STATE OF CALIFORNIA — EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
LEGAL UNIT
1515 Clay Street, Suite 1700
Oakland, California 94612
Tel (510) 286 -7100 Fax (510) 286-0687

October 27, 2017

Cesar Antonio Banda
6608 Mercy Court, Suite A
Fair Oaks, CA 95628

NOTICE OF PROVIDER SUSPENSION – WORKERS' COMPENSATION

Dear Mr. Banda:

The Administrative Director of the Division of Workers' Compensation (DWC) is required by Labor Code section 139.21(a)(1)(C) to suspend you from participation in the California workers' compensation system because your license, certification, or approval to provide health care services has been surrendered or revoked. Enclosed are copies of the documents relied upon by the Administrative Director as the basis for taking this action.

Your suspension will start 30 calendar days after the date of mailing of this notice, unless you submit a written request for a hearing, which will stay the suspension pending the outcome of the hearing. Your request must be made within 10 calendar days of the date of mailing of this notice. If you do not request a hearing within the 10-day time limit, you will be suspended from participation in the California workers' compensation system pursuant to California Code of Regulations, title 8, section 9788.2(b).

Your request for a hearing must contain:

- Your current mailing address;
- The legal and factual reasons as to why you do not believe Labor Code section 139.21(a)(1) is applicable to you; and
- Your original signature or the original signature of your legal representative.

The scope of the hearing is limited to whether or not Labor Code section 139.21(a)(1) is applicable to you. The Administrative Director is required to suspend you unless you provide proof in the hearing that Labor Code section 139.21(a)(1) does not apply.

Your original request for a hearing and one copy of the request must be filed with the Administrative Director. Additionally, you must also serve one copy of the request for a hearing on the DWC Legal Unit. The addresses for the Administrative Director and the Legal Unit are:

Cesar Antonio Banda
October 27, 2017

Hearing Request
Administrative Director
Division of Workers' Compensation
1515 Clay Street, Suite 1800
Oakland, California 94612

and

Hearing Request
Legal Unit, Division of Workers' Compensation
1515 Clay Street, Suite 1800
Oakland, California 94612

The original and all copies of the request for hearing must have a proof of service attached. A sample proof of service, containing all necessary elements, can be found on the DWC website at https://www.dir.ca.gov/dwc/forms.html, under the category "Court Forms," and then "Proof of Service." The Administrative Director is required to hold your hearing within 30 days of the receipt of your written request. The hearing will be conducted by a hearing officer appointed by the Administrative Director. You will be notified shortly after the receipt of your request of the date and time of the hearing.

For more information about the suspension procedure, please refer to Provider Suspension Regulations, California Code of Regulations, title 8, sections 9788.1 - 9788.4, which can be found on the DWC website at http://www.dir.ca.gov/dwc/DWCPropRegs/Provider-Suspension-Procedure/Clean-Version/Text-of-Regulations.pdf.

Sincerely,

George Parisotto
Administrative Director
Division of Workers' Compensation

Encls:
-Default Decision and Order – *In the Matter of the Accusation Against Cesar Antonio Banda, M.D.* (Case No. 800-2015-011004), Before the Medical Board of California, Department of Consumer Affairs, with accompanying Accusation
-Declaration of Socorro Tongco in Support of Notice of Provider Suspension
-Proof of Service

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

In the Matter of the Accusation Against, **CESAR ANTONIO BANDA, M.D.** 6608 Mercy Court, Suite A Fair Oaks, CA 95628 Physician's and Surgeon's Certificate No. A 54130 One.	Case No. 800-2015-011004 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about September 8, 2016, Complainant Kimberly Kirchmeyer ("Complainant"), in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board"), filed Accusation No. 800-2015-011004 against Cesar Antonio Banda, M.D. ("Respondent") before the Medical Board of California.

2. On or about April 19, 1995, the Board issued Physician's and Surgeon's Certificate No. A 54130 to 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 October 31, 2016, unless renewed.

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3. On or about September 8, 2016, Dianne Richards, an employee of the Complainant Agency, served by Certified Mail a copy of the Accusation No. 800-2015-011004, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is:

6608 Mercy Court, Suite A

Fair Oaks, CA 95628.

A copy of the Accusation, the related documents, and Declaration of Service are attached as Exhibit A, and are incorporated herein by reference.

A courtesy copy of the Accusation, the related documents, and Declaration of Service were sent to Respondent's attorney on September 9, 2016.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. Government Code section 11506 states, in pertinent part:

"(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing."

On September 14, 2016, Respondent through his attorney, Michael J. Zinicola, sent a letter to the Attorney General's Office (Declaration of John Gatschet, attached as Exhibit C, and is incorporated herein by reference) stating that Respondent did not wish to contest the Accusation, will not be filing a notice of defense, and will not request a hearing. Respondent also confirmed that he understood and consented to the Board proceeding by way of default against his license. Both Respondent and his attorney signed the letter.

A copy of Respondent's letter, acknowledging receipt of the Accusation, and waiving his right to file a notice of defense are attached as Exhibit D, and is incorporated herein by reference.

6. California Government Code section 11520 states, in pertinent part:

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"(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent."

7. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on Respondent's express admissions by way of default and the evidence before it, contained in exhibits A, B, C, and D, finds that the allegations in Accusation No. 800-2015-011004 are true.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Cesar Antonio Banda, M.D. has subjected his Physician's and Surgeon's Certificate No. A 54130 to discipline.

2. A copy of the Accusation and the related documents and Declaration of Service are attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Medical Board of California is authorized to revoke Respondent's Physician's and Surgeon's Certificate based upon the following violations alleged in the Accusation:

a. Gross Negligence, pursuant to Business and Professions Code section 2234, subdivision (b), during the care of patients B.R., J.J., C.W., A.W., J.N., and R.M.;

b. Repeated Negligent Acts, pursuant to Business and Professions Code section 2234, subdivision (c), during the care of patients B.R., J.J., C.W., A.W., J.N., and R.M.;

c. Prescribing Dangerous Drugs without an Examination and Medical Indication, pursuant to Business and Professions Code section 2242, during the care of patients B.R., C.W., A.W., and J.N.;

d. Corrupt and Dishonest Acts, pursuant to Business and Professions Code section 2234, subdivision (e), by knowingly declaring that records were complete when he in fact knew they were incomplete;

e. False Representations, pursuant to Business and Professions Code section 2261, by knowingly declaring that records were complete when he in fact knew they were incomplete;

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f. and, Inadequate and Inaccurate Records, pursuant to Business and Professions Code section 2266, by failing to keep adequate and accurate records.

ORDER

IT IS SO ORDERED that Physician's and Surgeon's Certificate No. A 54130, heretofore issued to Respondent Cesar Antonio Banda, M.D., is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on October 27, 2016.

It is so ORDERED September 27, 2016

FOR THE MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
Kimberly Kirchmeyer, Executive Director

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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: **Cesar Antonio Banda, M.D.** 6608 Mercy Court, Suite A Fair Oaks, CA 95628 Physician's and Surgeon's Certificate No. A54130, Respondent.	Case No. 800-2015-011004 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about April 19, 1995, the Medical Board issued Physician's and Surgeon's Certificate Number A54130 to Cesar Antonio Banda, 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 October 31, 2016, unless renewed.

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JURISDICTION

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

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

5. Section 2234 of the Code, states, in pertinent part:

"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.

"...

"(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.

"..."

6. 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.

"..."

7. Section 2261 of the Code states, in pertinent part:

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

8. Section 2266 of the Code states, in pertinent part:

"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."

DRUGS

9. This Accusation concerns controlled substances prescribed to various patients by Respondent, as more fully described below:

10. Fentanyl – Generic name for the drug Duragesic. Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. The fentanyl transdermal patch is used for long term chronic pain. It has an extremely high danger of abuse and can lead to addiction as the medication is estimated to be 80 times more potent than morphine and hundreds of times more potent than heroin.[1] Fentanyl is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Fentanyl is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(c).

11. Oxycodone – Generic name for the drug Oxycontin. Oxycodone is a long acting opioid analgesic used to treat moderate to severe pain. It has a high danger of abuse and can lead to addiction. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal

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

Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

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

13. Morphine – Generic name for the drug MScontin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12 and Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. Methadone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12 and Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal

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Regulations Title 21 section 1308.13(e).[2] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

16. Oxycodone with Acetaminophen – Generic name for Percocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

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

18. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Alprazolam – Generic name for Xanax. Alprazolam is a short-acting anxiolytic of the benzodiazepine class of psychoactive drugs used for treatment of panic disorder, and anxiety disorders. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

20. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia.

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[2] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12.

Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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

22. Temazepam – Generic name for Restoril. Temazepam is an intermediate-acting benzodiazepine used to treat insomnia. Temazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Butalbital with caffeine and with aspirin – Generic name for Fiorinal. Bultalbital is a barbiturate with an immediate duration of action. Often combined with other medications, it is commonly used for the treatment of pain and headache. Fiorinal is a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13 and Health and Safety Code section 11056, and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence in the treatment of patients B.R., J.J., C.W., A.W., J.N., and, R.M. The circumstances are as follows:

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Patient B.R.

25. On May 1, 2012, Respondent began providing treatment to Patient B.R for chronic pain. Respondent provided a prescription for 90 pills of 10/325 mg oxycodone with acetaminophen. Prior to providing controlled substances to Patient B.R., Respondent failed to conduct and/or document a history and physical examination of B.R. Respondent's first progress note from May 1, 2012, noted a "Cures panel" but did not indicate the findings and/or whether Respondent even conducted a review of Patient B.R.'s Controlled Substance Utilization Review and Evaluation System[3] Report ("CURES Report"). The rest of the May 1, 2012 chart entry documented a blood pressure valuation, described the cause and location of Patient B.R.'s pain, and documented a brief diagnosis as follows, "Follow-up joints pain severe. Started after first pregnancy rapidly progressing in severity mostly LE hips, knees, ankles. Norco not helping much and does not last. P.E. unchanged. D.P. Polyarthritis acute onset progression. R.A. ruled out. Cures Panel". Respondent failed to conduct and/or document whether he assessed Patient B.R. for psychological diseases or addiction risk. In addition Respondent failed to consider and/or document whether there were appropriate non-opioid treatments, and whether Patient B.R. had provided a baseline urine drug screening.

26. Patient B.R. received treatment from Respondent in the form of controlled substances until May 2, 2015. Between May 1, 2012, and May 2, 2015. Respondent prescribed controlled substances to Patient B.R. which included Norco 10/325 mg., Soma 350 mg., Percocet 10/325 mg., and Fentanyl patch of 100 mcg./hr. In 2012, Respondent prescribed 1080 pills of 10/325 mg. of hydrocodone with acetaminophen, 570 pills of 10/325 mg. oxycodone with acetaminophen, and 640 pills of 350 mg. carisprodol to Patient B.R. Respondent documented 5 medical progress notes where he saw Patient B.R. in office in 2012. In 2013, Respondent prescribed 135 100 mcg./hr. fentanyl patches, 110 75 mcg./hr. fentanyl patches, 1,780 pills of 10/325 mg. of hydrocodone with acetaminophen, 180 pills of 10/325 mg. oxycodone with acetaminophen, and 540 pills of 350 mg. carisprodol. Respondent documented 8 medical

[3] A database kept by the Department of Justice which tracks the controlled substance prescriptions to patients.

progress notes where Respondent saw Patient B.R. in his office in 2013. In 2014, Respondent prescribed 15 50 mcg./hr. fentanyl patches and 300 pills of 350 mg. carisprodol to B.R. Respondent did not document any medical progress notes for B.R. in 2014. In 2015, Respondent prescribed 5 50 mcg./hr. fentanyl patches, 10 75 mcg./hr. fentanyl patches and 540 pills of 350 mg. carisprodol. Respondent documented 1 progress note where he saw patient B.R. in his office in 2015.

27. Despite prescribing controlled substances to Patient B.R. between May 1, 2012, and May 2, 2015, Respondent failed to obtain and/or document obtaining informed consent from Patient B.R prior to prescribing controlled substances. During Respondent's interview with the Board's investigators on June 2, 2016, Respondent claimed that he has patients sign a controlled substances agreement describing risks and benefits of taking controlled substances. On June 2, 2016, Respondent executed a certification under penalty of perjury that the copy of B.R.'s medical records he provided to the Board was complete and accurate. These certified records, however, contained no such informed consent or agreement. Respondent failed to obtain and/or document obtaining informed consent from Patient B.R. at any point during treatment.

28. Between May 1, 2012, and May 21, 2015, Respondent failed to obtain a clear diagnosis or a recognized medical indication in support of the use of controlled substances to treat B.R. Patient B.R. was 24 years old when she began receiving treatment from Respondent. Patient B.R. complained of multiple joint pains involving her hips, knees and ankles. Despite her young age, and without performing and/or documenting any examination, Respondent diagnosed polymyalgia rheumatic, autoimmune arthritis, and/or fibromyalgia as causing Patient B.R.'s severe pain. On one occasion, Respondent diagnosed cervical radiculitis. Despite Respondent ordering further work-up and testing, Patient B.R. never followed through with blood work or an MRI of the cervical spine to help diagnose or rule out conditions, citing a lack of insurance to pay for testing. Respondent continued to prescribe controlled substances to Patient B.R. despite not having a clear diagnosis or medical indication for the use of chronic opioid therapy and only relied on Patient B.R.'s continued complaints of pain to justify prescribing controlled substances to her.

29. Between May 1, 2012, and May 21, 2015, Respondent failed to develop a treatment plan to help Patient B.R. manage her chronic pain. None of the records state a specific recommendation for an alternative or multidisciplinary treatment other than controlled substances. Respondent failed to evaluate and/or document whether he evaluated if Patient B.R.'s chronic pain was being adequately treated by chronic opioid therapy, whether he should taper and/or discontinue controlled substances, and whether chronic opioid therapy was effective.

30. After initiating prescription opioid therapy, Respondent failed to document a clear medication plan for Patient B.R.'s medication dosing, dosing strengths, refill schedules, and delineate at which pharmacy Patient B.R. would be receiving her medications. Respondent failed to document the titration of new medications and failed to evaluate whether Patient B.R. was consuming too much medication. On September 28, 2012, Patient B.R. filled a prescription from Respondent for 150 pills of 10/325 mg. hydrocodone with acetaminophen at Mason Pharmacy. On October 2, 2012, Patient B.R. filled a prescription from Respondent for 150 pills of 10/325 mg. hydrocodone with acetaminophen at Rite Aide Pharmacy No. 6046. On October 14, 2012, Patient B.R. filled a prescription from Respondent for 90 pills of 10/325 mg. oxycodone with acetaminophen at Safeway Pharmacy No. 1895. On October 24, 2012, Patient B.R. filled a prescription for 150 pills of 10/325 mg. hydrocodone with acetaminophen at Rite Aide Pharmacy No. 6046. In the 27 days between September 28, 2012, and October 23, 2012, Patient B.R. obtained 390 pills of opioid medication from Respondent and each pill also contained 325 mg. of acetaminophen. Assuming that Patient B.R. was consuming all of the two different short-acting controlled substances that Respondent prescribed to her, she would have been consuming 4694 mg. of acetaminophen a day. Respondent failed to evaluate and/or document whether Patient B.R. was receiving a potentially unhealthy dose of acetaminophen and failed to explain and/or document why he would prescribe two short-acting controlled substances to B.R. at the same time.

31. Between May 1, 2012, and May 21, 2015, Respondent documented Patient B.R.'s care in fifteen short follow-up notes. Respondent's records fail to adequately support and/or

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document the reasons why Patient B.R. was receiving extensive and potentially harmful controlled substance prescriptions.

32. Respondent's treatment of B.R. as described above represents a separate and distinct extreme departure from the standard of care in each of the following: (A.) that Respondent failed to adequately screen and/or document screening the patient before beginning controlled substances; (B.) failed to, at any point during B.R.'s treatment, to obtain and/or document obtaining informed consent; (C.) failed to, at any point during B.R.'s treatment, establish and/or document establishing a clear medical indication for opioid therapy; (D.) failed, at any point during B.R.'s treatment, to develop and/or document a multidisciplinary treatment plan for ongoing opioid therapy; (E.) failed to monitor and/or document whether B.R. was following a consistent medication plan; (F.) failed to evaluate and/or document if B.R. was abusing medication and consuming a dangerous amount of acetaminophen; (G.) and failed to keep accurate and adequate records.

Patient J.J.

33. On June 12, 2012, Respondent began providing treatment to Patient J.J. for multiple pain complaints, including left wrist and hand pain, and in his bilateral upper extremities. A Magnetic Resonance Imaging ("MRI") conducted on February 10, 2012 revealed a high grade tear of the scapholunate ligament on the left wrist. There was also a previous work-up that indicated Patient J.J. had a cervical herniated disc, but surgery was not indicated. In 2012, Respondent prescribed 1,515 10/325 mg pills. of hydrocodone with acetaminophen, 195 10/325 mg. pills of oxycodone with acetaminophen, and 150 10 mg. pills of zolpidem tartrate to Patient J.J. Respondent documented 7 visits where he saw Patient J.J. at his medical practice in 2012. In 2013, Respondent prescribed a total of 3,240 10/325 mg. pills of hydrocodone with acetaminophen, 780 100 mg. pills of morphine extended release, 570 2 mg. pills of alprazolam, and 150 10 mg. pills of zolpidem tartrate to Patient J.J. Respondent documented 13 visits where he saw Patient J.J. at his medical practice in 2013.

34. In 2014, Respondent prescribed a total of 20 100 mcg./hr. fentanyl patches, 1,320 2 mg. pills of alprazolam, 1,680 100 mg. pills of morphine extended release, and 2,720 10/325 mg.

pills of hydrocodone with acetaminophen to Patient J.J. At one point, in January and February 2014, Respondent was prescribing Patient J.J. a 700 mg. morphine equivalent dose[4] ("MED") per day by by writing prescriptions for 100 mg of morphine every six hours, a 100 mcg./hr. fentanyl patch every 72 hours, and 1 tablet of 10/325 mg. of hydrocodone with acetaminophen every four hours. Respondent documented 9 visits where he saw Patient J.J. at his medical practice in 2014. In 2015, Respondent prescribed a total of 1,200 8 mg. pills of hydromorphone, 1,780 pills 10/325 mg. of hydrocodone with acetaminophen, and 900 2 mg. pills of alprazolam to Patient J.J. Respondent documented 13 visits where he saw Patient J.J. at his medical practice in 2015. As more fully documented above, Respondent repeatedly prescribed zolpidem tartrate and/or alprazolam while he was prescribing opioid medication to Patient J.J. Respondent stopped treating Patient J.J. on November 17, 2015, after Patient J.J. provided a urine drug test that was positive for cocaine.

35. On June 12, 2012, Respondent documented a brief history and physical examination prior to initiating controlled substances for Patient J.J.'s pain. Respondent noted that he examined the neck, chest, heart and wrists. Respondent failed to conduct and/or document past medical history, allergies, social history, and family history and left those entries blank. Under the medications section he listed "Norco 10/325" but failed to document medication frequency, refill pattern, and any other information related to the prior prescription. Respondent failed to assess and/or document Patient J.J.'s psychological and/or addiction risk, didn't review CURES, and didn't perform a drug urine screen at the initial appointment.

36. Respondent prescribed more than 200 MED per day to Patient J.J. for most of the time that he provided care. While Patient J.J. made monthly follow-up visits with Respondent, Respondent failed to create and/or document clear functional goals related to Patient J.J.'s therapy and/or document improvement in Patient J.J.'s conditions. A review of the records between June 12, 2012, and November 17, 2015, reveals that at most visits Patient J.J. complained of

[4] An MED is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency. Morphine is used as the basis for this comparison and other opioids with higher potencies are converted to their MED to provide the comparison. All MED doses are in a comparable mg. amount of morphine.

intolerable, worsening, or severe pain despite receiving high doses of opioids. For example, on December 30, 2013, Patient J.J. complained of chest pain from a cough and mentioned that he had a "compressing bulging disk". Respondent documented that Patient J.J. was dealing with depression and trying to obtain disability. Respondent added fentanyl to Patient J.J.'s morphine regimen and kept him on Xanax. On February 7, 2014, Respondent documented that Patient J.J. complained that, "patch helped but that night drowsy next day vomiting all day," and documented an adverse reaction to medication. As noted more fully above, Patient J.J. was receiving a 700 mg. MED during that time. Respondent discontinued the Fentanyl but continued to keep Patient J.J. on high dose morphine. On March 18, 2014, Respondent documented under history of present illness that Patient J.J. has, "(n)o changes steady pain does mnot [sic] subside completly [sic] with medication." Despite having Patient J.J. on high dose opioids above 200 MED per day, Respondent failed to use and/or document using appropriate monitoring tools like CURES and/or urine drug screening tests until October 13, 2015. Respondent failed to consider and/or document whether Patient J.J. was making functional improvement while on high dose opioids.

37. Respondent's treatment of Patient J.J. as described above represents a separate and extreme departure from the standard of care in each of the following: (A.) by failing to perform and/or document a complete initial screening before initiating controlled substances; (B.) by providing high dose opioid therapy without sufficient documentation of functional improvement and side effects; and (C.) by providing high does opioid therapy without using proper monitoring tools.

Patient C.W.

38. On February 7, 2013, Respondent began providing treatment to Patient C.W. Respondent claimed that Patient C.W. suffered from depression, anxiety, and fibromyalgia. Prior to beginning treatment with Respondent, Patient C.W. had previously been taking 80 mg. a day of methadone or over 800 MED per day. Even though C.W.'s opioid treatment with Respondent began on February 7, 2013, the first documented progress note that Respondent provided to the Board for Patient C.W. is dated June 21, 2013. On August 4, 2014, Patient C.W. admitted to Respondent that she had attempted to commit suicide and had been hospitalized for a possible

overdose. Patient C.W. also admitted a strong family history of depression and that her mother had tried suicide. Patient C.W. also stated she had a history of taking street drugs and an addiction to clonazepam. Respondent never lowered her methadone dose below 50 mg. despite her admissions and continued her on clonazepam. Respondent treated Patient C.W. until November 10, 2015, eventually lowering her methadone dosage to 50 mg. a day or 500 MED per day. In 2013, Respondent prescribed 1,980 10 mg. pills of methadone and 630 1 mg. pills of clonazepam to Patient C.W. In 2013, Respondent documented seeing Patient C.W. two times at his medical practice. In 2014, Respondent prescribed 2,220 10 mg. pills of methadone and 1080 1 mg. pills of clonazepam to Patient C.W. Respondent documented seeing Patient C.W. 12 times at his medical practice in 2014. In 2015, Respondent prescribed 1260 10 mg. pills of methadone and 990 1 mg. pills of clonazepam to Patient C.W. Respondent documented seeing Patient C.W. 10 times at his medical practice in 2015.

39. On or about February 7, 2013, Respondent failed to perform and/or document that he performed a history and physical examination of Patient C.W. prior to Respondent initiating treatment with controlled substances. Respondent did not perform and/or document a screening evaluation, or an assessment of addiction risk. Respondent did not consider and/or document consideration of non-opioid treatment. Respondent did not review CURES, did not perform and/or document performing a urine drug screen, and did not perform and/or document performing a baseline electrocardiogram ("EKG") to determine her QTc interval. Respondent failed to perform a sufficient screening assessment before he began providing controlled substances prescriptions to Patient C.W.

40. Between February 7, 2013, and November 10, 2015, Respondent failed to obtain informed consent and/or document obtaining informed consent prior to initiating controlled substance therapy. Respondent did not discuss and/or document a discussion of the risks and benefits of opioid therapy with Patient C.W. While Respondent stated on June 2, 2016, at his interview with the Board investigators that he has patients sign a controlled substances agreement describing risks and benefits of taking controlled substances, C.W.'s medical records, which

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Respondent certified to be complete and accurate on April 28, 2016, did not contain any record of informed consent.

41. Between February 7, 2013, and November 10, 2015, Respondent documented that Patient C.W. suffered from dysfunction and aberrant behaviors, including constant depression with at least one suicide attempt, insomnia, poor sleep patterns, concentration and memory problems, dizziness with loss of balance and falls, visual hallucinations and a hospitalization for overdose. While Respondent did taper her initial starting dose of 80 mg. methadone a day to 50 mg. a day by the end of treatment, Respondent failed to taper Patient C.W. more rapidly off of her opioids or refer her treatment to a pain specialist despite evidence that she was not progressing well on opioid medications.

42. Respondent certified that he provided C.W.'s complete and accurate medical records to the Board on April 28, 2016. At his under-oath interview with the Board's investigators on June 2, 2016, Respondent claimed that an initial screening and evaluation are missing from these records. Respondent also stated that he had Patient C.W. sign an opioid agreement and take urine tests, but Respondent never provided these documents to the Board. Respondent failed to properly document the treatment provided to Patient C.W.

43. Respondent's treatment of C.W. as described above represents a separate and distinct extreme departure from the standard of care in each of the following: (A.) by failing to perform and/or document performing an initial screening prior to initiating controlled substances therapy; (B.) by failing to obtain and/or document obtaining informed consent prior to initiating controlled substances therapy; (C.) by failing to do a more aggressive taper and/or document failing to taper Patient C.W. off of high dose methadone despite evidence of aberrant behaviors; and (D.) by failing to adequately and accurately document Patient C.W.'s care in the medical records.

Patient A.W.

44. On or about July 12, 2012, Respondent began providing treatment to Patient A.W. Patient A.W. had a complaint of chronic headaches and back pain. The first progress note in A.W.'s records, which Respondent provided to the Board and certified to be complete and accurate under penalty of perjury, is dated July 30, 2013. While providing treatment to Patient

A.W., Respondent diagnosed her as suffering from migraine headaches and syringomyelia. Patient A.W. was on hydrocodone with acetaminophen, carisoprodol, and lorazepam when she began treatment with Respondent. In 2012, Respondent prescribed 90 pills of 7.5/325 mg. oxycodone with acetaminophen, 120 pills of 10/325 mg. hydrocodone with acetaminophen, 570 pills of 10/325 mg. oxycodone with acetaminophen, 570 doses of 325/50/40 mg butalbital/asa/caffeine, 480 350 mg. pills of carisprodol, and 200 pills of 1 mg. lorazepam. Respondent kept no medical records from 2012, despite prescribing controlled substances.

45. In 2013, Respondent began prescribing fentanyl to Patient A.W. Starting with the smallest fentanyl dose at first, in total Respondent prescribed 10 25 mcg./hr. fentanyl patches, 85 50 mcg./hr. fentanyl patches, 45 75 mcg./hr. fentanyl patches, and 45 100 mcg./hr. fentanyl patches to Patient A.W. Respondent also prescribed 1,350 pills of 10/325 mg. oxycodone with acetaminophen, 1,080 pills of 10 mg. oxycodone hcl, 720 pills of 1 mg. lorazepam, 1,020 pills of 350 mg. carisprodol, and 450 doses of 325/50/40 mg butalbital/asa/caffeine in 2013. Respondent documented seeing Patient A.W. 3 times in his medical practice in 2013. In 2014, Respondent prescribed 195 100 mcg./hr. fentanyl patches, 720 pills of 10 mg. oxycodone hcl, 1,620 pills of 30 mg. oxycodone hcl, 1,650 pills of 350 mg carisprodol, 660 pills of 1 mg. lorazepam, and 1,360 doses of 450 doses of 325/50/40 mg butalbital/asa/caffeine. Respondent documented seeing Patient A.W. 7 times in his medical practice in 2014. Of note, on May 6, 2014, Respondent documented that he prescribed 15 patches of 100 mcg./hr. fentanyl and 180 pills of 10/325 mg. oxycodone/acetaminophen. He failed to document that he also prescribed 180 pills of 30 mg. oxycodone hcl and failed to explain why he was increasing Patient A.W. from 330 MED per day to 510 MED per day. While Patient A.W. never filled the prescription for 180 pills of 10/325 mg. oxycodone/acetaminophen prescription from May 6, 2014, if she had filled the 180 pills, she would have potentially consumed up to 600 MED per day. The May 6, 2014, record was electronically signed by Respondent on April 26, 2016.

46. In 2015, Respondent prescribed 195 100 mcg./hr. fentanyl patches, 2,160 pills of 30 mg. oxycodone hcl, 1,560 pills of 350 mg carisprodol, 1,080 pills 1 mg. lorazepam, 450 doses of of 325/50/40 mg butalbital/asa/caffeine. Respondent documented seeing Patient A.W. 14 times in

his medical practice in 2015. Respondent stopped providing treatment to Patient A.W. on or about March 30, 2016. By January 2016, Respondent was prescribing a daily dose consisting of one fentanyl 100 mcg./hr. patch, 6 pills of 30 mg. oxycodone, 4 pills of 350 mg. carisoprodol, 3 pills of 1 mg. of lorazepam, and two doses of 325/50/40 mg. butalbital with caffeine and with aspirin a day to Patient A.W.

47. On or about July 12, 2012, Respondent failed to perform and/or document that he performed a history and physical on Patient A.W. prior to Respondent initiating controlled substances treatment. Respondent failed to review and/or document that he reviewed prior non-opioid treatments that Patient A.W. had received. The medical records do not show that Respondent performed an assessment of psychological or addiction risks, aside from an occasional mention of anxiety. Respondent failed to obtain and/or document obtaining a baseline urine drug screen before initiating controlled substance treatment to Patient A.W. Respondent did not review A.W.'s CURES.

48. Between July 12, 2012, and January 7, 2016, Respondent failed to obtain informed consent and/or document obtaining informed consent prior to initiating controlled substance therapy of A.W. Respondent did not discuss the risks and benefits of opioid therapy to Patient A.W. Respondent certified that he provided A.W.'s complete and accurate medical records to the Board on April 28, 2016. At his under-oath interview with the Board's investigators on June 2, 2016, Respondent claimed that he has patients sign a controlled substances agreement describing risks and benefits of taking controlled substances, but there was no such document in A.W.'s medical records which Respondent certified to be complete and accurate under penalty of perjury.

49. Between July 12, 2012 and January 7, 2016, Respondent diagnosed Patient A.W. as having suffered from migraine headaches, Chiari malformation, and syringomyelia. Respondent's medical records for A.W. do not contain any evidence of diagnostic test results or medical indication to support his diagnoses. Respondent's medical records for A.W. fail to take into account that Patient A.W. may suffer rebound headaches as a result of being on high dose controlled substances. Respondent's medical records for A.W. do not contain any evidence that he attempted to taper down the controlled substances that she was on.

50. On or about July 12, 2012, Patient A.W. was receiving 4 pills of 10/325 mg hydrocodone with acetaminophen per day or less than 60 MED a day. By January 7, 2016, Patient A.W. was receiving 510 MED a day. The medical records between July 12, 2012, and January 7, 2016, do not contain any clear rationale for escalation to high dose opioids other than Patient A.W.'s subjective pain complaints. There are no diagnostic tests that provide evidence that support worsening pathology or disease. Patient A.W. was not evaluated by a pain specialist until 2016. Respondent failed to document goals for Patient A.W. and failed to document whether high dose opioid therapy led to improvement in her condition. The medical records between July 12, 2012, and January 7, 2016, do include documentation of morbidity suffered by A.W., including irregular menses, nausea, anxiety, emotional ability, and difficulty working. Despite documenting these potentially adverse effects from high dose opioid therapy, Respondent never considered and/or documented that he considered whether the high dose opioids being prescribed to Patient A.W. were having an adverse effect on her.

51. As more fully discussed above, by January 7, 2016, Patient A.W. was receiving fentanyl, oxycodone, carisoprodol, lorazepam, and butalbital/asa/caffeine. Respondent failed to consider and/or document that he considered whether it was appropriate to prescribe opioids, benzodiazepines, and barbiturates at the same time to Patient A.W. Respondent did not discuss and did not document a discussion of the risks of this medication combination to Patient A.W., including an increased risk of addiction, sedation, and overdose. Respondent did not attempt to taper Patient A.W. off her non-opioid controlled substances as he increased her opioid pain medication therapy.

52. The records between July 12, 2012, and January 7, 2016, are incomplete. At his under-oath interview with the Board's investigators on June 2, 2016, Respondent claimed that initial screening and evaluation records were missing from A.W.'s medical records. Respondent also stated that he had Patient A.W. sign an opioid agreement and take urine tests, but A.W.'s medical records, which Respondent certified to be complete and accurate under penalty of perjury on April 28, 2016, did not include these records. As noted above, electronic records were

electronically signed years after the patient encounters occurred. Respondent failed to properly document the treatment provided to Patient A.W.

53. Respondent's treatment of A.W. as described above represents a separate and distinct extreme departure from the standard of care in each of the following ways: (A.) failed to perform and/or document performing an initial screening prior to initiating controlled substances therapy; (B.) failed to obtain and/or document obtaining informed consent prior to initiating controlled substances therapy; (C.) failed to support and/or document supporting the diagnoses that were being used for high dose opioid therapy, (D.) failed to provide a rationale and/or document a rationale for why he escalated Patient A.W.'s opioid therapy, (E.) failed to consider and/or document whether he considered that she was being adversely affected by being on high dose opioid therapy, (F.) failed to consider and/or document whether he considered the increased risk of addiction, sedation, and overdose posed by having Patient A.W. on three different classes of controlled substances; and (G.) failed to adequately and accurately document Patient A.W.'s care in the medical records.

Patient J.N.

54. On or about October 28, 2012, Respondent began providing treatment to Patient J.N., but the first documented treatment note in Patient J.N.'s medical record is dated August 8, 2013. Patient J.N. had chronic abdominal pain complaints originating from prior surgery sites and chronic neck pain related to degenerative disk disease. According to CURES, Patient J.N. was taking 3 pills of hydrocodone 10/325 mg. per day, 2 pills of .5 mg. of lorazepam a day, 2 pills of .5 mg. of clonazepam a day, and 1 pill of 15 mg. of temazepam a day when she presented to Respondent. According to pharmacy records, on October 28 2012, Patient J.N.'s daily opioid dose was 30 MED, as Respondent prescribed 90 pills of 10/325 mg. hydrocodone with acetaminophen. In 2012, in total Respondent prescribed 180 pills of 10/325 mg. hydrocodone with acetaminophen, 180 pills of .5 mg. clonazepam, 60 pills of .5 lorazepam, and 60 pills of 15 mg. temazepam. As noted above, Respondent did not provide any medical records documenting visits in 2012 with Patient J.N. In 2013, Respondent prescribed 10 patches of 75 mcg./hr. fentanyl, 20 patches of 50 mcg./hr. fentanyl, 640 pills of 2 mg. hydromorphone hydrochloride,

1,205 pills of 10/325 mg. hydrocodone with acetaminophen, 360 pills of 1 mg. clonazepam, 240 pills of .5 mg. clonazepam, and 240 pills of 15 mg. temazepam to Patient J.N. In 2013, Respondent documented one visit with Patient J.N. in his medical practice.

55. In 2014, Respondent prescribed 70 patches of 75 mcg./hr. fentanyl, 600 pills of 4 mg. hydromorphone hydrochloride, 1,230 pills of 10/325 mg. hydrocodone with acetaminophen, 240 pills of 15 mg. temazepam, 90 pills of 30 mg. temazepam, 600 pills of 10 mg. diazepam, and 630 pills of 1 mg. clonazepam. Of note, on January 27, 2014, Respondent prescribed 240 pills of 10/325 mg. hydrocodone with acetaminophen, 30 pills of 15 mg. temazepam, and 60 pills of 1 mg. clonazepam. Two days later, on January 29, 2014, he prescribed 10 75 mcg./hr. patches of fentanyl, 150 pills of 4 mg. hydromorphone hydrochloride, and 60 pills of 10 mg. diazepam to J.N. At that point, if Patient J.N. was taking all of the medications prescribed by the Respondent, she was consuming 340 MED per day. The Respondent's note for January 29, 2014, does not mention the increase in medications or note any concerns with the patient being on a long-acting opiate, two-short acting opiates, and three different benzodiazepines. In 2014, Respondent documented seven treatment visits with Patient J.N. in his medical practice.

56. In 2015, Respondent prescribed 110 patches of 75 mcg./hr. fentanyl, 1,080 pills of hydrocodone with acetaminophen, 930 pills of 10 mg. diazepam, 720 pills of 1 mg. clonazepam, and 360 pills of 30 mg. temazepam to Patient J.N. In 2016, Respondent prescribed 270 pills of 10/325 mg. hydrocodone with acetaminophen, 120 pills of 30 mg. temazepam, 180 pills of 10 mg. diazepam, and 250 pills of 1 mg. clonazepam to Patient J.N. In 2015, Respondent documented 14 treatment visits with Patient J.N. in his medical practice. Respondent stopped providing treatment to Patient J.N. on March 14, 2016. By December 16, 2015, Respondent was prescribing Patient J.N., a 75 mcg/hr. of fentanyl patch, and 3 10/325 mg hydrocodone with acetaminophen per day and her daily opioid dose was approximately 200 MED. He was also prescribing 60 pills of 1 mg. clonazepam on December 4, 2015, 30 pills of 30 mg. temazepam on December 8, 2015, and 90 pills of 10 mg. diazepam on December 15, 2015, while prescribing opioids.

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57. On or about October 28, 2012, Respondent failed to perform and/or document that he performed a history and a physical examination of Patient J.N. prior to initiating controlled substances. Respondent did not conduct and/or document an appraisal of prior non-opioid treatments. Respondent did not perform and did not document an assessment of psychological or addiction risk before the initiation of controlled substances treatment, with only a passing mention of Patient J.N.'s depression and anxiety. Respondent did not obtain a baseline urine drug screen and did not review CURES prior to initiating controlled substance therapy to Patient J.N.

58. Between October 28, 2012, and March 14, 2016, Respondent failed to obtain informed consent and/or document obtaining informed consent from J.N. prior to initiating controlled substance therapy. Respondent did not discuss and/or did not document a discussion of the risks and benefits of opioid therapy with Patient J.N. On June 2, 2016, at his under-oath interview with Board investigators, Respondent claimed that he has patients sign a controlled substances agreement describing risks and benefits of taking controlled substances. Respondent certified Patient J.N.'s medical record which he provided to the Board to be complete and accurate, under penalty of perjury, on April 28, 2016. J.N.'s medical records did not include the documents he claimed J.N. signed.

59. Between October 28, 2012, and March 14, 2016, Respondent increased Patient J.N.'s opioid medication over time as more fully discussed above. During treatment Respondent prescribed increasing amounts of hydrocodone with acetaminophen and hydromorphone hydrochloride between 2012 and 2016. Respondent eventually prescribed fentanyl to J.N. Respondent did not obtain and did not document any diagnostic tests that demonstrate worsening pathology or disease. Patient J.N. was not seen by a pain management specialist and only the last progress note dated March 14, 2016, documented a referral to a pain management specialist. The medical records do not include functional goals nor document functional improvements in Patient J.N.'s life as a result of being on high dose opioid therapy. The records do not provide a clear rationale for the escalation of Patient J.N.'s medications. The records do show that there were possible adverse effects and dysfunction, including balance problems, falls, and short term memory problems. Respondent's own records show a pattern of aberrant drug seeking behavior

by this patient, between August 2, 2013, and September 20, 2013, where Patient J.N. filled 9 opioid prescriptions, including 3 prescriptions from 3 providers other than Respondent, for 305 tablets of 10/325 mg hydrocodone with acetaminophen, 370 tablets of 2 mg hydromorphone hydrochloride, and 10 50 mcg/hr. fentanyl patches. Respondent noted on August 8, 2013, that Patient J.N., "has recently fallen and hit her head…(she) has noticed short term memory loss recently and balance is getting worse." Respondent's note on January 29, 2014, does not mention Patient J.N.'s aberrant behavior.

60. Between October 28, 2012, and March 14, 2016, Respondent prescribed an atypical pattern of controlled substances to Patient J.N. where she was taking two different short acting opioids and two different benzodiazepines at the same time. For example, on August 12, 2014, a different medical provider prescribed 90 pills of .5 mg. lorazepam to Patient J.N. On August 15, 2014, Respondent prescribed 150 pills of 4 mg. hydromorphone hydrochloride, 10 75 mcg./hr. fentanyl patches, and 90 pills of 10/325 mg. hydrocodone with acetaminophen to Patient J.N. for a 290 MED per day. On August 25, 2014, Respondent prescribed 60 pills of 10 mg. diazepam. On August 27, 2014, Respondent prescribed 30 pills of 30 mg. temazepam. Respondent did not discuss and did not document a discussion with J.N. about the risks of taking opioids and benzodiazepines at the same time. Respondent never attempted to taper J.N. off her non-opioid controlled substances.

61. The records between October 28, 2012, and March 14, 2016, are incomplete. At his subject interview on June 2, 2016, Respondent claimed that an initial screening and evaluation records were missing from J.N.'s medical records. On August 8, 2013, Respondent documented that Patient J.N. was receiving a 75 mcg./hr. fentanyl patch and 10/325 mg. hydrocodone with acetaminophen as her current medications. However, a review of the pharmacy profiles show that Respondent first prescribed 180 2 mg. pills of hydromorphone on September 17, 2013, 10 50 mcg./hr. fentanyl patches on September 18, 2013, and 180 pills of 10/325 mg. hydrocodone with acetaminophen on September 20, 2013. Respondent did not correctly document the prescriptions that Patient J.N. was actually receiving. Respondent also stated that he had Patient J.N. sign an opioid agreement, but J.N.'s medical records, which Respondent certified to be complete and

accurate under penalty of perjury on April 28, 2016, did not include these records. Respondent failed to properly document the treatment provided to Patient J.N.

62. Respondent's treatment of Patient J.N. as described above represents a separate and extreme departure from the standard of care in the following ways: (A.) Respondent failed to perform and/or document performing an initial screening prior to initiating controlled substances therapy; (B.) failed to obtain and/or document obtaining informed consent prior to initiating controlled substances therapy; (C.) failed to support and/or document supporting the diagnoses that were being used for high dose opioid therapy, (D.) failed to provide a rationale and/or document a rationale for why he escalated Patient J.N.'s opioid therapy, (E.) failed to consider and/or document whether he considered that she was being adversely affected by being on high dose opioid therapy, (F.) failed to consider and/or document whether he considered the increased risk of addiction, sedation, and overdose posed by having Patient J.N. on two short acting opioids and two or more different benzodiazepines; and (G.) failed to adequately and accurately document Patient J.N.'s care in the medical records.

Patient R.M.

63. Respondent began treating Patient R.M. on June 22, 2012. Patient R.M. suffered from end stage renal disease, was on dialysis, and had hepatic failure from ascites. Respondent noted that Patient R.M.'s main chronic pain complaints were abdominal pain due to ascites and osteoarthritis. At the time Respondent began treatment, Patient R.M. was receiving 120 pills of 10/325 mg hydrocodone with acetaminophen, and 90 tablets of 350 mg. carisoprodol per month. Respondent last treated Patient R.M. on July 2, 2013. Patient R.M. was hospitalized for respiratory failure on July 20, 2013, and died on July 23, 2013. On June 4, 2013, Respondent prescribed 240 tablets of 350 mg. carisoprodol to Patient R.M. On June 4, 2013, Patient R.M. received 30 pills of 10/325 mg hydrocodone with acetaminophen from a different physician. On June 14, 2013, Respondent prescribed 120 pills of 10/325 mg. hydrocodone with acetaminophen to Patient R.M. On July 2, 2013, Respondent prescribed 150 pills of 10/325 mg. hydrocodone with acetaminophen, and 240 tablets of 350 mg. carisoprodol to Patient R.M. On July 8, 2013, Patient R.M. received 100 pills of 10/325 mg. hydrocodone with acetaminophen from a different

physician. On July 9, 2013, Patient R.M. received 20 pills of 10/325 mg. hydrocodone with acetaminophen from a different physician. By July 2013, Patient R.M. was receiving 270 pills of 10/325 mg. hydrocodone with acetaminophen, and 240 tablets of 350 mg. carisoprodol from Respondent and a different physician. Between May 29, 2013, and July 2, 2013, there were ten documented encounters between Respondent and Patient R.M.

64. On May 29, 2012, Respondent performed an initial history and physical on Patient R.M., but his records of this encounter do not contain any information related to Patient R.M.'s chronic pain, prior treatments, and an analysis of psychological or addiction risk. Although ascites is listed as a medical problem, Respondent failed to document whether the ascites was causing pain or to describe the characteristics of the pain being caused. Respondent failed to obtain a urine drug screen nor review a CURES report. On June 29, 2012, pursuant to Respondent's prescription, Patient R.M. received 60 pills of 10/325 mg. hydrocodone with acetaminophen. Respondent did not document in Patient R.M.'s medical record that he was actually prescribing controlled substances until July 17, 2012.

65. Between May 29, 2012, and July 2, 2013, Respondent failed to obtain informed consent and/or document obtaining informed consent prior to initiating the controlled substance therapy of R.M. Respondent did not discuss the risks and benefits of opioid therapy with Patient R.M. Respondent certified that he provided R.M.'s complete and accurate medical records to the Board on June 2, 2016. Respondent claimed that he has patients sign a controlled substances agreement describing risks and benefits of taking controlled substances but there was no such document in R.M.'s medical records which Respondent certified to be complete and accurate under penalty of perjury.

66. Between May 29, 2012, and July 2, 2013, Respondent failed to clearly document the medical indication that supported the use of controlled substances in treating R.M. At his interview with the Board's investigators on June 2, 2016, Respondent stated that Patient R.M. suffered from chronic pain as a result of osteoarthritis and ascites. Respondent first documented osteoarthritis in Patient R.M.'s medical record on October 23, 2012. Respondent failed to

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mention the location of the osteoarthritis being treated. Respondent failed to have imaging tests conducted to support his diagnosis of osteoarthritis.

67. Between May 29, 2013, and July 2, 2013, Respondent failed to document any functional goals related to the prescribing of opioid medication. Respondent failed to consider and/or document whether he considered the fact that Patient R.M. was hospitalized on December 6, 2012, for chest pain and shortness of breath. In 2013, Respondent failed to consider and/or document that he considered the fact that Patient R.M. was on home oxygen while taking controlled substances. Respondent did not order a urine drug screen or review CURES and did not know that Patient R.M. was receiving controlled substances from another provider.

68. As more fully discussed above, Respondent prescribed both opioid pain medication and non-opioid controlled substances to Patient R.M. Respondent did not discuss and/or did not document that he discussed the risks of taking hydrocodone with acetaminophen and carisoprodol at the same time with Patient R.M. Respondent did not taper Patient R.M. off of non-opioid controlled substances, but instead increased the carisoprodol dosing.

69. The records between May 29, 2012 and July 2, 2013, are incomplete. Respondent prescribed controlled substances to Patient R.M. before documenting controlled substance treatment in the medical records. Respondent failed to obtain and/or document obtaining a controlled substances agreement in the medical records. Respondent failed to obtain and/or document obtaining informed consent for treatment in the medical records. Respondent did not document a rationale for the changes that he made to Patient R.M.'s medication regime. The records do not contain a complete treatment plan. The records do not indicate whether Respondent considered alternatives to controlled substance prescribing.

70. Respondent's treatment of Patient R.M. as described above represents a separate and extreme departure from the standard of care in the following ways: (A.) Respondent failed to obtain and/or document obtaining informed consent prior to initiating controlled substances therapy; (B.) failed to support and/or document supporting the diagnoses that were being used for high dose opioid therapy, (C.) failed to provide a rationale and/or document a rationale for why he escalated Patient R.M.'s opioid therapy, (D.) failed to consider and/or document whether he

considered that Patient R.M. was in poor health, (E.) failed to consider and/or document whether he considered the increased risk of addiction, sedation, and overdose posed by having Patient R.M. on opioids and carisoprodol; (F.) and failed to adequately and accurately document Patient R.M.'s care in the medical records.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligence Act)

71. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts. The circumstances are as follows:

72. Complainant realleges paragraphs 24 through 70, and those paragraphs are incorporated by reference as if fully set forth herein.

73. On January 4, 2013, Patient J.J. signed a controlled substances agreement with Respondent that set forth Patient J.J's rights and responsibilities. The agreement was signed more than six months after Respondent began providing controlled substance treatment to Patient J.J. The agreement did not discuss medication side effects and/or risks from taking opioid pain medication. Respondent failed to discuss and/or document discussing the risks of taking controlled substances with Patient J.J.

74. In January 2013, Patient J.J. filled prescriptions for a total of 380 pills of 10/325 mg. hydrocodone with acetaminophen. Patient J.J. filled a prescription from Respondent for 180 pills at Walgreens and filled a prescription from Respondent for 180 pills at Rite Aid. Patient J.J. also filled a 20 pill prescription from a different provider at Rite Aid. In February 2013, Patient J.J. filled prescriptions for a total of 380 tablets of 10/325 mg. hydrocodone with acetaminophen. Patient J.J. filled a prescription from Respondent for 360 pills at Walgreens. Patient J.J. also filled a 20 pill prescription from a different provider at Rite Aid. In March 2013, Patient J.J. filled prescriptions for 180 tablets of 10/325 mg. hydrocodone with acetaminophen from one pharmacy. Assuming Patient J.J. was taking all of the medication that he was prescribed in January and February 2013, he would have consumed 760 pills containing 325 mg. of acetaminophen. Assuming he consumed the medication over a 60 day period, he would have consumed 4116 mg. of acetaminophen per day. Despite signing a medication agreement on

January 4, 2013, that stated he would only fill medications from one medical provider at one pharmacy, Patient J.J. violated the agreement by filling prescriptions at multiple pharmacies. Respondent never discovered the violation of the medication agreement. Respondent did not consider whether Patient J.J. was taking an excessive amount of acetaminophen.

75. Respondent's actions represent negligent acts for the following reasons:

a. As more fully described above in paragraphs 25 through 32, Respondent's treatment of B.R. by failing to perform an appropriate screening, including failure to perform a history and physical, before initiating controlled substances represents a departure from the standard of care;

b. As more fully described above in paragraphs 25 through 32, Respondent's treatment of B.R. by failing to obtain informed consent and establish a treatment plan represents a departure from the standard of care;

c. As more fully described above in paragraphs 25 through 32, Respondent's treatment of B.R. by failing to establish a clear medical indication for opioid therapy and failing to monitor B.R.'s use of medication, in particular her intake of acetaminophen, represents a departure from the standard of care;

d. As more fully described above in paragraphs 25 through 32, Respondent's treatment of B.R. by failing to keep adequate and accurate records represents a departure from the standard of care;

e. As more fully described in paragraphs 33 through 37, Respondent's treatment of J.J. by failing to perform and document a complete screening before initiating controlled substances represents a departure from the standard of care;

f. As more fully described in paragraphs 33 through 37, Respondent's treatment of J.J. by providing high dose opioid therapy without proper monitoring tools and sufficient documentation of functional improvement represents a departure from the standard of care;

g. As more fully described in paragraph 73, Respondent's prescribing of controlled substances to Patient J.J. for six months before he signed a controlled substances agreement represents a departure from the standard of care;

h. As more fully described in paragraph 74, Respondent's treatment of Patient J.J. by failing to monitor his intake of acetaminophen and his aberrant refill patterns represents a departure from the standard of care;

i. As more fully described in paragraphs 38 through 43, Respondent's treatment of Patient C.W. by failing to perform and/or document an initial screening, including failure to perform a history and physical, represents a departure from the standard of care;

j. As more fully described in paragraphs 38 through 43, Respondent's treatment of Patient C.W. by failing to obtain informed consent prior to initiating controlled substance therapy represents a departure from the standard of care;

k. As more fully described in paragraphs 38 through 43, Respondent's treatment of Patient C.W. by failing to taper her off methadone despite evidence of aberrant behaviors, represents a departure from the standard of care;

l. As more fully described in paragraphs 38 through 43, Respondent's treatment of Patient C.W. by failing to keep adequate and accurate records represents a departure from the standard of care;

m. As more fully described in paragraphs 44 through 53, Respondent's treatment of Patient A.W. by failing to perform and/or document an initial screening, including failure to perform a history and physical, represents a departure from the standard of care;

n. As more fully described in paragraphs 44 through 53, Respondent's treatment of Patient A.W. by failing to obtain informed consent prior to initiating controlled substance therapy represents a departure from the standard of care;

o. As more fully described in paragraphs 44 through 53, Respondent's treatment of Patient A.W. by failing to support diagnoses being used to provide controlled substance therapy and failing to provide a rationale for increasing her opioid therapy represents a departure from the standard of care;

p. As more fully described in paragraphs 44 through 53, Respondent's treatment of Patient A.W. by failing to consider whether she was being adversely affected by being on both

and failing to provide a rationale for increasing her opioid therapy represents a departure from the standard of care;

y. As more fully described in paragraphs 63 through 70, Respondent's treatment of Patient R.M. by failing to consider whether he was being adversely affected by being on opioid therapy and carisprodol at the same time represents a departure from the standard of care;

z. As more fully described in paragraphs 63 through 70, Respondent's treatment of Patient R.M. by failing to keep adequate and accurate records represents a departure from the standard of care;

THIRD CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs without Examination and/or Medical Indication)

76. Respondent's license is subject to disciplinary action under section 2242 of the Code in that he prescribed dangerous drugs without an appropriate prior examination and a medical indication. The circumstances are as follows:

77. Complainant realleges paragraphs 24 through 75, and those paragraphs are incorporated by reference as if fully set forth herein.

78. As more fully described above, Respondent provided Patients B.R., C.W., A.W. and J.N. prescriptions for dangerous drugs without conducting a prior examination and/or without establishing a medical indication to support the initiation of controlled substance therapy.

FOURTH CAUSE FOR DISCIPLINE

(Corrupt or Dishonest Acts)

79. Respondent's license is subject to disciplinary action under section 2234, subdivision (e) of the Code, in that he committed acts of dishonesty or corruption substantially related to the qualifications, functions, or duties of a physician and surgeon, when he knowingly signed electronic medical charts years after the encounter visits and/or when he knowingly signed records certifications under penalty of perjury to the Medical Board that the records he provided were complete copies of all medical records when in fact they were not complete copies of the medical records.

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80. Complainant realleges paragraphs 24 through 75, and those paragraphs are incorporated by reference as if fully set forth herein.

81. As more fully described above, Respondent committed acts of dishonesty or corruption that are substantially related to the qualifications, functions, or duties of a physician and surgeon when he electronically signed medical charts years after the patient encounters and/or signed records certifications under penalty of perjury to the Medical Board that he had provided accurate and complete copies of all medical records when in fact they were not complete copies of the medical records.

FIFTH CAUSE FOR DISCIPLINE

(False Representations)

82. Respondent's license is subject to disciplinary action under section 2261 of the Code, in that he made false representations when he knowingly signed electronic medical charts years after the encounter visits and/or when he knowingly signed records certifications under penalty of perjury to the Medical Board that the records he provided were complete copies of all medical records when in fact they were not complete copies of the medical records.

83. Complainant realleges paragraphs 24 through 75, and those paragraphs are incorporated by reference as if fully set forth herein.

84. As more fully described above, Respondent made false representations when he electronically signed medical charts years after the patient encounters and/or signed records certifications under penalty of perjury to the Medical Board that he had provided accurate and complete copies of all medical records when in fact they were not complete copies of the medical records.

SIXTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

85. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to keep adequate and accurate records. The circumstances are as follows:

86. Complainant realleges paragraphs 24 through 75, and those paragraphs are incorporated by reference as if fully set forth herein.

87. As more fully described above, Respondent failed to properly document the care that he provided to Patients B.R., J.J., C.W., A.W., J.N., and R.M. Respondent repeatedly failed to produce documents to the Board that he stated were normally kept in the course of treatment and he repeatedly failed to adequately and accurately document the care that he was providing. On June 2, 2016, Respondent admitted under oath that the records he had previously certified under penalty of perjury as being complete were in fact incomplete and missing documentation.

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 A54130, issued to Cesar Antonio Banda, M.D.;

2. Revoking, suspending or denying approval of Cesar Antonio Banda, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Cesar Antonio Banda, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: September 8, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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