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

In the Matter of the First Amended Accusation Against: Cheryl A. Matossian, M.D. Physician's and Surgeon's Certificate No. A 64163 Respondent.	Case No.: 800-2017-035005

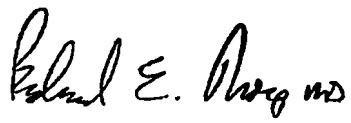
DECISION

The attached Stipulated Settlement 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 February 17, 2022.

IT IS SO ORDERED: January 18, 2022.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the First Amended Accusation Against: **CHERYL A. MATOSSIAN, M.D.** **4989 Golden Foothill Pkwy, Ste 5** **El Dorado Hills, CA 95762-9639** **Physician's and Surgeon's Certificate No. A 64163** Respondent.	Case No. 800-2017-035005 OAH No. 2020100549 **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 Rob Bonta, Attorney General of the State of California, by Jannsen Tan, Deputy Attorney General.

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2. Respondent Cheryl A. Matossian, M.D. (Respondent) is represented in this proceeding by attorney Dominique A. Pollara, whose address is: Pollara Law Group, 100 Howe Avenue, Suite 165N, Sacramento, CA 95825.

3. On or about December 19, 1997, the Board issued Physician's and Surgeon's Certificate No. A 64163 to Cheryl A. Matossian, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2017-035005, and will expire on December 31, 2023, unless renewed.

JURISDICTION

4. The First Amended Accusation No. 800-2017-035005 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent. Respondent timely filed her Notice of Defense contesting the First Amended Accusation.

5. A copy of the First Amended Accusation No. 800-2017-035005 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in the First Amended Accusation No. 800-2017-035005. 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 First Amended 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 the First Amended Accusation No. 800-2017-035005, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in the First Amended Accusation No. 800-2017-035005, a true and correct copy of which is attached hereto as Exhibit A, and that she has thereby subjected her Physician's and Surgeon's Certificate, No. A 64163 to disciplinary action.

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.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. 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.

15. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her before the Board, all of the charges and allegations contained in the First Amended Accusation No. 800-2017-035005 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.

ADDITIONAL PROVISIONS

16. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 64163 issued to Respondent Cheryl A. Matossian, 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 First Amended 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 First Amended 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 First Amended 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. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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' 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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 the First Amended Accusation No. 800-2017-035005 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, Dominique A. Pollara. 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.

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DATED: 11/8/2021

DocuSigned by:
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CHERYL A. MATOSSIAN, M.D.
Respondent

I have read and fully discussed with Respondent Cheryl A. Matossian, 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: 11/8/21

DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/14/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

Jannsen Tan

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2017-035005

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

In the Matter of the First Amended Accusation Against: **CHERYL A. MATOSSIAN, M.D.** **Suite 5** **4989 Golden Foothill Parkway** **El Dorado Hills, CA 95762** **Physician's and Surgeon's Certificate No. A 64163,** Respondent.	Case No. 800-2017-035005 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended 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 December 19, 1997, the Board issued Physician's and Surgeon's Certificate No. A 64163 to Cheryl A. Matossian, 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 December 31, 2021, unless renewed.

JURISDICTION

3. This First Amended 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 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

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

6. Section 2234.1 of the Code states:

(a) A physician and surgeon shall not be subject to discipline pursuant to subdivision (b), (c), or (d) of Section 2234 solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine, including the treatment of persistent Lyme Disease, if that treatment or advice meets all of the following requirements:

(1) It is provided after informed consent and a good-faith prior examination of the patient, and medical indication exists for the treatment or advice, or it is provided for health or well-being.

(2) It is provided after the physician and surgeon has given the patient information concerning conventional treatment and describing the education, experience, and credentials of the physician and surgeon related to the alternative or complementary medicine that he or she practices.

(3) In the case of alternative or complementary medicine, it does not cause a delay in, or discourage traditional diagnosis of, a condition of the patient.

(4) It does not cause death or serious bodily injury to the patient.

(b) For purposes of this section, "alternative or complementary medicine," means those health care methods of diagnosis, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the health care method.

(c) Since the National Institute of Medicine has reported that it can take up to 17 years for a new best practice to reach the average physician and surgeon, it is prudent to give attention to new developments not only in general medical care but in the actual treatment of specific diseases, particularly those that are not yet broadly recognized in California.

7. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

8. Section 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.

9. Section 2264 of the Code states:

The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

10. 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.

11. 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.

12. Section 11150 of the Health and Safety Code states:

No person other than a physician, dentist, podiatrist, or veterinarian, or naturopathic doctor acting pursuant to Section 3640.7 of the Business and Professions Code, or pharmacist acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or within the scope of Section 4052.1, 4052.2, or 4052.6 of the Business and Professions Code, a registered nurse acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107, a certified nurse-midwife acting within the scope of Section 2746.51 of the Business and Professions Code, a nurse practitioner acting within the scope of Section 2836.1 of the Business and Professions Code, a physician assistant acting within the scope of a project authorized under Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 or Section 3502.1 of the Business and Professions Code, a naturopathic doctor acting within the scope of Section 3640.5 of the Business and Professions Code, or an optometrist acting within the scope of Section 3041 of the Business and Professions Code, or an out-of-state prescriber acting pursuant to Section 4005 of the Business and Professions Code shall write or issue a prescription.

13. Section 11152 of the Health and Safety Code states:

No person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division.

14. Section 11157 of the Health and Safety Code states:

No person shall issue a prescription that is false or fictitious in any respect.

15. Section 11170 of the Health and Safety Code states:

No person shall prescribe, administer, or furnish a controlled substance for himself.

16. Section 11171 of the Health and Safety Code states:

No person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

17. Section 11172 of the Health and Safety Code states:

No person shall antedate or postdate a prescription.

DEFINITIONS

18. **Alprazolam** (generic name for the drug Xanax) is a short-acting benzodiazepine used to treat anxiety, and is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d).

19. **Carisoprodol** (generic name for the drug Soma) is a centrally acting skeletal muscle relaxant. On January 11, 2012, carisoprodol was classified a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a dangerous drug pursuant to Business and Professions Code section 4022.

20. **Cyclobenzaprine** (generic name for Flexeril) is a centrally acting skeletal muscle relaxant. Cyclobenzaprine may have drug interactions with central nervous system depressants. It is a dangerous drug pursuant to Business and Professions Code section 4022.

21. **Diazepam** (generic name for the drug Valium) is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Meniere's disease. It is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. **Fentanyl** (generic name for the drug Duragesic) is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse and can lead to

addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (c).

23. **Hydrocodone bitartrate with acetaminophen** (generic name for the drugs Vicodin, Norco, and Lortab) is an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). On October 6, 2014, hydrocodone combination products were reclassified as Schedule II controlled substances. Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

24. **Hydromorphone hydrochloride** (generic name for the drug Dilaudid) is a potent opioid agonist that has a high potential for abuse and risk of producing respiratory depression. Hydromorphone HCL is a short-acting medication used to treat severe pain. Hydromorphone HCL is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Hydromorphone HCL is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

25. **Lorazepam** (generic name for Ativan) is a member of the benzodiazepine family and is a fast-acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and California Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. **Methadone** (generic name for the drug Symoron) is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by

[1] http://www.cdc.gov/niosh/ershdb/EmergencyResponseCard_29750022.html

patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a Schedule II controlled substance pursuant to California Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. **Morphine Sulfate** (generic name for the drugs Kadian, MS Contin, and MorphaBond ER) is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine Sulfate dissolves readily in water and body fluids, creating an immediate release. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to California Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

28. **Oxycodone** (generic name for Oxycontin, Roxicodone, and Oxecta) is a short acting opioid analgesic used to treat moderate to severe pain. It is a high risk drug for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

29. **Oxycodone and acetaminophen** (generic name for Endocet and Percocet) is an opioid analgesic combination product used to treat moderate to severe pain. Oxycodone and acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

30. **Zolpidem Tartrate** (generic name for Ambien): is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV

controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

31. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that she committed gross negligence during the care and treatment of Patients A, B, C, D, and E[2]. The circumstances are as follows:

32. Respondent is a physician and surgeon, board certified in Family Practice who at all times relevant to the charges brought herein worked under the business name Folsom Family and Sports Medical Group.

Patient A

33. On or about July 28, 2014, Respondent saw Patient A for a clinic visit. Patient A was at the time of the visit, a 32-year-old male who presented with a chief complaint of "pain medication refill." It is noted the Patient A was seeing Dr. R. for his rheumatoid arthritis and will be staying on Enbrel. Physical exam confirmed tenderness on palpation of the hands and with motion of the hands as well as the wrists. Respondent assessments were "taking high risk medications," "rheumatoid arthritis," "trapezius muscle strain," "strained subscapularis muscle," "strained rhomboid muscles," "strain of muscle fascia, and tendon of upper extremity," and "muscle spasm." Respondent prescribed Oxycontin 80 mg 2 tabs in AM, one at noon and two at bedtime, Duragesic 100 mcg/hr patch. Apply two patches topically every 2-3 days and Dilaudid 8 mg seven tabs every 6 hours as needed. The total daily morphine equivalent is 1976, if Patient A was taking the maximum recommended dosage of each medication prescribed by Respondent. Respondent failed to obtain any rheumatologist notes or document consultations with Patient A's rheumatologist to verify the extent of Patient A's medical issues.

[2] Patient names and information have been removed to protect patient confidentiality.

34. On or about August 28, 2014, Respondent saw Patient A for a clinic visit. Patient A rated his pain at worst 8/10 and least 3/10 in the previous month. Patient A listed on this form he was taking the maximum recommended dosages.

35. Respondent saw Patient A monthly for clinic visits, and continued to prescribe medication refills of Oxycontin, Dilaudid, and Duragesic.

36. On or about February 4, 2015, and May 5, 2015, Respondent saw Patient A in clinic and noted Patient A had no consumption of alcohol or illicit drugs and no tobacco use. The patient stated he had a slightly better month because he did not miss any doses of Enbrel.

37. On or about June 9, 2015, during a clinic visit, Patient A followed up with Respondent in clinic for pain management. Patient A stated he had an appointment with his rheumatologist, Dr. R. that month. Also, he was not using his Valium at night if he works late or has to get up early in the day. Patient A reported that he called to schedule his pain management consultation with Dr. H. Respondent spoke to Patient A about decreasing his Dilaudid and then Oxycontin doses and Patient A was agreeable. Respondent failed to document any consultation notes from Dr. H in the present and subsequent notes. Respondent continued to refill and prescribe Oxycontin, Duragesic, and Dilaudid.

38. On or about July 7, 2015, Respondent saw Patient A for a clinic visit. Respondent documented that Patient A had not been seen in pain management because he was too busy at work. Respondent continued to prescribe Dilaudid 8mg, 7 tabs po q6h prn; Duragesic 2 patches topically q2-3 days prn; Oxycontin 80 mg 2 tab po qam, one tab po qnoon, 2 tabs po qhs.

39. On or about August 4, 2015, Respondent began tapering Patient A's prescriptions for Dilaudid. Respondent did not insist on the pain management referral.

40. On or about November 25, 2015, a nurse practitioner in Respondent's clinic saw Patient A. The nurse practitioner documented that Patient A used occasional alcohol.

41. Respondent continued to prescribe Oxycontin, Duragesic, and Dilaudid throughout January 2015- December 2015.

42. In 2016, Respondent gradually reduced Patient A's Dilaudid quantity. Respondent prescribed Dilaudid 8mg 4 to 5 tab po q6h prn; Oxycontin 80 mg 2 tabs po qam, one tab po qnoon, 2 tabs po qhs; Duragesic 100 mcg, 2 patches topically q 2-3 days prn.

43. Patient A had an inconsistent drug urine test dated April 21, 2016, where he tested positive for benzodiazepines not prescribed by Respondent.

44. Emergency department records faxed to Respondent's office dated September 23, 2016, indicated that Patient A used alcohol regularly.

45. On December 8, 2016, Respondent refilled Valium 10 mg #120 one in AM, one at noon and two in PM, Duragesic patch 100 mcg/hr patch #30 apply two patches every 2-3 days, Dilaudid 8 mg tablets #400. Take 3-4 tablets every 6 hours as needed and Oxycontin 80 mg extended release tablets #150, take two tablets in the morning, one tablet at noon and two tablets at bedtime.

46. On or about January 12, 2017, Respondent documented that Patient A reported adequate pain control over the past month and that he had seen the rheumatologist without change in management of his rheumatoid arthritis. Respondent reduced Patient A's Dilaudid from #400 to #370. There is no mention of any trouble Patient A had obtaining any of his medications in these progress notes.

47. Respondent's urine drug screening dated January 12, 2017, was positive for benzodiazepines, marijuana metabolite, and oxycodone but negative for hydromorphone. Respondent noted on the bottom of this urine drug screen report that "he is taking Dilaudid but not accounted for on this lab: all other meds accounted for; there are no inconsistencies. Respondent failed to follow up on the inconsistent hydromorphone. Respondent failed to order a repeat test to clear up the inconsistency. Respondent did not order another drug screen until November 2017.

48. On the progress note dated January 28, 2017, Respondent does not document anything about Patient A not taking Dilaudid. She does note that due to an insurance coverage change that Oxycontin will no longer be covered for Patient A. Opana was prescribed instead.

49. On or about July 3, 2017, Respondent developed an Opana ER tapering schedule for Patient A.

50. On or about November 2, 2017, Patient A saw a physician assistant in Respondent's clinic for a clinic visit. Patient A reported he had been taking 80 mg of morphine extended release once daily instead of twice daily as prescribed due to insurance coverage. His pain management was reported as "decent" with the lower dose. Medications ordered were Duragesic patch, Dilaudid, morphine and Valium. Patient A received hydromorphone 8 mg #240 pills on November 2, 2017, from Raley's pharmacy with a subsequent dispense of the same quantity on December 5, 2017.

51. On or about November 30, 2017, Patient A saw a physician assistant in Respondent's clinic, and stated good success decreasing dose of morphine from 80 mg daily to 60 mg daily. He was concerned about how his pain would be controlled in the winter months. His Dilaudid, Duragesic, Valium and morphine were refilled.

52. Patient A's urine drug screening dated November 30, 2017 was negative for opioids. Respondent noted on the bottom of that urine drug screening report that "opiate labs not run correctly; the correct opiates were not tested." Respondent failed to consider that Patient A should have had opioids in his urine. Respondent failed to follow up and clear the inconsistent results.

53. On or about January 2, 2018, Respondent saw Patient A for a clinic visit. Respondent noted that "he has had issues getting his medications filled on time and in the appropriate prescribed quantities." Respondent sent another urine drug screening on January 2, 2018, which was then positive for benzodiazepines and Dilaudid. It was not positive for fentanyl but Respondent documented on April 30, 2018, that Patient's Duragesic patch was observed to be on his skin at the time of this urine drug screening and that synthetic opioids were not always detected on the urine drug screen the lab was using.

54. On or about March 12, 2018, Respondent documented that Patient A was in an "increased amount of pain due to the drastic decrease in his pain medication regimen; the pain is mostly in the neck low back and left hand." She noted that his pain is not adequately controlled

with his current regimen due to his insurance refusing to cover the necessary regimen of Duragesic and Dilaudid.

55. On or about April 30, 2018, Respondent noted that Patient A's pain control was "completely inadequate" due to inability to get insurance to cover his Duragesic patch.

56. On or about July 26, 2018 Respondent continued to prescribe and refill Duragesic patches 100 mcg/hr #10 one patch every 3 days and Dilaudid 8 mg 120 pills per month for a total of 368 daily morphine equivalents (p. 162-164). A urine drug screen on July 26, 2018 was negative.

57. During the period of May 2015 to March, 2018, Respondent prescribed high dose opioids and benzodiazepines to Patient A.

58. Respondent committed gross negligence in her care and treatment of Patient A, which included, but not limited to the following:

a. Respondent prescribed high doses of opioids without documenting copies of Patient A's rheumatology consultations to determine actual diagnoses.

b. Respondent prescribed high doses of opioids despite multiple inconsistent urine drug tests.

c. Respondent prescribed high morphine equivalents in combination with benzodiazepines without a pain management specialist.

d. Respondent failed to respond with a more aggressive taper of Dilaudid despite the fact that Patient A was clearly not taking Dilaudid himself.

Patient B

59. On or about July 30, 2014, Respondent saw Patient B for a clinic visit. Patient B was at the time of the visit a 48-year-old female who presented to Respondent's clinic with a chief complaint of "pain management; [Patient B] had a stressful 2 months due to the illness and death of her dad. [Patient B] is living with in-laws and this has been stressful." Respondent documented the history of present illness as "lower back pain on the right, on the left, radiating to the buttocks, is chronic, worsens with sitting, with driving, with stooping, with bending, with lifting, with muscle spasm, back stiffness, muscle aches, pain in the lower extremities, muscle

spasms and limb pain." The physical exam included a back examination showing abnormal range of motion of the spine as well as tenderness on palpation. Respondent assessed Patient B's mood as "labile, unhappy, dysphoric, anxious and concerned." Respondent's assessments were "feeling tired or poorly, taking high-risk medication, lumbar disc degeneration, muscle spasm, secondary insomnia and bereavement without complications." Respondent documented her plan as: "Follow up for re-examination in 1 month;" and prescribed: morphine sulfate ER 120 mg 2 caps twice daily #120, morphine sulfate ER 90 mg 1 cap twice daily #60, Soma 350 mg 2 tabs four times daily #120, Norco 10/325 1-2 tabs every 4-6 hours as needed #180, and Xanax (alprazolam) XR 1 mg, 1-2 tablets twice daily. A review of the hand-written prescriptions from the various pharmacies supports that Patient B received the 120 mg doses of morphine but not the 90 mg tabs.

60. On or about January 12, 2015 Respondent saw Patient B for a clinic visit. Respondent documented that Patient B had not been taking the 90 mg dose, but was unclear for how long, and the plan from Respondent's progress note indicated Respondent expected Patient B would be taking both the 120 mg and the 90 mg formulations of long acting morphine sulfate. The total daily morphine equivalent (MED) for both formulations (3 of the 90 mg tabs and 4 of the 120 mg tabs) and a total of 8 of the hydromorphone pills daily as prescribed, would have been 1006 morphine equivalents daily (MED) along with the benzodiazepine, alprazolam.

61. On or about March 23, 2015, Respondent saw Patient B for a clinic visit. Respondent documented the chief complaint as: "Pain management, frequent muscle spasms in the lower extremities. [Patient B] is not able to get her Avinza (morphine sulfate) scripts." Respondent continued to write the prescriptions for both morphine formulations (120mg and 90mg) for this visit and subsequent visits, but this is the last time both dose formulations are listed on the progress notes.

62. On or about April 27, 2015, Respondent saw Patient B for a clinic visit. Respondent documented the chief complaint as: "Pain management; she has been getting over the flu and is mostly back to normal. Her regimen is working well but she is having trouble getting her 90 mg morphine script due to her insurance changes. She has no new sx's." At this visit, Respondent

prescribed morphine sulfate 120 mg two in the morning and 3 in the afternoon, Dilaudid 8 mg, 3 tabs four times daily, and alprazolam 1 mg 1-2 tablets twice daily. This represented 856 daily morphine equivalents along with the benzodiazepine, alprazolam. Respondent increased Patient B's monthly Dilaudid quantity from 240 to 450 8 mg doses. Respondent failed to document her rationale for increasing the Dilaudid prescription. Respondent failed to consider a reasonable taper. Patient B did not report that her pain had significantly improved at her next visit.

63. On or about June 30, 2015 Respondent documented the chief complaint as "Pain management; need drug screening; she does not yet have an appt. with the pain management. She is having difficulty getting her Dilaudid refilled." Respondent documented the same medications that was prescribed on April 27, 2015, and there is a note that the patient is on a taper of her Dilaudid--#395.

64. On or about August 25, 2015, Respondent documented the chief complaint as: "Pain management; she does have an appt. with h/h (with pain management) on October 8. She has been running low (on her meds) due to not getting her appt. with h/h sooner. There are no new sx's, but she states that her pain is worse because she has run low on her meds. She has not been able to tolerate Cymbalta." Respondent made no further clarification as to why Patient B was running low on her meds, nor document what Patient B's reaction to the Cymbalta was. Respondent wrote prescriptions for Dilaudid #300, morphine sulfate 120 mg #115, Valium 10 mg one tab three times daily with instructions to "do not to take if you need to use lorazepam." Prescriptions were also written for Lasix[3], Wellbutrin[4] and Prozac[5]. Respondent also changed Patient B's prescription for alprazolam to diazepam without documenting her rationale. Respondent failed to consider the longer half-life of diazepam which placed Patient B at higher risk of opioid-benzodiazepine interaction.

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[3] Furosemide, sold under the brand name Lasix among others, is a medication used to treat fluid build-up due to heart failure, liver scarring, or kidney disease. It may also be used for the treatment of high blood pressure.

[4] Bupropion, sold under the brand names Wellbutrin, among others, is a medication primarily used to treat major depressive disorder and to support stopping smoking.

[5] Fluoxetine, sold under the brand names Prozac, among others, is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. It is used for the treatment of major depressive disorder, obsessive–compulsive disorder (OCD), bulimia nervosa, panic disorder, and premenstrual dysphoric disorder.

65. On or about September 23, 2015, Respondent saw Patient B for a clinic visit. During the visit, Respondent prescribed two benzodiazepines without documenting her rationale. Patient B's history did not mention any anxiety or other psychological distress on that day, and she was not noted to be nervous or anxious on physical exam. Patient B's psychiatric exam was documented as normal. The assessment of "Panic disorder without agoraphobia, intermittent, infrequent" was made without any documented clinical justification.

66. On or about September 13, 2016, Respondent saw Patient B for pain management. Patient B stated that her "pain has been worse than usual this month because she has been more active." She was using a cane for ambulation and her stress level was high. She had been diagnosed with pulmonary hypertension. Respondent documented a pain assessment on the chart. It was noted that because of insurance restrictions, Patient B's total pain medication dose had been cut by more than half. The medication list at this visit indicated that Patient B was taking morphine sulfate 120 mg one tab twice daily, and Dilaudid 8 mg 2-3 tablets four times daily. This represented 624 morphine equivalents daily (MED). Respondent added Duragesic patch 50 mcg/hr at this visit which represented an addition of 120 morphine equivalents daily. The documented reason was that the patient was "more active." It is unclear what "more active" means when a patient with pulmonary hypertension is required to use a cane for ambulation. The clinical reason for the opioid escalation was unjustified in the medical record. Respondent failed to consider a lower starting dose for Duragesic at 25 mcg/hr. In subsequent visits, Patient B did not indicate that her pain improved with this additional opioid treatment.

67. On or about October 6, 2016, Patient B noted that the Duragesic patch provided pain relief on the level of 6. In the Patient Comfort Assessment Guide form, Patient B indicated that her other pain medications provided more relief than the addition of the Duragesic. The Duragesic patch was discontinued on November 23, 2016, due to skin irritation and Avinza (morphine sulfate) was changed to MS Contin because Avinza had been discontinued in the US.

68. On or about December 22, 2016, Patient B was consuming 684 morphine equivalents daily in the form of MS Contin and Dilaudid.

69. On or about March 23, 2017, Patient B expressed an interest in tapering off her opioids, starting with the MS Contin. Later in the month Patient B was hospitalized with pneumonia. Opioid overdose was in the differential of Patient B's altered mental status, but, it is much more likely Patient B's documented pneumonia with hypoxia along with underlying comorbidities were the proximate causes of her deterioration.

70. On or about May 16, 2017, Patient B noted during her visit that her back and leg pain were not being controlled by taking only Dilaudid. She was also taking Motrin 800 mg three times daily. Respondent added Cymbalta[6] at this visit.

71. Patient B titrated up her Cymbalta without any additional benefit but also, this time, she did not report side effects. She had become sedentary due to insufficient pain control only with Dilaudid for several weeks. Respondent added back MS Contin 15 mg one tablet three times daily on June 25, 2017.

72. On or about July 20, 2017, Patient B's pain assessments indicated that MS Contin was not helpful for pain control and it was discontinued. Dilaudid 300 pills every 23 days was continued, which represents 416 total daily morphine equivalent dose.

73. In 2014 – 2017, Respondent failed to refer Patient B to a pain specialist despite Patient B using excessive high doses of opioids without adequate pain control. Respondent also failed to consider and/or rule out that Patient B had myofascial pain syndrome with some arthritis complicated by her obesity and cardiopulmonary conditions.

74. Respondent committed gross negligence in her care and treatment of Patient B, which included, but not limited to the following:

A. Respondent prescribed high doses of opioids and concurrent, multiple benzodiazepines with neither clinical justification nor patient consent.

Patient C

75. On or about July 22, 2014, Patient C was seen in Respondent's clinic by Respondent's Physician Assistant (PA). Patient C was at the time of the visit a 58-year-old

[6] Duloxetine, sold under the brand name Cymbalta among others, is a medication used to treat major depressive disorder, generalized anxiety disorder, fibromyalgia, and neuropathic pain.

female who presented with a chief complaint of "Refill pain meds." Patient C had a history of chronic low back pain after lumbar surgery with hardware placement as well as a recent hospitalization for empyema[7] involving the use of a pigtail drainage catheter through the chest wall. That drain had been recently removed by Patient C's surgeon. Patient C came in on multiple pain medications to include Duragesic (fentanyl) 50 mcg/hr patch, Oxycontin (oxycodone) 80 mg four times daily, Dilaudid (hydromorphone) 8 mg, two tablets every 6 hours and Soma (carisoprodol) 350 mg four times daily for the severe muscle spasms. It was also noted that Patient C was on Xeralto (rivaroxaban) a treatment for her upper extremity deep vein thrombosis (blood clot). The PA refilled all these medications without changes and Respondent co-signed the note.

76. On or about August 19, 2014, Patient C returned for a follow up visit and saw Respondent's PA, who noted that Patient C's pain was mostly from her back now and stated that she only has mild chest wall pain at the time of this visit. Patient C rated her low back pain 7/10 with the best 5/10 because she was unable to obtain her fentanyl patch that month. Patient C stated that there was a problem with the way the prescription for fentanyl was written and the pharmacy would not fill the prescription. Respondent co-signed the note.

77. On or about September 16, 2014, Respondent saw Patient C for a clinic visit. Respondent documented the chief complaint as "Pain Med Refill; [Patient C] is having trouble with mouth mucosal ulcers. [Patient C] has sx's of vaginal redness and irritation, that is focal and not resolving, and is now a purplish color..." The chest symptoms were noted to be "gradually resolving" and the abscess had resolved. "The incisions from the chest tubes have healed." Patient C reported no new back issues. Respondent ordered Oxycontin 80 mg ER, one tablet by mouth every 6 hours as needed, Dilaudid 8 mg oral tablet, two tablets by mouth every 6 hours as needed and triamcinolone 0.1% mucous membrane paste. Fentanyl was not refilled at this visit.

78. Patient C continued to be seen in Respondent's office regularly and on January 13, 2015, Respondent saw Patient C for pain management. Respondent documented under history of

[7] Empyema is defined as a collection of pus in the pleural cavity, gram-positive, or culture from the pleural fluid. Empyema is usually associated with pneumonia but may also develop after thoracic surgery or thoracic trauma.

present illness that "there was chest pain or discomfort in the post right side." Respondent documented under assessment that Patient C was complaining of shortness of breath. Respondent ordered a chest x-ray. For the lumbar disc degeneration and lumbar spondylosis, Respondent refilled Oxycontin, Dilaudid and Soma, but Respondent also ordered Duragesic patch 50 mcg/hr one patch topically every 2-3 days as needed. Patient C did not rate her pain as significantly improved after this adjustment and in fact her "worst" pain during the month increased from August 10 to September 10, 2015. Respondent escalated Patient C's MED without adequate justification.

79. On or about February 10, 2015, Respondent saw Patient C for pain management. Respondent documented that "pain control has not been as good, which [Patient C] thought was due to the weather. [Patient C] states that pain control is at best a 2/10; and standing for more than 10 minutes causes her the most; her low back starts throbbing and aching." Physical exam included normal vital signs and a statement that Patient C was in no acute distress. There was no muscular or back examination on this date. Respondent assessments were "taking high risk medication, lumbar disc degeneration/ failed back syndrome and lumbar spondylosis." Respondent ordered Neurontin 300 mg one capsule at bedtime, Oxycontin 80 mg one tablet every 6 hours as needed, and Duragesic patch was increased to 75 mcg/hr one patch every 2-3 days. Patient C did not report a significant improvement in her pain management after this adjustment. Respondent failed to consult with a pain specialist before increasing Patient C's MED to 916 total daily morphine equivalent.

80. On or about June 30, 2015, Respondent saw Patient C for an office visit and noted that Patient C "would prefer to continue working with me to reduce her narcotic doses rather than seeing the pain specialist." Respondent prescribed Robaxin-750 (methocarbamol, a skeletal muscle relaxer) one tablet twice daily as needed, Oxycontin 80 mg ER 1-2 tabs three times daily, Dilaudid 8 mg 2 tabs every 6 hours as needed and Duragesic 50 mcg/hr patch one patch every 3 days. Respondent failed to taper Patient C's opioids for the next two years.

81. On or about September 1, 2015, Respondent saw Patient C for an office visit. Respondent documented Patient C's chief complaint as pain management, and dizziness with her

Flexeril. Patient C also complained that stiffness and spasm were on-going problems for her. Respondent prescribed Oxycontin 80 mg ER 1-2 tabs three times daily, Dilaudid 8 mg, two tabs three times daily and Baclofen 10 mg one tablet three times daily (a muscle spasm reliever).

82. In November 2015, Patient C's GI specialist put her back on Soma for esophageal spasms. On or about November 24, 2015, during a visit with Respondent's nurse practitioner, Patient C agreed to bring in her bottle when she needed a refill of Soma.

83. During the period of April 2015 to March 2018, Respondent prescribed multiple opioids to Patient C. Respondent failed to have a comprehensive informed consent until March 2018.

84. Respondent committed gross negligence in her care and treatment of Patient C, which included, but not limited to the following:

A. Respondent prescribed excessive doses of opioids without a pain specialist which substantially increased risk without adequate patient consent or clinical justification.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

85. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts during the care and treatment of Patient A, B, C, D, E, and F as more particularly alleged hereinafter. Paragraphs 31 through 105, above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient D

86. Respondent first saw Patient D in 2007. On or about June 9, 2014, Respondent saw Patient D for a clinic visit. Patient D was at the time of the visit, a 49-year-old male, who presented for a medication refill. Respondent noted Patient D's baseline pain level at rest and with activity. The pain and the pain medication was not interfering with his job or sleep. Respondent documented that Patient D was having chronic lower back pain worse with certain movements, but he did not have red flag symptoms such as motor or sensory deficits. Respondent documented that Patient D did not use alcohol or illicit drugs. The physical exam included vital signs and general comments about Patient D's appearance and mood. There was

no back examination done at this visit. Respondent documented his assessments as "taking high risk medication" and "lumbar disc degeneration." Possible adverse reactions to medications were discussed. Respondent refilled Patient D's prescriptions for hydromorphone 8 mg and fentanyl 50 mcg/hr patches. Respondent instructed Patient D to return in 2 months.

87. On the October 29, 2014 office visit, Respondent noted Patient D had tried topical products for his pain which were ineffective, but his current medication program was working for him. Respondent noted that Patient D had "neck pain and mid back pain likely from the computer work he does." The thoracic and lumbar spine physical exam showed tenderness on the muscles as well as pain elicited on various movements. There was no change in management.

88. Patient D was subsequently seen by Respondent's advanced practice providers and kept on the same medication. On or about June 21, 2017, Patient D reported he had self-discontinued his fentanyl patch and didn't notice any difference in his pain level, but that his hydromorphone 8 mg, 8 pills per day were managing his pain well. Respondent co-signed this progress note.

89. On or about August 22, 2017, Respondent saw Patient D for pain management and both hydromorphone 8mg pills and fentanyl 50 mcg/hr patch were on Patient D's medication list. However, the fentanyl patch was not ordered during this visit. Respondent ordered only the hydromorphone prescription for Patient D's pain management. The fentanyl patches remained on the medication list on future visits as well.

90. On or about May 15, 2018, Respondent's Physician Assistant saw Patient D in the office and discussed the alcohol that was found in his urine drug screening. Patient D noted that he drank one beer prior to the drug test. The PA discussed the serious risks of mixing opioids with alcohol with the patient. The fentanyl patch was removed from the medication list at this visit.

91. On or about June 15, 2018, Respondent began a taper of the 64 mg daily of hydromorphone and transferred Patient D's care to a pain specialist.

92. By the office visit of August 10, 2018, Patient D had tapered down to four of the 8 mg hydromorphone pills per day and his pain was not adequately controlled and was interfering

with his ability to work. He reported he did fine with 6 pills per day. Respondent increased his pain management to six hydromorphone pills per day and a second referral was sent to a pain management specialist.

93. Respondent committed repeated negligent acts in her care and treatment of Patient D, which included, but not limited to the following:

A. Respondent failed to document informed consent and for failing to attempt tapering for several years while Patient D was consuming a high risk, total daily opioid dose.

Patient E

94. Patient E was Respondent's patient for many years. On or about August 11, 2014, Respondent's PA saw Patient E for a clinic visit. Patient E was at the time of the visit a 66-year-old female who was in the office for pain management. She wanted refills of her MS Contin, Dilaudid, Fioricet and Valium. Patient E took the opioids and benzodiazepine for her chronic neck and back pain due to degenerative disc disease with muscle spasm. The Fioricet was for chronic tension -type headaches. Patient E had spinal surgeries with hardware placement for her back problems with included degenerative scoliosis, facet arthropathy as well as herniated intervertebral discs. During this visit, Patient E rated her pain 7/10 due to her having to sit in the car to get to her appointment as well as a trip across the country on a train that jarred her back. Respondent's PA refilled Patient E's medications.

95. On or about October 9, 2014, Respondent saw Patient E for pain management. Respondent documented a physical examination which included back muscle spasms as well as abnormal range of motion of the spine, pain with movement of the spine and tenderness to palpation of the cervical and lumbar region muscle groups. Respondent refilled Patient E's medications during this visit.

96. On or about September 29, 2015, Respondent saw Patient E for a clinic visit. Respondent noted that Patient E had fallen down the stairs when her left knee gave way. Patient E had been evaluated at a hospital in Lodi, California and did not have any fractures. Respondent's physical examination of both knees was documented as normal but there was some weakness and decreased vibratory sensation of the left lower extremity. Respondent documented

her assessments as "taking high-risk medication," "sprain of the interosseous ligament of the left ankle," "strain of the anterior tibialis muscle of left leg," "lumbar neuritis L4-L5," "lumbar neuritis L5-Sl," and "ligament injury." The plan was for re-examination in 1 and 2 months and a physical therapy consultation. Respondent failed to document her rationale for increasing Dilaudid. Patient E consumed an additional 80 pills per month, but there is no documentation of any discussion of how Patient E was to take these pills to ensure safety. It wasn't clear why Respondent decided on an extra 80 pills nor why Respondent did not consider using NSAIDs for a short time, instead, which would have been a safer therapeutic plan. Respondent's note on that day did not have a medication list nor was Patient E's medication log updated with the September 29, 2015 prescriptions.

97. On or about June 1, 2016, Patient E presented to Respondent's PA for a clinic visit after being with a different primary care office for the previous 6 months. Patient E was working with a neurosurgeon at UC Davis during this time. Patient E stated that she had been on MS Contin 200 mg twice daily and this wasn't as effective as 130 mg three times daily that she was previously on with Dilaudid in between. She asked to restart the previous regimen. (MS Contin 100 and 30 mg tabs three times daily and Dilaudid 8 mg one tab every 6 hours as needed.) When Patient E followed up with the PA on June 29, 2016, Patient E noted that since switching back to her previous pain management regimen her pain improved to a level of 3-4 daily and without her medication it is 9-10. Patient E's pain was noted to be in her legs and keeping her up at night.

98. On or about November 22, 2016, Patient E complained of increased pain due to damp and colder weather. Respondent recommended CBD/THC edibles as an adjunctive therapy for Patient E's pain with the plan to eventually taper her Dilaudid and MS Contin 30 mg. Patient E was unable to tolerate medicinal marijuana due to side effects.

99. At her August 10, 2017 visit with Respondent, Patient E reported that the only thing that the UCD neurosurgeons could do for her worsening leg symptoms and pain would be to put in a cage but that the success rate would be quite low. She increased her Gabapentin as a result of her visits to UCD specialists.

100. On or about October 5, 2017, Respondent noted that they had tried to lower Patient E's doses of opioids without success. Patient E's physical disabilities had progressed, and she reported significant emotional stress as well.

101. During the period of May 2015 to May 2016, Respondent prescribed high dose opioids together with benzodiazepines. Respondent resumed prescribing high dose opioids from June 2016 to March 2017. Respondent also prescribed Floricet on a regular basis for headaches.

102. Respondent committed repeated negligent acts in her care and treatment of Patient E, which included, but not limited to the following:

A. Respondent prescribed high doses of opioids combined with benzodiazepines without adequate patient consent and for not trying safer treatments when Patient E had an acute injury.

Patient F

103. On or about February 16, 2018, Respondent saw Patient F for stem cell therapy on his penis for erectile dysfunction. Subsequently on or about May 10, 2018, Respondent saw Patient F for stem cell therapy to his knee for arthritis on his knee. Respondent documented an informed consent together with a legal release and covenant not to sue. Respondent documented a procedure note that the consent form was explained to Patient F. Respondent noted that the joint was prepped for a sterile procedure; the stem cell solution was defrosted and injected into a saline solution which was then injected into the specified area. Respondent added that Patient F was given post procedural instructions. Respondent failed to document that she performed an examination on Patient F prior to administering, on separate occasions, stem cell therapy on Patient F.

104. Respondent also administered Extracorporeal Shock Wave Therapy (ESWT) to treat Patient F's erectile dysfunction. Respondent documented that Patient F sought treatment for sexual performance and erectile dysfunction. Respondent documented a diagram of a penis in her records, and noted that Patient F was circumcised, although on other notes, she documented that Patient F was not circumcised. Respondent failed to document a physical examination prior to initiation of the ESWT GAINSWave therapy. Respondent also failed to document progress notes, assessment or plan of care involving the stem cell therapy and ESWT GAINSWave therapy.

105. Respondent committed repeated negligent acts in her care and treatment of Patient F, which included, but not limited to the following:

A. Respondent failed to document a good faith medical examination and evaluation to determine the medical indication for the treatment prior to the administration of the stem cell therapy.

B. Respondent failed to document a good faith examination before administering ESWT GAINSWave therapy.

C. Respondent failed to document a progress notes, assessment, plan of care prior to initiation of stem cell therapy.

THIRD CAUSE FOR DISCIPLINE
(Excessive Prescribing)

106. Respondent is further subject to disciplinary action under sections 2227, 2234 and 725, in that she has excessively prescribed controlled substances and dangerous drugs to Patient A, B, C, D, and E, as more particularly alleged hereinafter. Paragraphs 31 through 102, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE
(Self-Prescription of Controlled Substances)

107. Respondent is further subject to disciplinary action under sections 2227, 2234, 2242, and Health and Safety Code sections 11150 et seq., and 11170 et seq., in that she has prescribed to herself.

108. On or about April 17, 2015, to May 19, 2017, Respondent and her colleague prescribed to herself multiple prescriptions for Ketamine HCL, and Testosterone.

FIFTH CAUSE FOR DISCIPLINE
(Ante-Dating or Post-Dating Prescriptions for Controlled Substances)

109. Respondent is further subject to disciplinary action under sections 2227, 2234, 2242, and Health and Safety Code sections 11150 et seq., and 11170 et seq., and the federal rules on prescription of controlled substances under 21 CFR 1304.04 et seq., in that she has ante-dated or

post-dated her prescriptions of controlled substances and dangerous drugs to her patients as more particularly alleged hereinafter. Paragraphs 31 through 108, above, are hereby incorporated by reference and realleged as if fully set forth herein.

110. During the period of 2014-2018, Respondent pre-filled and/or pre-signed prescriptions for controlled substances to be utilized by her support staff.

SIXTH CAUSE FOR DISCIPLINE
(False Prescriptions for Controlled Substances)

111. Respondent is further subject to disciplinary action under sections 2227, 2234, 2242, and Health and Safety Code sections 11150 et seq., and 11170 et seq., and the federal rules on prescription of controlled substances under 21 CFR 1304.04 et seq., in that he she has ante-dated and/or post-dated her prescriptions for controlled substances and dangerous drugs to her patients, as more particularly alleged hereinafter. Paragraph 31 to 110, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

112. Respondent's license is subject to disciplinary action under section 2266, of the Code, in that she failed to maintain adequate and accurate medical records relating to her care and treatment of Patient A, B, C, D, E, and F as more particularly alleged hereinafter. Paragraphs 31 through 110, above, are hereby incorporated by reference and realleged as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

113. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming of a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 31 through 112, above, which are hereby realleged and incorporated by reference as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 64163, issued to Respondent Cheryl A. Matossian, M.D.;

2. Revoking, suspending or denying approval of Respondent Cheryl A. Matossian, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Cheryl A. Matossian, 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: DEC 09 2021

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

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