windsor, CA 95492-8675** **Physician's and Surgeon's Certificate No. G 42185,** Respondent.	**ACCUSATION**

PARTIES

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

2. On or about July 1, 1980, the Medical Board issued Physician's and Surgeon's Certificate Number G 42185 to Frances Dee Filgas, 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 January 31, 2022, unless renewed.

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JURISDICTION

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

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

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

"(b) The administration and hearing of disciplinary actions.

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

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

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

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

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

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

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

5. Section 2001.1 of the Code provides that the Board's highest priority shall be public protection.

6. 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."

7. Section 2234 of the Code states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

"...."

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 2266 of the Code states:

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

10. Section 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.

11. All of the incidents alleged herein occurred in California.

PERTINENT DRUGS

12. Alprazolam (trade name Xanax) is a psychotropic triazolo analog of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. 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. The usual starting dose of Xanax is 0.25 to 0.5 mg three times per day.

13. Benzodiazepines belong to the group of medicines called central nervous system (CNS) depressants (medicines that slow down the nervous system). Some benzodiazepines are used to relieve anxiety. However, benzodiazepines should not be used to relieve nervousness or tension caused by the stress of everyday life. Some benzodiazepines are used to treat insomnia (trouble in sleeping). However, if used regularly (for example, every day) for insomnia, they usually are not effective for more than a few weeks.

14. Dilaudid is a trade name for hydromorphone hydrochloride. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and Safety Code. Dilaudid is a hydrogenated ketone of morphine and is a narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, Dilaudid should be prescribed and administered with caution. Physical dependence, the

condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, usually assumes clinically significant proportions after several weeks of continued use. Side effects include drowsiness, mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic antidepressants and other central nervous system depressants, including alcohol, may exhibit an additive central nervous system depression. When such combined therapy is contemplated, the use of one or both agents should be reduced.

15. Lorazepam, also known by the trade name Ativan, is a medication of the benzodiazepine group used for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures. Like other benzodiazepines, lorazepam can produce psychological and physical dependence.

16. Methadone hydrochloride is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It also goes by the trade names Methadose and Dolophine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics. The usual adult dosage is 2.5 mg to 10 mg every three to four hours as necessary for severe acute pain.

17. Morphine sulfate is for use in patients who require a potent opioid analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022, a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration. Abrupt cessation or a sudden reduction in dose after prolonged use may result in withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must be undertaken gradually.

18. Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

19. Soma, known by the trade name Carisoprodol, is a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022 of the Business and Professions Code, and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Since the effects of carisoprodol and alcohol, or carisoprodol and other central nervous system depressants, or psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously. Carisoprodol is metabolized in the liver and excreted by the kidneys; to avoid its excess accumulation, caution should be exercised in administration to patients with compromised liver or kidney functions.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Lack of Knowledge/ Inadequate or Inaccurate Medical Records – Patient One)

20. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2266 [inadequate or inaccurate medical records] for unprofessional conduct, in that her

care and treatment of Patient One[1] included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or inadequate or inaccurate medical records, in conjunction with the other departures alleged herein, repeated negligent acts. The circumstances are as follows:

21. Respondent appears to have treated Patient One and prescribed controlled substances since 2011. From January 17, 2017, through February, 17, 2020, records indicate that Respondent treated Patient One 38 times for low back and leg pain due to a worker's compensation issue.

22. During the course of these 38 visits, Respondent prescribed a combination of controlled substances, including opioids (oxycodone and morphine), benzodiazepines (lorazepam), and Soma. Additionally, during the course of this three-year treatment, Patient One required three emergency room visits for symptoms consistent with controlled substance overdose, which required Narcan.

23. Further, when Patient One presented with symptoms of hypercoagulable state on two separate occasions,[2] Respondent failed to address the symptoms or appropriately refer the patient to other treatment providers.

24. When Patient One presented with signs of Cauda Equina Syndrome[3] on October 5, 2017, Respondent failed to advise the patient to present to the emergency room. Instead, Respondent advised that the patient should have a lumbar MRI.

25. Respondent prescribed opioids for long-term therapy without establishing a diagnosis of medical necessity, and Respondent prescribed Soma and lorazepam for sleep disorder, but failed to provide evidence to support long term use of these medications for sleep disorder.

26. Respondent prescribed to Patient One long-term use of opioids for chronic non-cancer pain without undertaking risk stratification, while also prescribing benzodiazepines and

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[1] The patient is identified herein as Patient One to preserve confidentiality. All patients' names will be provided to Respondent in discovery.

[2] A "hypercoagulable state" is the medical term for a condition in which there is an abnormally increased tendency toward blood clotting (coagulation). In this case, the patient appeared with blue toes.

[3] Cauda Equina Syndrome (CES) occurs when the nerve roots of the cauda equina are compressed and disrupt motor and sensory function to the lower extremities and bladder. Patients with this syndrome are often admitted to the hospital as a medical emergency. CES can lead to incontinence and even permanent paralysis.

Soma. There is no evidence that screening tools were used for Patient One; nor is there evidence that Respondent fully evaluated potential risks of combining oxycodone with benzodiazepines and Soma.

27. Respondent failed to create a treatment plan and objectives for Patient One while treating the patient with long-term use of opioids for chronic non-cancer pain, and failed to create or record an exit strategy for discontinuing controlled substances therapy. Additionally, there is no evidence that Respondent evaluated Patient One's progress toward any treatment objectives.

28. Respondent's medical records for Patient One were generally duplicative, contained inaccuracies, and failed to include relevant medical information necessary for planning and maintaining quality care by another provider. Additionally, there was no signed pain contract prior to November 13, 2019, even though Respondent was prescribing opioids prior to that date. Further, the records fail to evidence discussions between Respondent and Patient One of the risks and benefits of combined opioid, benzodiazepine and Soma use.

29. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 [unprofessional conduct], and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2266 [inaccurate or inadequate medical records], of the Code, including but not limited to, the following:

A. Respondent failed to establish the necessity of chronic opioid therapy.

B. Respondent failed to classify Patient One's risk stratification.

C. Respondent failed to have a comprehensive treatment plan and objectives when treating Patient One.

D. Respondent failed to have patient consent and discussion of risks/benefits of long-term opioid use, combined opioid use, and combined narcotic and benzodiazepine use.

E. Respondent failed to ensure appropriate compliance monitoring of Patient One after prescribing opioids or other controlled substances.

F. Respondent failed to base Patient One's care on outcomes such as making progress toward functional goals, presence and nature of side effects, pain status and lack of evidence of patient misuse, abuse or diversion.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Lack of Knowledge/ Excessive Prescribing/ Inadequate Medical Records – Patient Two)

30. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2266 [inadequate or inaccurate medical records] for unprofessional conduct, and/or 725 [excessive prescribing], in that her care and treatment of Patient Two included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or inadequate or inaccurate medical records, and/or excessive prescribing in conjunction with the other departures alleged herein, repeated negligent acts. The circumstances are as follows:

31. Respondent appears to have treated Patient Two from at least May 2015. Medical records show 26 treatment visits between January 12, 2017 and October 22, 2018, for long-standing lumbar and cervical injuries, along with possible Carpal Tunnel Syndrome, Complex Regional Pain Syndrome, depression, and migraine headache, among issues.

32. During the treatment from 2015 through 2018, Respondent prescribed opioids to Patient Two in excess of the Morphine Milligram Equivalents (MME)[4] during the following time periods:

- December 2, 2015 – April 7, 2016, 906 MME avg. per day.
- April 19, 2016 – August 23, 2016, 924 MME avg. per day.
- August 23, 2016 – January 12, 2017, 750 MME avg. per day.
- January 12, 2017 – August 8, 2018, 837 MME avg. per day.

33. Examples of Respondent's prescribing include the following:

- January 19, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg methadone HCL #180.
- March 11, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg methadone HCL #180.
- November 8, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg

[4] In 2014, the Board issued guidelines stating that doses greater than 80 MME were considered a high dose and that physicians should move cautiously. In 2016, the CDC advised that greater than 50 MME would be considered a high dose.

methadone HCL #180.

- July 11, 2017 - 8 mg Dilaudid #150; 10 mg diazapam #60; 10 mg methadone HCL #180.
- May 3, 2018 – 8 mg Dilaudid #120; 1 mg lorazapam #90; 10 mg methadone HCL #180.

34. Respondent provided Patient Two with numerous early refills:

- Dilaudid – 7 days early; 8 days early; 5 days early; 7 days early; 9 days early; 4 days early; 4 days early; 4 days early; and 7 days early.
- Morphine – 8 days early; 5 days early; 7 days early; and 7 days early.
- Methadone – 9 days early; 4 days early; 5 days early; 4 days early; and 29 days early.
- Oxycodone – 9 days early; 4 days early; 5 days early; 4 days early; and 10 days early.
- Diazapam – 4 days early; 6 days early; and 10 days early.

35. Respondent failed to fully evaluate potential risks of combining high dose opioid therapy with other medications that placed Patient Two at risk for respiratory depression.

36. Respondent failed to create a treatment plan and objectives for Patient Two while treating the patient with long-term use of opioids for chronic non-cancer pain. Respondent also failed to create or record an exit strategy for discontinuing controlled substances therapy. Additionally, there is no evidence that Respondent evaluated Patient Two's progress toward any treatment objectives. Further, there is no evidence to indicate that Respondent undertook review of CURES[5] reports and/or conducted pill counts.

37. Respondent's medical records for Patient Two were generally duplicative, contained inaccuracies, and failed to include relevant medical information necessary for planning and maintaining quality care by another provider. Additionally, there was no signed controlled

[5] CURES "is California's prescription drug monitoring program. By statute, every prescription of a Schedule II, III, or IV controlled substance must be logged in CURES, along with the patient's name, address, telephone number, gender, date of birth, drug name, quantity, number of refills, and information about the prescribing physician and pharmacy." (*Lewis v. Superior Court* (2017) 3 Cal.5th 561, 565 (*Lewis*).) The Board is authorized to access the CURES database (*id.* at p. 567), which is maintained by the California Department of Justice. (*Id.* at p. 566).

substance contract prior to November 17, 2017, even though Respondent was prescribing opioids prior to that date. Further, the records fail to evidence discussions between Respondent and Patient Two of the limited evidence of benefit of long-term opioid therapy for chronic musculo-skeletal pain and that it may be associated with increased pain, allodynia, with long-term use.

38. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 [unprofessional conduct], and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 725 [excessive prescribing], and/or 2266 [inaccurate or inadequate medical records], of the Code, including but not limited to, the following:

A. Respondent excessively prescribed controlled substances to Patient Two.

B. Respondent failed to classify Patient Two's risk stratification.

C. Respondent failed to have a comprehensive treatment plan and objectives when treating Patient Two.

D. Respondent failed to ensure appropriate compliance monitoring of Patient Two after prescribing opioids or other controlled substances.

E. Respondent failed to base Patient Two's care on outcomes such as making progress toward functional goals, presence and nature of side effects, pain status and lack of evidence of patient misuse, abuse or diversion.

F. Respondent failed to keep adequate and accurate medical records for Patient Two.

G. Respondent failed to have patient consent prior to November 2017 when prescribing controlled substances, and then failed to provide evidence of risk versus benefits of long-term opioid therapy for chronic musculo-skeletal pain.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Lack of Knowledge/ Excessive Prescribing/ Inaccurate Medical Records – Patient Three)

39. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2266 [inadequate or inaccurate medical records] for unprofessional conduct, and/or 725 [excessive prescribing], in that her care and treatment of Patient Three included departures from

the standard of care constituting gross negligence, and or repeated negligent acts, and/or inadequate or inaccurate medical records, and/or excessive prescribing in conjunction with the other departures alleged herein, repeated negligent acts. The circumstances are as follows:

40. Respondent appears to have treated Patient Three from at least September 2015 for injuries stemming from a 2007 motor vehicle accident that caused a T7 compression fracture. Medical records show 39 treatment visits from January 12, 2017, through February 19, 2020. During the treatment from September 29, 2015 through December 30, 2020, Respondent prescribed controlled substances to Patient Three consisting of an average daily MME of 1076. Examples are as follows:

- April 19, 2016 – September 8, 2016, 1078 MME avg. per day.
- September 20, 2016 – February 17, 2017, 1221 MME avg. per day.
- September 1, 2017 – February 8, 2018, 664 MME avg. per day.
- March 22, 2018 – October 2, 2018, 735 MME avg. per day.
- October 17, 2018 – May 1, 2019, 779 MME avg. per day.
- May 16, 2019 – December 30, 2019, 454 MME avg. per day.

41. Respondent provided Patient Three with numerous early refills, even noting in the medical records on May 18, 2017, that Patient Three was short on her medication due to overuse:

- Dilaudid – 9 days early; 5 days early; 4 days early; 4 days early; 9 days early; 5 days early; 7 days early; 5 days early; 7 days early; 5 days early; 5 days early; 4 days early; 10 days early; 4 days early; 8 days early; 4 days early; and 5 days early.
- Morphine – 9 days early; and 5 days early.
- Methadone – 4 days early; 4 days early; 9 days early; 7 days early; 5 days early; 5 days early; 5 days early; 4 days early; 10 days early; and 4 days early.
- Oxycodone – 9 days early; 4 days early; 5 days early; 4 days early; and 10 days early.
- Diazapam – 4 days early; 6 days early; and 10 days early.

42. Examples of Respondent's prescribing include the following:

- August 8, 2016 – 1 mg alprazalam #90.
- August 23, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg

methadone HCL #210.

- September 8, 2016 – 1 mg alprazalam #90.
- September 20, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg methadone HCL #180.
- October 10, 2016 – 325 mg/4.8 mg oxycodone #90; 8 mg Dilaudid #150; 10 mg methadone HCL #210.
- November 3, 2016 – 1 mg alprazalam #90.

43. Respondent failed to fully evaluate potential risks of combining high dose opioid therapy with other medications that placed Patient Three at risk for respiratory depression.

44. Respondent prescribed opioids for long-term therapy without establishing a serious diagnosis of medical necessity in light of the fact that the motor vehicle accident occurred 10 years prior to the medical records that were provided to the Board.

45. Respondent prescribed to Patient Three long-term use of opioids for chronic non-cancer pain without undertaking risk stratification, while also prescribing other controlled substances, including benzodiazepines. There is no evidence that screening tools were used for Patient Three; nor is there evidence that Respondent fully evaluated potential risks of combining these medications.

46. Respondent failed to create a treatment plan and objectives for Patient Three while treating the patient with long-term use of opioids for chronic non-cancer pain, nor is there evidence of an exit strategy for discontinuing controlled substances therapy. Additionally, there is no evidence that Respondent evaluated Patient Three's progress toward any treatment objectives. Further, there is no evidence to indicate that Respondent undertook review of CURES reports and/or conducted pill counts.

47. Respondent's medical records for Patient Three were generally duplicative, contained inaccuracies, and failed to include relevant medical information necessary for planning and maintaining quality care by another provider. Additionally, there is no evidence showing that CURES reports were reviewed or that pill counts were conducted.

48. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 [unprofessional conduct], and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 725 [excessive prescribing], and/or 2266 [inaccurate or inadequate medical records], of the Code, including but not limited to, the following:

A. Respondent excessively prescribed controlled substances to Patient Three.

B. Respondent failed to establish the necessity of chronic opioid therapy.

C. Respondent failed to classify Patient Three's risk stratification.

D. Respondent failed to have a comprehensive treatment plan and objectives when treating Patient Three.

E. Respondent failed to ensure appropriate compliance monitoring of Patient Three after prescribing opioids or other controlled substances.

F. Respondent failed to base Patient Three's care on outcomes such as making progress toward functional goals, presence and nature of side effects, pain status and lack of evidence of patient misuse, abuse or diversion.

G. Respondent failed to keep adequate and accurate medical records for Patient Three.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence/Repeated Negligent Acts/Lack of Knowledge/ Excessive Prescribing/ Inaccurate Medical Records – Patient Four)

49. Respondent has subjected her license to disciplinary action under section 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 2266 [inadequate or inaccurate medical records] for unprofessional conduct, and/or 725 [excessive prescribing], in that her care and treatment of Patient Four included departures from the standard of care constituting gross negligence, and or repeated negligent acts, and/or inadequate or inaccurate medical records, and/or excessive prescribing in conjunction with the other departures alleged herein, repeated negligent acts. The circumstances are as follows:

50. According to CURES reports, Respondent appears to have treated Patient Four from at least November 15, 2011, for injuries stemming from a motor vehicle accident that caused an

undefined crush injury to the left side of the body and causalgia,[6] among other symptoms including headaches. Medical records show 22 treatment visits from January 5, 2017, through February 10, 2020. During the treatment from September 29, 2015 through December 30, 2020, Respondent prescribed controlled substances to Patient Four with excessively high MMEs. Examples are as follows:

- January 6, 2014 – April 21, 2014, 788 MME avg. per day.
- April 21, 2014 – September 10, 2014, 776 MME avg. per day.
- September 21, 2014 – March 22, 2015, 754 MME avg. per day.
- April 11, 2015 – September 29, 2015, 562 MME avg. per day.
- October 4, 2015 – April 11, 2016, 350 MME avg. per day.
- May 6, 2016 – September 19, 2016, 332 MME avg. per day.
- September 19, 2016 – January 10, 2017, 407 MME avg. per day.
- January 6, 2017 – May 8, 2017, 364 MME avg. per day.
- May 30, 2017 – September 20, 2017, 364 MME avg. per day.
- September 27, 2017 – February 4, 2018, 385 MME avg. per day.
- February 15, 2018 – June 9, 2018, 395 MME avg. per day.
- June 9, 2018 – October 16, 2018, 329 MME avg. per day.
- March 12, 2019 – June 3, 2019, 391 MME avg. per day.
- June 24, 2019 – February 15, 2020, 334 MME avg. per day.

51. Respondent provided Patient Four with numerous early refills, even noting in the medical records on May 18, 2017, that Patient Three was short on her medication due to overuse:

- Morphine – 4 days early; 5 days early; 4 days early; 5 days early; 4 days early; 4 days early; 4 days early; 4 days early; 6 days early; 4 days early and 5 days early.
- Dilaudid – 29 days early; 4 days early; 4 days early; 8 days early; 4 days early; 4 days early; 7 days early; 4 days early; and 4 days early,

[6] A rare pain syndrome related to peripheral nerve injuries. This is also known as Complex Regional Pain Syndrome II.

52. Respondent prescribed opioids for long-term therapy to treat muscle and skeletal pain from remote injuries without establishing a serious diagnosis of medical necessity. Additionally, the diagnosis of mixed headache syndrome may be considered contraindicated for opioid use.

53. Respondent prescribed to Patient Four long-term use of opioids for chronic non-cancer pain without undertaking risk stratification, including the use of screening tools, for high-dose combined opioid therapy that placed the patient at risk for respiratory depression.

54. During the course of treatment, Respondent appears to have consistently assessed the intensity of pain (analgesia). However, Respondent failed to consistently evaluate other treatment goals such as Patient Four's functional goals, side effects, aberrant behaviors, and affect.

55. Respondent prescribed opioids to Patient Four for years prior to the patient signing a controlled substance contract on November 13, 2019.

56. Respondent's medical records for Patient Four were generally duplicative, contained inaccuracies, and failed to include relevant medical information necessary for planning and maintaining quality care by another provider. Additionally, Patient Four was prescribed a stimulant (Nuvigil) during the time in which records were available without any clear indication for use.

57. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 [unprofessional conduct], and/or 2234(b) [gross negligence], and/or 2234(c) [repeated negligent acts], and/or 2234(d) [lack of knowledge], and/or 725 [excessive prescribing], and/or 2266 [inaccurate or inadequate medical records], of the Code, including but not limited to, the following:

A. Respondent excessively prescribed controlled substances to Patient Four.

B. Respondent failed to establish the necessity of chronic opioid therapy.

C. Respondent failed to classify Patient Four's risk stratification.

D. Respondent failed to have a comprehensive treatment plan and objectives when treating Patient Four.

E. Respondent failed to ensure appropriate compliance monitoring of Patient Four after prescribing opioids or other controlled substances.

F. Respondent failed to base Patient Four's care on outcomes such as making progress toward functional goals, presence and nature of side effects, pain status and lack of evidence of patient misuse, abuse or diversion.

G. Respondent failed to keep adequate and accurate medical records for Patient Four.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 42185, issued to Frances Dee Filgas, M.D.;

2. Revoking, suspending or denying approval of Frances Dee Filgas, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Frances Dee Filgas, 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: JAN 22 2021

WILLIAM PRASICKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant