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

In the Matter of the Accusation Against: Hossein Babaali, M.D. Physician's and Surgeon's Certificate No. G 86162 Respondent.	Case No.: 800-2018-043431

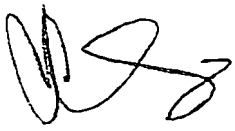
DECISION

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 September 29, 2022.

IT IS SO ORDERED: August 30, 2022.

MEDICAL BOARD OF CALIFORNIA



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

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: HOSSEIN BABAALI, M.D. 2428 Santa Monica Blvd., Suite 402 Santa Monica, CA 90034 Physician's and Surgeon's Certificate G 86162, Respondent.	Case No. 800-2018-043431 OAH No. 2021070592 **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 Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Hossein Babaali, M.D. (Respondent) is represented in this proceeding by attorney Raymond J. McMahon, whose address is: 5440 Trabuco Road, Irvine, CA 926202.1.

3. On August 1, 2001, the Board issued Physician's and Surgeon's Certificate No. G 86162 to Hossein Babaali, M.D. (Respondent). That license was in full force and effect at all

times relevant to the charges brought in Accusation No. 800-2018-043431, and will expire on July 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-043431 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 13, 2022. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-043431 is attached as Exhibit A and is 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. 800-2018-043431. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-043431, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the Accusation, and that Respondent hereby gives up his 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 Accusation No. 800-2018-043431, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. G 86162 to disciplinary action.

12. Respondent agrees that if he 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. 800-2018-043431 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.

13. Respondent acknowledges the Disciplinary Order below, requiring the disclosure of probation pursuant to Business and Professions Code section 2228.1, serves to protect the public interest.

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

CONTINGENCY

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

action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

16. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2018-043431 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.

17. 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.

18. 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 86162 issued to Respondent Hossein Babaali, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions:

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

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection

and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 50 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, including but not limited to ethics and prescribing practices, 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 75 hours of CME of which 50 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Respondent shall not prescribe controlled substances prior to completion of a Prescribing Practices Course.

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

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

this Decision.

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

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

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

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

5. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the

time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

Within 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 m and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

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

7. PATIENT NOTIFICATION. Respondent shall provide a separate written disclosure all patients he treats in his office. The written disclosure shall be made at the time of the patient's first visit to Respondent's office following the effective date of this order. The written disclosure shall include Respondent's probation status, the length of the probation, the probation end date, all practice restrictions placed on Respondent by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet website. The written disclosure shall be signed by the patient, and maintained by Respondent as a part of the patient's medical record. A copy of the written disclosure shall be signed by the patient and retained in the patient's medical record.

8. FACILITY 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.

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

10. 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.

11. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby ordered to reimburse the Board its costs of investigation and enforcement, in the amount of $7,500.00 (seven thousand five hundred dollars. Costs shall be payable to the Medical Board of

California. Failure to pay such costs shall be considered a violation of probation.

Any and all requests for a payment plan shall be submitted in writing by respondent to the Board.

The filing of bankruptcy by respondent shall not relieve respondent of the responsibility to repay investigation and enforcement costs, including expert review costs.

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

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

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, 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.

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

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

16. 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.

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

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his 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.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated

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

20. 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. 800-2018-043431 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, Raymond J. McMahon. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 02/14/2022

HOSSEIN BABAALI, M.D.
Respondent

I have read and fully discussed with Respondent Hossein Babaali, 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: February 15, 2022

RAYMOND J. MCMAHON
Attorney for Respondent

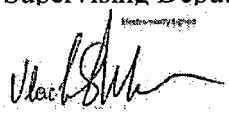
ENDORSEMENT

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

DATED: February 15, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-043431

ROB BONTA
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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: **HOSSEIN BABAALI, M.D.** **2428 Santa Monica Blvd., Suite 402** **Santa Monica, CA 90034** **Physician's and Surgeon's Certificate No. G 86162,** Respondent.	Case No. 800-2018-043431 **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 August 1, 2001, the Board issued Physician's and Surgeon's Certificate Number G 86162 to Hossein Babaali, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2023, 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.

5. Section 2234 of the Code, states:

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

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

(b) Gross negligence.

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

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

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the

licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

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

6. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

7. Section 2241 of the Code states:

(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting

under his or her instruction and supervision, under the following circumstances:

(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

(d) (1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

(A) Impaired control over drug use.

(B) Compulsive use.

(C) Continued use despite harm.

(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5.

8. Section 2242 of the Code states, in pertinent part:

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

9. 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.

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. Effective on January 1, 2022, section 125.3 of the Code provides:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement

for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.[1]

DEFINITIONS

12. Methadone HCL is a potent, long-acting synthetic opioid. It is a Schedule II controlled substance.

13. Percocet is a combination narcotic used for relief of moderate to severe pain. It contains an opioid pain reliever oxycodone and a non-opioid pain reliever acetaminophen. Percocet is a dangerous drug pursuant to Business and Professions Code section 4022, and, because it contains oxycodone, it is a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

14. Promethazine with codeine is a combination antihistamine. Because it contains codeine, it is a dangerous drug pursuant to Business and Professions Code section 4022 and a Schedule III controlled substance pursuant Health and Safety Code section 11056, subdivision (3).

15. Tramadol is a centrally acting synthetic opioid analectic marketed under the brand name Ultram, as well as other brand names. It is used to treat moderate to severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant to the federal Controlled Substances Act.

16. Oxycodone is an opioid narcotic used for relief of moderate to severe pain. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule II controlled substance pursuant Health and Safety Code section 11055, subdivision (M).

17. Ambien is the brand name for zolpidem tartrate, a hypnotic sedative that is generally used to treat insomnia. It is a dangerous drug pursuant to Business and Professions Code section

[1] Effective January 1, 2022, subdivision (k) of Section 125.3, which exempted physicians and surgeons from paying recovery of the costs of investigation and prosecution by the Board, was repealed.

4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 110575, subdivision (d)(32).

18. Xanax is a brand name of alprazolam, a benzodiazepine depressant, generally used to treat anxiety. Xanax is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 11057, subdivision (d)(1).

19. Valium is a brand name of diazepam, a benzodiazepine depressant, used to treat anxiety and insomnia. It is a dangerous drug pursuant to Business and Professions Code section 4022, and a Schedule IV controlled substance pursuant Health and Safety Code section 11057, subdivision (d)(9).

20. Modafinil is a stimulant, usually used to treat narcolepsy. It is a dangerous drug pursuant to Business and Professions Code section 4022. It is a Schedule IV controlled substance pursuant to the Health and Safety Code section 11057, subdivision (f)(3).

FACTUAL ALLEGATIONS

Patient 1

21. On April 26, 2018, the Board received a complaint from a licensed physician who cared for Patient 1.[2] The physician complained that Respondent, who is trained as a pulmonologist, prescribed a large quantity of methadone HCL 10 mg to Patient 1, and believed that this medication was inappropriately prescribed. The Board then proceeded to investigate the care and treatment rendered by Respondent to Patient 1.

22. Patient 1 was a 50-year-old male, when he first became Respondent's patient on or about May 13, 2013. Respondent obtained a history of back surgery 11 years prior and a broken wrist surgery 17 years before. Patient 1 complained of severe pain all over his body, a boil on the lower part of his buttocks, extreme fatigue, severe joint, back, leg and arm pain, and recent weight gain. Respondent documented the patient's chief complaint as "pain in sacral area and knees – chronic; his glucose not controlled; blood pressure poorly controlled." The physical examination noted edema with purulent drainage on the patient's left gluteal region, and a positive finding of a

[2] The patients are identified in this Accusation by number to protect their privacy.

tremor on neurological exam. Otherwise, the physical examination was normal. The patient's blood sugar was elevated. The patient's problem list included a perianal abscess, hypoglycemia, hypertension, COPD, osteoporosis, rheumatoid arthritis, depression, and chronic pain.

23. Respondent saw Patient 1 86 times between May 13, 2013, and December 16, 2019 (76 times after April 24, 2014.) During his treatment of Patient 1, Respondent prescribed increasing quantities of controlled substances, including opiates, sedatives, and stimulants, as detailed below. Respondent initially failed to obtain and document Patient 1's informed consent for the use of controlled substances. It was not until May 12, 2014, when the dose of methadone HCL 10 mg reached 70 mg bid did Respondent document in Patient 1's medical record that he "explained to patient extensively about various side effect [sic.]" Just two months later, on July 10, 2014, Respondent made the first of many documented efforts to refer Patient 1 to a pain management specialist.

24. During the entire course of treatment, Respondent did not formulate or document a treatment plan for Patient 1. Without a detailed plan and without concrete benchmarks, Respondent had no control over his treatment of Patient 1. This resulted in massive over-prescription of methadone HCL 10 mg to Patient 1, complicated by the concomitant prescription of multiple agents with synergistic risks.

25. During the entire course of treatment, Respondent failed to ensure accurate documentation of medications he prescribed to Patient 1, making it nearly impossible to use Respondent's medical record to easily and accurately determine exactly which controlled medications were in use and which medications were prescribed when, in what quantity, and with what instructions.

26. Respondent was aware that Patient 1 was a high-risk, drug-seeking patient. During his interview with the Board, Respondent described Patient 1 as follows:

> "[H]e was seeing me because of chronic pain. A lot of pain. He would complain of his knees, his back pain, and he would have all kinds of excuses, but -- uh -- yes. He does have severe arthritis, and uh -- medical conditions that require pain medication. But this guy was living in an environment that was infested with drugs. Cocaine, all kinds of things. And

with prostitutes, and different things he was involved with. And I explained to him that, you know, he needs to stop using illicit drugs, and if he has pain, he can take pain medication. From my training, if I can get somebody away from abusive drugs like heroin, cocaine, Percocet, these things that make them high, and that would be -- to me that's success. And this guy, from my training -- what's good about methadone HCL 10 mg is that it controls the pain, but at the same time doesn't allow them to get high."

". . . he was on pain – on narcotics. Before I had him. He was using it. He was using drugs and all that to control his pain... Illicit drugs and some prescribed by physicians. A lot of it was illicit drugs."

Respondent never documented in the chart that Patient 1 was abusing illicit drugs. Instead, Respondent documented treating Patient 1 for chronic pain, insomnia, and depression. Patient 1 often presented with elevated blood pressure or pulse, which signaled potential stimulant abuse, yet Respondent never obtained or documented a detailed substance abuse history. Respondent never included substance use disorder as one of Patient 1's differential diagnoses. Respondent never obtained toxicological screening of Patient 1.

27. On November 13, 2014, Respondent denied a request by Patient 1 for the use of medical marijuana. Even if it was Respondent's practice, at that time, not to use routine toxicological screening in patients to whom he prescribed massive doses of methadone HCL 10 mg, Patient 1's request for medical marijuana should have increased his index of suspicion for substance use disorder well beyond the threshold necessary to trigger toxicological screening. On June 16, 2016, when Patient 1 requested an increased dose of Xanax and Respondent documented that he "encouraged him to quit marijuana," Respondent still did not order toxicological screening. On July 14, 2016, Patient 1 presented complaining of chest tightness with a pulse of 110. Tachycardia and chest tightness may be evidence of stimulant drug abuse, but Respondent ordered no toxicological screen. Even on September 1, 2016, when Respondent documented "[illegible] drug use. Marijuana," he still did not order toxicological screening. On or about May 7, 2019, a note from the Interdisciplinary Spine Clinic reported that methamphetamine was present in Patient 1's first toxicological screen done there and that his urine drug screen of April

25, 2019 was "inconsistent," indicating that the methadone HCL 10 mg prescribed by Respondent was not present in the patient's urine sample. When he was confronted with the fact that toxicological screens showed no methadone HCL 10 mg in Patient 1's urine, Respondent's response was to describe himself as "naïve." Even then, faced with concrete evidence of "inconsistent" toxicology screening and documented methamphetamine use, Respondent not only failed to institute his own toxicological screen, but he continued to issue prescriptions for massive quantities of methadone HCL 10 mg for another six months.

28. In his interview with the Board's investigators, Respondent admitted that the reason he finally stopped prescribing controlled medications to Patient 1 was because he came under investigation by the Board. At all times alleged herein, Respondent failed to monitor controlled substances he prescribed to Patient 1 by using CURES.[3] It was not until December 16, 2019, after Respondent became aware of the Board's investigation, that Respondent's records contain a CURES data review.

29. Starting before May 23, 2014 and continuing through December 16, 2019, Respondent prescribed methadone HCL 10 mg to Patient 1 in an inappropriate and excessive manner, prescribing massive quantities of methadone HCL 10 mg and allowing Patient 1 to have access to as much as 300 mg of methadone HCL 10 mg per day. Before finally determining on December 15, 2019 that he could no longer prescribe methadone HCL 10 mg to Patient 1, Respondent documented several attempts to decrease Patient 1's use of Methadone HCL 10 mg: on 2/12/15 "he should try to decrease methadone HCL 10 mg", on 10/20/15 "try to decrease pain meds," and 12/15/16 "he is trying to reduce his pain meds." On 10/8/19, Respondent documented

[3] "CURES" means the Department of Justice, Bureau of Narcotics Enforcement's California Utilization, Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, III, IV and V controlled substances dispensed to patients in California pursuant to Health and Safety Code section 11165. The CURES database captures data from controlled substance prescriptions filled as submitted by pharmacies, hospitals, and dispensing physicians. Law enforcement and regulatory agencies use the data to assist in their efforts to control the diversion and resultant abuse of controlled substances. Prescribers and pharmacists may request a patient's history of controlled substances dispensed in accordance with guidelines developed by the Department of Justice. Starting on October 2, 2018, all California physicians and other prescribing health care professionals were mandated by Health and Safety Code section 11165.4 to consult CURES before prescribing Schedule II, III or IV controlled substance for the first time, and at least once every six months thereafter.

that he would taper methadone HCL 10 mg by 10% unless a pain specialist recommended otherwise. On 11/8/19, that taper was nominally implemented, yet #424 tablets of 10 mg methadone HCL 10 mg were prescribed that day and the next.

30. Due to Respondent's inadequate record of care and treatment of Patient 1, it is unclear how much methadone HCL 10 mg Respondent was actually giving Patient 1 at any given point. On 11/2/13, when 180 tablets were dispensed, the intended dose was 60 mg per day. On 1/3/14, Respondent documented increasing methadone HCL 10 mg to 50 mg bid. CURES data shows that dose was dispensed to the patient. On 2/13/14, 3/20/14, and 4/24/14, the quantity of methadone HCL 10 mg intended to be prescribed was not documented. On 5/12/14, the dose of methadone HCL 10 mg was increased to 70 mg bid, 14 tablets daily. But, Patient 1 actually had 22 tablets per day available from the prescriptions filled on 1/24/14 to 2/4/14. The daily dosage available in the spring and summer of 2014 varied from 20 mg to 330 mg per day. Omitting that chaotic period, the average daily dosage of methadone HCL 10 mg prescribed by Respondent to Patient 1, between September 3, 2014 and September 17, 2018, was 159 mg, a 14% increase in dose from the intended 140 mg. Between 12/19/14 and 1/19/15, Respondent gave Patient 1 840 tablets of methadone HCL 10 mg, enough to take 27.1 tablets per day, every day for 31 days. Respondent made no comment anywhere in the medical record to explain why he consistently overdosed Patient 1 with methadone HCL 10 mg over a period of years.

31. Starting in approximately February 2, 2016, and continuing through December 16, 2019 Respondent inappropriately and excessively prescribed promethazine (Phenegran with codeine) to Patient 1, concomitantly with methadone HCL 10 mg. On August 24, 2017, Respondent documented his intent to taper and discontinue giving this medication to Patient 1: "Promethazine was given 12 oz next time 6 oz and then d/c." However, CURES data reveals that Respondent did not discontinue his prescription of promethazine to Patient 1. Respondent did indeed prescribe 12 oz (360 mL) in late August 2017. Instead of following the plan to taper and discontinue Patient 1's promethazine, Respondent prescribed 8 oz (240 mL), not 6 oz in September 2017, before prescribing 12 oz more in October 2017 and then returning to monthly prescriptions of at least 8 oz, which continued until January 2019. Respondent lacked control of

the quantity of promethazine with codeine he prescribed to Patient 1, from August to November 2017. While he documented that he was discontinuing treatment, he actually prescribed 14.4, 12.9, 8.6, and 14.4 mL of promethazine with codeine per day. On average, between February 1, 2016, and February 2, 2019, Respondent prescribed 11.5 mL of promethazine per day to Patient 1.

32. During his interview with Board's investigators, Respondent explained that this prescribing of promethazine to a patient he knew was suffering from a substance use disorder was because the patient told him it was the only thing that worked. Respondent further suggested that Phenergan with codeine may be indicated to treat the postnasal drip that can occur after nasal use of illicit drugs. Phenergan with codeine is the key ingredient of "Purple Drank," a concoction often abused by people who snort cocaine or methamphetamine. It is highly inappropriate to prescribe it to treat the adverse effects of intranasal stimulant abuse.

33. Respondent prescribed tramadol HCL to Patient 1 sporadically from June 4, 2015, through November 17, 2016. Respondent never documented in Patient 1's medical record when or why tramadol HCL was prescribed to Patient 1. Respondent never documented in Patient 1's medical record when or why he discontinued prescribing tramadol HCL to Patient 1.

34. A combination of opioids and benzodiazepines is among the most dangerous combination therapies a physician can prescribe for his patient. Methadone HCL 10 mg, Xanax, and Ambien all contain Black Box warnings about the risk of concomitant prescription of opiates and benzodiazepines. While Respondent documented on September 11, 2014, that he was "also concerned about mixing anxiolytics & Methadone HCL 10 mg," he did nothing about that concern. Respondent went on to prescribe massive doses of methadone HCL 10 mg, steady doses of Xanax, and variable doses of Ambien to Patient 1 over a period of five more years. During the interview, Respondent attempted to explain his use of high-dose treatment with Ambien as a reaction to Patient 1's known use of cocaine. Respondent stated that typically, he would start with Benadryl or perhaps 5 mg Ambien. "But with the guy who was on cocaine, lots of drugs... you can give them Ambien 10 mg... It may not even touch them, you know?"

35. Respondent did not document his prescribing of Xanax to Patient 1 consistently and

had no record of how much Xanax he prescribed to Patient 1. On March 12, 2015, when Respondent documented that Patient 1 requested a refill of Xanax, Xanax was not listed as one of the medications prescribed previously. Xanax was absent from the medication list on March 5, 2015, March 12, 2015, and January 28, 2016. Xanax was listed on Patient 1's medication list on April 21, 2016, but then absent again on November 17, 2016. On May 11, 2015, Respondent documented: "He feels anxious and can't focus." "Xanax 30" is written. Yet on that date, CURES data shows that #60, not #30 Xanax 1 mg was prescribed. Similarly, on January 7, 2016, when Patient 1 complained of nervousness with Ambien, Respondent documented prescribing Xanax 1 mg daily. Yet on January 4, 2016 and February 1, 2016, #60 of 1 mg Xanax was prescribed, according to CURES data. CURES data also shows that from May 5, 2015 through December 4, 2018, Respondent prescribed sufficient Xanax for Patient 1 to take approximately 2 mg per day, every day, either as two 1 mg tabs daily or one 2 mg tab daily.

36. From October 18, 2014 through May 10, 2015, Respondent prescribed Ambien to Patient 1, one 5 mg tablet or fewer daily. On May 11, 2015, the same day that sixty 1 mg tablets of Xanax were prescribed, 30 tablets of 5 mg Ambien were prescribed, as well as methadone HCL 10 mg. From that point forward, through September 16, 2018, Respondent issued a total of fifteen prescriptions for Ambien 5 mg tablets. On June 9, 2015, the second of those prescriptions was issued, giving Patient 1 access to 1.3 Ambien tablets per day, a 30% increase in dose of the intended quantity. Respondent failed to accurately document his prescribing of Ambien to Patient 1.

37. On December 12, 2014, February 14, 2015, and June 4, 2015, Respondent prescribed #30 tablets of 5 mg Valium to Patient 1. The only mention in the medical record of Valium is when its discontinuation is noted on November 9, 2015. The concomitant use of Valium together with Xanax and Ambien is never discussed in Respondent's record. Respondent never documented any consideration or reason why he prescribed Valium to Patient 1, or why he discontinued prescribing Valium to Patient 1.

38. Respondent prescribed all three medications (Valium, Xanax, and Ambien) to Patient 1 between June 4, 2015, and June 12, 2015.

39. During his care and treatment of Patient 1, Respondent prescribed modafinil to Patient 1 consistently from January 31, 2014, to January 12, 2017, at approximately 200 mg per day. Respondent did not consider and did not document any reasoning for his use of modafinil and the risks of prescribing it with multiple sedatives and opioids. The rationale for prescribing a stimulant, presumably to treat obstructive sleep apnea (OSA), while at the same time prescribing methadone HCL 10 mg, Phenergan with codeine, Flexeril, Xanax, Valium, and Ambien is never discussed in the patient's chart. Modafinil is modestly effective as an adjuvant therapy for OSA because it alters sleep-wake cycles, operating as a stimulant. Giving a stimulant to treat OSA while at the same time as giving seven different sedative agents is irrational, and the risks exceed benefits, particularly in a man who is known to abuse marijuana and was known or should have been known to abuse methamphetamine.

40. Between May 23, 2014 and December 16, 2019, Patient 1 was dispensed controlled substances, prescribed to him by Respondent, as follows:

Date Prescription Dispensed:	Controlled substance Dispensed	Quantity Dispensed
5/23/14	Methadone HCL 10 mg	360 Pills
6/4/14	Methadone HCL 10 mg	60 Pills
6/6/14	Modafinil 200 mg	30 Pills
7/10/14	Modafinil 200 mg	30 Pills
7/11/14	Methadone HCL 10 mg	100 Pills
7/14/14	Methadone HCL 10 mg	420 Pills
8/11/14	Methadone HCL 10 mg	290 Pills
8/13/14	Methadone HCL 10 mg Modafinil 200 mg	130 Pills 30 Pills
9/3/14	Methadone HCL 10 mg	420 Pills
9/5/14	Modafinil 200 mg	30 Pills

9/19/14	Diazepam 10 mg Acetaminophen with Codeine 300/30 mg	1 Pill 1 Pill
9/26/14	Methadone HCL 10 mg	390 Pills
9/29/14	Diazepam 10 mg Acetaminophen with Codeine 300/30 mg	1 Pill 1 Pill
10/18/14	Ambien 5 mg	30 Pills
10/24/14	Methadone HCL 10 mg	420 Pills
11/17/14	Ambien 5 mg Modafinil 200 mg	30 Pills 30 Pills
11/22/14	Methadone HCL 10 mg	420 Pills
12/12/14	Valium 5 mg Modafinil 200 mg	30 Pills 30 Pills
12/17/14	Ambien 5 mg	30 Pills
12/19/14	Methadone HCL 10 mg	420 Pills
1/5/14	Methadone HCL 10 mg	420 Pills
1/12/15	Ambien 5 mg	30 Pills
1/19/15	Methadone HCL 10 mg	420 Pills
2/19/15	Methadone HCL 10 mg	420 Pills
3/17/15	Methadone HCL 10 mg	420 Pills
4/17/15	Ambien 5 mg Methadone HCL 10 mg10 mg Modafinil 200 mg	30 Pills 420 Pills 30 Pills
5/11/15	Ambien 5 mg Xanax 1mg Methadone HCL 10 mg	30 Pills 60 Pills 420 Pills

	Modafinil 200 mg	30 Pills
6/4/15	Tramadol HCL 50 mg	120 Pills
	Valium 5 mg	30 Pills
6/9/15	Ambien 5mg	30 Pills
	Modafinil 200 mg	30 Pills
6/12/15	Xanax 1mg	60 Pills
	Methadone HCL 10 mg	420 Pills
7/7/15	Xanax	60 Pills
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
7/9/15	Ambien 5 mg	30 Pills
8/1/15	Modafinil 200 mg	30 Pills
8/3/15	Ambien 5 mg	30 Pills
8/6/15	Xanax 1 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
8/17/15	Tramadol HCL 50 mg	120 Pills
8/28/15	Ambien 5mg	30 Pills
	Modafinil 200 mg.	30 Pills
8/29/15	Xanax 1 mg	120 Pills
9/2/15	Methadone HCL 10 mg	420 Pills
9/16/15	Tramadol HCL 50 mg	120 Pills
9/25/15	Methadone HCL 10 mg	420 Pills
9/26/15	Ambien 5 mg	30 Pills
	Modafinil 200 mg	30 Pills
10/16/15	Xanax 1 mg	60 Pills
10/17/15	Tramadol HCL 50 mg	120 Pills
10/21/15	Ambien 5 mg	30 Pills

	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
11/12/15	Xanax 2 mg	30 Pills
11/13/15	Methadone HCL 10 mg	420 Pills
11/20/15	Modafinil 200 mg	30 Pills
11/21/15	Ambien 5 mg	30 Pills
12/5/15	Xanax 1 mg	60 Pills
12/12/15	Methadone HCL 10 mg	420 Pills
12/16/15	Tramadol HCL 50 mg	120 Pills
12/19/15	Modafinil 200 mg	30 Pills
12/31/15	Ambien 5 mg	30 Pills
	Xanax 1 mg	60 Pills
1/4/16	Xanax 1 mg	60 Pills
1/8/16	Methadone HCL 10 mg	420 Pills
1/14/16	Tramadol HCL 50 mg	120 Pills
1/19/16	Modafinil 200 mg.	30 Pills
1/28/16	Ambien 5 mg	30 Pills
1/29/16	Modafinil 200 mg	30 Pills
2/1/16	Xanax 1mg	60 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
2/11/16	Modafinil 200 mg	30 Pills
2/29/16	Promethazine HCL - Codeine	240 mL
3/1/16	Xanax 2 mg	30 Pills
	Methadone HCL 10 mg	420 Pills
3/5/16	Modafinil 200 mg	30 Pills

3/14/16	Tramadol HCL 50 mg	120 Pills
3/29/16	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
4/6/16	Promethazine HCL - Codeine	240 mL
4/21/16	Xanax 1 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
4/27/16	Promethazine HCL - Codeine	240 mL
5/9/16	Tramadol HCL 50 mg	90 Pills
5/19/16	Xanax 1 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
5/27/16	Promethazine HCL - Codeine	240 mL
6/9/16	Tramadol HCL 50 mg	90 Pills
6/16/16	Xanax 1 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
6/18/16	Modafinil 200 mg	30 Pills
6/27/16	Promethazine HCL - Codeine	240 mL
7/14/16	Xanax 1 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
7/25/16	Promethazine HCL - Codeine	360 mL
8/8/16	Methadone HCL 10 mg	420 Pills
8/16/16	Modafinil 200 mg	30 Pills
8/20/16	Xanax 1 mg	60 Pills

8/25/16	Promethazine HCL - Codeine	360 mL
9/7/16	Methadone HCL 10 mg	420 Pills
9/14/16	Xanax 2mg	30 Pills
9/24/16	Promethazine HCL - Codeine	360 mL
9/30/16	Methadone HCL 10 mg	420 Pills
10/7/16	Xanax 2mg	30 Pills
10/24/16	Promethazine HCL - Codeine	780 mL
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
10/31/16	Xanax 2mg	30 Pills
11/17/16	Tramadol HCL 50 mg	120 Pills
11/21/16	Promethazine HCL - Codeine	360 ML
	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
12/5/16	Xanax 2 mg	30 Pills
12/16/16	Methadone HCL 10 mg	420 Pills
	Modafinil 200 mg	30 Pills
12/17/16	Tramadol CHL 50 mg	60 Pills
12/21/16	Promethazine HCL - Codeine	360 ML
12/28/16	Xanax 2mg	30 Pills
1/12/16	Modafinil 200 mg	30 Pills
1/16/17	Methadone HCL 10 mg	420 Pills
1/20/17	Promethazine HCL - Codeine	360 mL
1/21/17	Promethazine HCL - Codeine	240 mL
1/24/17	Xanax 2 mg	30 Pills
1/31/17	Tramadol HCL 50 mg	60 Pills
2/8/17	Methadone HCL 10 mg	420 Pills

2/22/17	Promethazine HCL - Codeine	240 mL
3/3/17	Xanax 60 mg	30 Pills
	Methadone HCL 10 mg	420 Pills
3/16/17	Promethazine HCL - Codeine	240 mL
3/27/17	Methadone HCL 10 mg	420 Pills
	Tramadol HCL 50 mg	90 Pills
4/5/17	Xanax 2 mg	30 Pills
4/14/17	Promethazine HCL - Codeine	360 mL
4/19/17	Methadone HCL 10 mg	420 Pills
5/2/17	Xanax 2 mg	30 Pills
5/10/17	Promethazine HCL - Codeine	600 mL
5/12/17	Methadone HCL 10 mg	420 Pills
5/26/17	Xanax 2 mg	30 Pills
6/7/17	Promethazine HCL - Codeine	360 ML
6/8/17	Methadone HCL 10 mg	420 Pills
7/7/17	Ambien 5 mg	30 Pills
	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	360 ML
	Methadone HCL 10 mg	420 Pills
7/25/17	Promethazine HCL - Codeine	113 mL
8/3/17	Xanax 2 mg	30 Pills
	Promethazine HCL – Codeine	360 ML
	Methadone HCL 10 mg	420 Pills
8/17/17	Ambien 5 mg	30 Pills
8/28/17	Xanax 1 mg	60 Pills
	Promethazine HCL - Codeine	360 ML

	Methadone HCL 10 mg	420 Pills
9/19/17	Ambien 5 mg	30 Pills
9/21/17	Xanax 2 mg	30 Pills
	Methadone HCL 10 mg	420 Pills
9/25/17	Promethazine HCL - Codeine	360 ML
10/19/17	Xanax 2 mg	30 Pills
	Methadone HCL 10 mg	420 Pills
10/23/17	Promethazine HCL - Codeine	360 ML
11/17/17	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
	Tramadol HCL 50 mg	30 Pills
12/11/17	Xanax 2 mg	30 Pills
	Methadone HCL 10 mg	420 Pills
12/19/17	Promethazine HCL - Codeine	240 mL
1/5/18	Promethazine HCL - Codeine	240 mL
1/10/18	Methadone HCL 10 mg	420 Pills
1/27/18	Xanax 2 mg	30 Pills
2/1/18	Promethazine HCL - Codeine	240 mL
2/2/18	Methadone HCL 10 mg	420 Pills
2/27/18	Xanax 2mg	30 Pills
3/1/18	Ambien 5 mg	30 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
3/27/18	Xanax 2 mg	30 Pills
4/2/18	Promethazine HCL - Codeine	360 ML
	Methadone HCL 10 mg	420 Pills
5/1/18	Promethazine HCL - Codeine	240 mL

	Methadone HCL 10 mg	420 Pills
5/22/18	Promethazine HCL - Codeine	240 mL
5/30/18	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
6/30/18	Promethazine HCL - Codeine	180 mL
	Methadone HCL 10 mg	420 Pills
7/30/18	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
8/16/18	Ambien 5 mg	30 Pills
8/30/18	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills
9/16/18	Ambien 5 mg	30 Pills
9/17/18	Xanax 2 mg	30 Pills
	Promethazine HCL - Codeine	540 mL
	Methadone HCL 10 mg	420 Pills
	Tramadol HCL 50 mg	30 Pills
9/16/18	Ambien 5 mg	30 Pills
10/11/18	Promethazine HCL - Codeine	30 mL
11/1/18	Xanax 2 mg	60 Pills
	Methadone HCL 10 mg	420 Pills
11/13/18	Promethazine HCL - Codeine	240 mL
12/4/18	Xanax 2 mg	60 Pills
	Promethazine HCL - Codeine	240 mL
	Methadone HCL 10 mg	420 Pills

1/3/19	Promethazine HCL - Codeine	240 mL
1/4/19	Methadone HCL 10 mg	420 Pills
2/2/19	Promethazine HCL - Codeine	240 mL
2/4/19	Methadone HCL 10 mg	420 Pills
3/6/19	Methadone HCL 10 mg	420 Pills
4/8/19	Methadone HCL 10 mg	196 Pills
6/7/19	Methadone HCL 10 mg	420 Pills
7/1/19	Methadone HCL 10 mg	420 Pills
8/8/19	Methadone HCL 10 mg	420 Pills
9/5/19	Methadone HCL 10 mg	360 Pills
10/8/19	Methadone HCL 10 mg	360 Pills
11/18/19	Methadone HCL 10 mg	324 Pills
11/19/19	Methadone HCL 10 mg	100 Pills
12/16/19	Methadone HCL 10 mg	60 Pills

Patient 2

41. Patient 2 was a male 47-year-old non-smoker when he first saw Respondent on or about June 6, 2012, after inhaling toxic fumes from a concrete sealer that was applied in his apartment building. Respondent recorded in Patient 2's record that Patient 2 had no prior medical problems. After a few hours of exposure, he complained that he was suffering shortness of breath, blurry vision, headache, sinus and throat irritation, chest discomfort, and abdominal pain. At that time, Patient 2 was taking over the counter medications Aleve[4] and Nyquil.

42. Respondent saw Patient 2 112 times between June 6, 2012, and March 28, 2019 (57 times after June 5, 2014). While under Respondent's care, Patient 2's condition transitioned from a relatively healthy patient whom Respondent documented had no prior medical problems to a drug-seeking patient with opioid dependence.

43. During 2012, Respondent noted that Patient 2 complained that he suffered from back

[4] Aleve is an over-the-counter naproxen.

pain, headaches, and anxiety. However, Respondent failed to document a recognized indication for the institution of chronic opioid and benzodiazepine treatment. During his interview with the Board's investigators, Respondent related a history of war-related injuries to Patient 2's back, and fall with re-injury during the incident of exposure to toxic fumes when the treatment started. Respondent also claimed that Patient 2 was taking significant amounts of pain medications before he began to see Respondent. However, none of this history is documented anywhere in Patient 2's medical record. Respondent began treatment of Patient 2 with opioids and benzodiazepines without obtaining a psychological evaluation of Patient 2.

44. Initially, Respondent prescribed Vicodin and Xanax to Patient 2. One month later, on July 5, 2012, Respondent was prescribing MS-Contin 15 mg twice a day, along with Xanax, to Patient 2. Respondent's records show that he doubled the dose of Xanax because Patient 2 requested it.

45. By January 10, 2013, Respondent was prescribing 200 mg daily of MS-Contin, 2 mg daily of Xanax, and 10 mg of Ambien, at which time Respondent documented for the first time that Patient 2 was "cautioned about getting used to pain medications."

46. By the June 5, 2014 visit, Respondent's medical record documented sufficient information to diagnose Patient 2 with opioid use disorder. Respondent documented that "mentally he may be depended on the meds. He denies it when discussed with him." "He is very resistant to lowering his meds. He wants to increase it." However, despite these observations Respondent did not attempt to taper medications to which Patient 2 has become "addicted," and he did not refer Patient 2 to an addiction specialist. Instead, Respondent documented that he "encouraged him take less meds as possible." Regardless of what Respondent encouraged, he, in fact, steadily increased the dose and quantity of opioids, Percocet and oxycodone, he concomitantly prescribed to Patient 2. Respondent also prescribed methadone to Patient 2 on July 21, 2015, August 20, 2015, November 5, 2015, and August 30, 2017. Respondent did not document any reason or the thought process for prescribing methadone to Patient 2.

47. On or about December 11, 2017, Respondent documented a diagnosis of "addiction" in Patient 2's medical record.

48. At all times during his treatment of Patient 2, Respondent failed to perform and/or document an adequate physical examination to justify initiation and continuation of chronic opioid treatment of Patient 2.

49. At all times during his treatment of Patient 2, Respondent failed to obtain and document Patient 2's informed consent for initiation and continuation of Patient 2's chronic opioid treatment or to enter into a pain agreement with Patient 2.

50. At all times during his treatment of Patient 2, Respondent failed to obtain any toxicology screening of Patient 2 to confirm that his medication intake was consistent with what Respondent prescribed.

51. At all times during his treatment of Patient 2, Respondent failed to develop and document a treatment plan with goals and benchmarks for Patient 2. Respondent failed to assess the effectiveness of treatment of Patient 2 and to modify it accordingly. During Respondent's treatment of Patient 2, the patient made no progress and continued to complain of pain. Respondent repeatedly documented that he advised Patient 2 to reduce his opioid doses. On March 24, 2016, when Respondent documented the need to decrease Patient 2's pain medication, Patient 2 protested and indicated that his psychologist and psychiatrist told him "he needs the medication." Respondent never contacted Patient 2's psychologist or psychiatrist, but instead allowed Patient 2, who was developing a dependence on opioids, to control his opioid treatment. This pattern continued even after Respondent documented on August 18, 2016 that Patient 2 threatened to kill himself if his medications were changed. Even after Respondent was, or should have been, aware that Patient 2 became dependent on opioids, Respondent failed to arrange for an addiction referral. Despite repeatedly documenting his intent to do so, Respondent failed to arrange for a referral of Patient 2 to a pain management specialist. Respondent failed to arrange and follow up on a referral to mental health treatment of Patient 2. Instead, Respondent prescribed dangerous doses of opioids to Patient 2 for years. Despite repeatedly documenting his intent to reduce the amount of controlled substances he was prescribing to Patient 2, including on June 15, 2014, November 19, 2015, and March 24, 2016, Respondent failed to do so.

52. Having previously described Patient 2 in his assessment as suffering from memory

loss, starting on or about November 17, 2016, he assessed Patient 2 with dementia, and described Patient 2's neurological/psychiatric assessment as "depressed, anxious, nervous and fearful." Respondent did not document any explanation of how he arrived at the diagnosis of "dementia" in a 50-year-old man who had no medical issues four years prior. Early dementia in a 50-year-old man requires an extensive neurological workup. Respondent, however, failed to refer Patient 2 for a neurological assessment and did not perform and did not document that he performed one himself.

53. At all times during his treatment of Patient 2, Respondent failed to keep an accurate and complete list of medications he was prescribing to Patient 2. Respondent failed to document the dose, frequency, indication, and amount of each prescription issued for controlled medications he prescribed to Patient 2.

54. Between April 22, 2014 and December 16, 2019, Patient 2 was dispensed controlled substances, prescribed to him by Respondent, as follows:

Date Prescription Dispensed:	Controlled substance Dispensed	Quantity Dispensed
4/22/14	Oxycodone HCL 15 mg	90 Pills
5/12/14	Oxycodone CHL 15 mg Xanax 2mg	90 Pills 72 Pills
5/22/14	Oxycodone HCL 15 mg	90 Pills
7/20/14	Oxycodone HCL 15 mg Ambien 10 mg	90 Pills 30 Pills
8/13/14	Oxycodone HCL 15 mg	90 Pills
9/2/14	Oxycodone HCL 15 mg	90 Pills
9/24/14	Oxycodone HCL 15 mg	120 Pills
10/13/14	Oxycodone HCL 15 mg	120 Pills
10/31/14	Oxycodone HCL 15 mg	120 Pills

11/14/14	Oxycodone HCL 15 mg	180 Pills
12/14/14	Oxycodone HCL 15 mg	180 Pills
1/15/15	Oxycodone HCL 15 mg	180 Pills
2/13/15	Oxycodone HCL 15 mg	180 Pills
3/13/15	Oxycodone HCL 15 mg	180 Pills
3/20/15	Vicodin 325-5 mg	100 Pills
4/14/15	Oxycodone HCL 15 mg	120 Pills
4/24/15	Percocet 325-5	120 Pills
5/11/15	Oxycodone HCL 15 mg	120 Pills
6/12/15	Oxycodone HCL 15 mg	120 Pills
7/9/15	Ambien 10 mg	30 Pills
7/10/15	Oxycodone HCL 15 mg	120 Pills
7/21/15	Methadone HCL 10 mg	240 Pills
8/20/15	Methadone HCL 10 mg	240 Pills
9/29/15	Oxycodone HCL 15 mg Percocet 325-10 mg	120 Pills 120 Pills
10/29/15	Oxycodone HCL 15 mg Percocet 325-10 mg	120 Pills 120 Pills
11/5/15	Methadone HCL 10 mg	120 Pills
11/23/15	Oxycodone HCL 15 mg Percocet 325-10 mg	120 Pills 120 Pills
12/21/15	Oxycodone HCL 15 mg Percocet 325-10 mg	120 Pills 120 Pills
1/21/16	Oxycodone HCL 15 mg Percocet 325-10 mg	120 Pills 120 Pills
2/23/16	Oxycodone HCL 15 mg	120 Pills

	Percocet 325-10 mg	120 Pills
3/22/16	Oxycodone HCL 15 mg	120 Pills
	Percocet 325-10 mg	120 Pills
4/22/16	Oxycodone HCL 15 mg	120 Pills
	Percocet 325-10 mg	120 Pills
5/23/16	Oxycodone HCL 15 mg	120 Pills
	Percocet 325-10 mg	120 Pills
6/20/16	Oxycodone HCL 15 mg	180 Pills
7/5/16	Percocet 325-10 mg	120 Pills
7/21/16	Oxycodone HCL 15 mg	120 Pills
8/4/16	Percocet 325-10 mg	120 Pills
8/17/16	Oxycodone HCL 15 mg	120 Pills
9/2/16	Percocet 325-10 mg	120 Pills
9/26/16	Percocet 325-10 mg	120 Pills
10/14/16	Oxycodone HCL 15 mg	120 Pills
11/4/16	Percocet 325-10 mg	120 Pills
11/14/16	Oxycodone HCL 15 mg	120 Pills
12/15/16	Promethazine HCL with Codeine	270 Ml
1/4/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
2/2/17	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
3/1/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
4/25/17	Percocet 325-10 mg	120 Pills
4/26/17	Oxycodone HCL 15 mg	120 Pills
6/1/17	Percocet 325-10 mg	120 Pills

	Oxycodone HCL 15 mg	120 Pills
6/30/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
7/28/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
8/30/17	Methadone HCL 10 mg	240 Pills
9/29/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
10/27/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
11/30/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
12/29/17	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
1/31/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
2/27/18	Percocet 325-10 mg	120 Pills
2/28/18	Oxycodone HCL 15 mg	120 Pills
3/30/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
5/1/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
6/29/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
7/31/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
8/30/18	Percocet 325-10 mg	120 Pills

	Oxycodone HCL 15 mg	120 Pills
10/4/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
11/5/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
12/4/18	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
1/3/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
2/4/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
3/1/19	Percocet 325-10 mg Oxycodone HCL 15 mg	120 Pills 120 Pills
4/3/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
5/2/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
5/31/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
7/3/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
8/2/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
8/30/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
10/1/19	Percocet 325-10 mg	120 Pills
	Oxycodone HCL 15 mg	120 Pills
10/31/19	Percocet 325-10 mg	108 Pills

	Oxycodone HCL 15 mg	108 Pills
11/26/19	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
12/31/19	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
1/31/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	45 Pills
2/28/20	Percocet 325-10 mg	60 Pills
	Oxycodone HCL 15 mg	60 Pills
4/1/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
4/30/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
6/1/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
6/30/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
7/30/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
8/31/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills
9/29/20	Percocet 325-10 mg	90 Pills
	Oxycodone HCL 15 mg	90 Pills

Patient 3

55. Patient 3 was a 41-year-old woman at the time she consulted with Respondent for a cosmetic procedure on or about April 10, 2018. Respondent documented that Patient 3's face was treated on that day with a Titan laser for "tightening jawline and fat reduction." The fee for this treatment was $500. Respondent failed to document any examination of the area and did not

describe the procedure he performed.

56. Also, on April 10, 2018, Respondent prepared a diagram on which he marked the posterior upper thigh for liposuction of areas 10, 11, and 12 with a discounted fee of $5000. The patient completed an application to Care Credit for a loan of $5000 to be used for her next procedure.

57. The patient returned to Respondent's office two days later, on or about April 12, 2018. She was given Tylenol with codeine 30mg and lorazepam 0.5mg at 4pm. At 5:30 pm she was given another Tylenol with Codeine and lorazepam tablet.

58. Patient 3 signed a consent form for the surgery. She consented to "Cellulaze" as the treatment to be performed. Respondent's chart for Patient 3 fails to explain or document why and how the patient decided and consented to have a "Cellulaze" procedure when the form dated April 10, 2012 quoted the patient a price for liposuction. Respondent wrote on the consent form that the Cellulaze was "cancelled changed to liposuction of inner post thigh + lateral." At the bottom of the page, Respondent wrote, "Addendum: Explained to her + she wants liposuction instead of cellulaze." Neither this addendum nor the addendum note indicating that Cellulaze was canceled and changed to liposuction were co-signed by Patient 3. Neither change to the informed consent form was timed to indicate if the changes were made before or after the patient was sedated.

59. The procedure began at 5:30 pm. There is no documentation of when the surgery ended. The patient was given additional medication (hydrocodone 5-325 #2, lorazepam 0.5, and clonidine 0.1) at 7:00 pm. She was discharged to home by "Charrise." Patient 3's post-surgical caregiver was not noted in Respondent's records. Respondent's discharge note is timed at 2300 (11:00 pm). The patient complained that she "stumbled out" of the office by herself.

60. The patient claimed that she had significant pain and a slow recuperation post-operatively. Respondent's next note, dated April 30, 2018, states Patient 3 was "satisfied with result."

61. Patient 3 returned on June 15, 2018, for treatment "picogenesis face" for which she was charged $450. Patient 3 returned once again on July 18, 2018. Respondent noted that the

patient is "unhappy with her liposuction and wants her money back" and that she "asked for freecellulaze procedure." He wrote: "I told her that her cellulite may improve in the area of liposuction. There were some improvement but not much. She [doesn't] like the result of her liposuction for not improving her cellulite. Since she consented to lipo No refund given. She said she will complain to Medical board if I don't give her refund. She was pleased with her liposuction but claimed she didn't want it. Requested refund since didn't understand the procedure that was done for which she consented. . . ."

62. Patient 3 then sent a certified letter to Respondent requesting copies of her medical records and an invoice for the procedure showing a $0 balance. Three invoices were provided by the patient: #01514 dated 4/12/18 for $7,000; #01608 dated 9/10/18 for $7,000 less $550 care credit – 25% cancelation fee Reimburse check of $3,255; and a second version of #01608 for $5,000 - $550 care credit – 25% cancelation fee Reimburse check of $3,255. The patient never received her medical records following her written request.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

64. The allegations of paragraphs 12 through 54 are incorporated herein by reference.

65. Each of the following was an extreme departure from the standard of care:

A) The manner of prescribing controlled substances to Patient 1 was an extreme departure from the standard of care.

B) It was an extreme departure from the standard of practice for Respondent to fail to obtain and document informed consent to treat Patient 2 with opioids.

C) It was an extreme departure from the standard of practice for Respondent to fail to obtain informed consent from Patient 1 to treat him with opioids and benzodiazepines simultaneously.

D) It was an extreme departure from the standard of care for Respondent to fail to

obtain and document a detailed medical history of Patient 1, including his history of substance use or abuse.

E) It was an extreme departure from the standard of care for Respondent to fail to document a treatment plan with specific objective goals for Patient 1.

F) It was an extreme departures from the standard of care for Respondent to fail to assess ongoing treatment of Patient 1 and the patient's progress.

G) It was an extreme departure from the standard of care for Respondent to fail to accurately document the exact treatment plan he formulated each time Respondent issued a prescription for a controlled medication to Patient 1.

H) After Patient 1's aberrant drug behavior became evident to Respondent, it was an extreme departure from the standard of care for Respondent to fail to address it and take vigorous steps to control it on an ongoing basis.

I) After Patient 1's aberrant drug behavior became obvious and known to Respondent, it was an extreme departure from the standard of care for Respondent to fail to obtain urine drug screening for Patient 1.

J) It was an extreme departure from the standard of care for Respondent to fail to obtain and/or assess Patient 1's EKG each time Respondent increased Patient 1's methadone dose while prescribing other medications that have an impact on the patient's Q.T. segment.

K) Each prescription of the stimulant modafinil from 1/13/14 to 1/12/17 while at the same time prescribing the sedative agents methadone, Phenergan with codeine, Flexeril, Xanax, Valium, and Ambien to Patient 1 was an extreme departure from the standard of care.

L) After he became aware of Patient 1's illicit drug use, it was an extreme departure from the standard of care for Respondent to fail to document this in Patient 1's medical record.

M) It was an extreme departure from the standard of care for Respondent to fail to reduce or discontinue prescribing controlled substances to Patient 1 after Respondent documented that controlled substances he was prescribing to Patient 1 should be reduced.

O) It was an extreme departure from the standard of care for Respondent to fail to

refer Patient 1 for specialty care.

P) Respondent's manner of prescribing controlled substances to Patient 2 was an extreme departure from the standard of care.

Q) Respondent's failure to document any reason to begin prescribing controlled substances to Patient 2 was an extreme departure from the standard of care.

R) It was an extreme departure from the standard of care for Respondent to fail to document that Patient 2 was suffering from physical and/or mental war injuries in Patient 2's medical record.

S) It was an extreme departure from the standard of care for Respondent to fail to obtain and record an informed consent for Patient 2 for treatment with opioids and/or benzodiazepines.

T) It was an extreme departure from the standard of care for Respondent to fail to develop and document an ongoing treatment plan for Patient 2.

U) It was an extreme departure from the standard of care for Respondent to fail to assess the effectiveness of Patient 2's treatment and modify it accordingly.

V) It was an extreme departure from the standard of care for Respondent to fail to provide ongoing toxicology screening for Patient 2.

W) It was an extreme departure from the standard of care for Respondent to fail to ensure that Patient 2 established treatment with a mental health provider, and to communicate with that provider about Patient 2's mental health progress.

X) After assessing Patient 2 with dementia, it was an extreme departure from the standard of care for Respondent to fail to refer Patient 2 for a neurological evaluation.

Y) Respondent's failure to clearly document the dose, frequency, indication, and amount of each prescription for controlled medication issued to Patient 2 was an extreme departure from the standard of care.

Z) Respondent's failure to document his rationale and treatment instructions for Patient 2's use of methadone was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

66. Respondent Hossein Babaali, M.D. is subject to disciplinary action under section 2234, subdivision (c) of the Code in that Respondent committed repeated acts of negligence in his care and treatment of three patients. The circumstances are as follows:

67. The allegations of paragraphs 12 through 62 are incorporated herein by reference.

68. In addition to the departures from the standard of care in his care and treatment of Patients 1 and 2, as alleged in paragraph 65, Respondent departed from the standard of care in his care and treatment of Patient 3, as follows:

AA) Respondent's failure to obtain and properly document informed consent for the liposuction procedure he performed on Patient 3 was a departure from the standard of care.

BB) Respondent's failure to evaluate and document the evaluation of Patient 3 upon her discharge and to document the identity of the patient's post-operative caregiver was a departure from the standard of care.

CC) Respondent's failure to provide Patient 3's medical records to her upon her written request was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

69. Respondent Hossein Babaali, M.D. is subject to disciplinary action under section 2234, subdivision (d) of the Code in that Respondent demonstrated a lack of knowledge and/or ability in his care and treatment of two patients. The circumstances are as follows:

70. The allegations of paragraphs 11 through 54 are incorporated herein by reference.

71. Each of the following, taken separately or together, exhibits Respondent's lack of knowledge and/or ability:

A) During his interview with the Board's investigators, Respondent related that he was unaware of potential diversion of methadone.

B) During his interview with the Board's investigators, Respondent related that he was unaware of the use of toxicology screening for patients taking controlled substances.

C) During his interview with the Board's investigators Respondent explained that he treated Patient 1 with Ambien, Xanax, and methadone as a reaction to Patient 1's known use of cocaine.

D) Respondent exhibited a lack of knowledge when he prescribed sedative agents to Patient 1 when Respondent knew or should have been aware of his prior assessment that Patient 1 suffered from obstructive sleep apnea.

E) Respondent's care and treatment of Patient 1 demonstrated his lack of knowledge regarding the evaluation and management of chronic pain and substance use disorder.

F) Respondent's care and treatment of Patient 1 demonstrated his lack of knowledge regarding the abuse potential of methadone.

G) Respondent's care and treatment of Patient 1 demonstrated Respondent's lack of knowledge regarding the abuse potential of Phenergan with Codeine, when during his interview Respondent stated that this medication was indicated to treat post-nasal drip associated with nasal use of illicit medication.

H) Respondent exhibited a lack of knowledge regarding the need to enter into pain agreements with patients, during his interview with Board investigators.

I) Respondent's failure to discuss in the medical record his rationale for prescribing multiple controlled medications to Patient 1, who suffered from severe polysubstance use disorder is an extreme departure from the standard of practice and an indication of shocking lack of knowledge.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

72. Respondent Hossein Babaali, M.D., is subject to disciplinary action under section 2266 of the Code in that Respondent failed to keep and adequate and accurate records of his care and treatment of two patients. The circumstances are as follows:

73. The allegations of First, Second, and Third Causes for Discipline are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Prescribing of Controlled Substances)

74. Respondent Hossein Babaali, M.D., is subject to disciplinary action under section 725 of the Code in that Respondent prescribed various drugs in a manner that was clearly excessive to two patients. The circumstances are as follows:

75. The allegations of First, Second, Third, and Fourth Causes for Discipline are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing of Controlled Substances to Addicts)

76. Respondent Hossein Babaali, M.D., is subject to disciplinary action under section 2234, subdivision (a), of the code in that Respondent prescribed controlled substances to addicts, in violation of section 2241. The circumstances are as follows:

77. The allegations of First, Second, Third, Fourth, and Fifth Causes for Discipline are incorporated herein by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing of Controlled Substances Without Medical Indication)

78. Respondent Hossein Babaali, M.D., is subject to disciplinary action under section 2234, subdivision (a) of the Code, in that Respondent prescribed controlled substances without medical indication, in violation of section 2242. The circumstances are as follows:

79. The allegations of First, Second, Third, Fourth, and Fifth Causes for Discipline are incorporated herein by reference.

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 86162, issued to Respondent Hossein Babaali, M.D.;

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

3. Ordering Respondent Hossein Babaali, M.D. to pay the Board reasonable costs of investigation and prosecution incurred after January 1, 2022.

4. Ordering Respondent Hossein Babaali, M.D., if placed on probation, to pay the Board the costs of probation monitoring.

5. If disciplined, ordering Respondent Hossein Babaali, M.D. to disclose his discipline to patients as required by section 2228.1 of the Code; and

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

DATED: JAN 13 2022

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

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