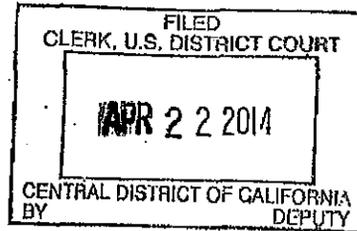


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CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
LOS ANGELES



UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

CRT 4-0231

10 UNITED STATES OF AMERICA,
11 Plaintiff,
12 v.
13 JASON C. LING,
14 Defendant.
15

CR No.
I N F O R M A T I O N
[18 U.S.C. § 1349: Conspiracy
to Commit Health Care Fraud]

The United States Attorney charges:

[18 U.S.C. § 1349]

A. INTRODUCTORY ALLEGATIONS

At all times relevant to this Information:

The Conspirators

1. Defendant JASON C. LING ("LING") was a physician licensed to practice medicine in the State of California, who operated a medical clinic located at 9430 Crest Drive, Spring Valley, California.

2. Co-conspirator E.O. was the owner and operator of a durable medical equipment ("DME") company in Los Angeles, California.

///

1 The Medicare Program

2 3. Medicare was a federal health care benefit program,
3 affecting commerce, that provided benefits to individuals who
4 were over the age of 65 or disabled. Medicare was administered
5 by the Centers for Medicare and Medicaid Services ("CMS"), a
6 federal agency under the United States Department of Health and
7 Human Services ("HHS").

8 4. CMS contracted with private insurance companies to (a)
9 certify DME providers for participation in Medicare and monitor
10 their compliance with Medicare standards; (b) process and pay
11 claims; and (c) perform program safeguard functions, such as
12 identifying and reviewing suspect claims.

13 5. Individuals who qualified for Medicare benefits were
14 referred to as Medicare beneficiaries. Each Medicare beneficiary
15 was given a Health Identification Card containing a unique
16 identification number ("HICN").

17 6. DME companies, physicians, and other health care
18 providers that provided medical services that were reimbursed by
19 Medicare were referred to as Medicare "providers."

20 7. To obtain payment from Medicare, a DME company first
21 had to apply for and obtain a provider number. By signing the
22 provider application, the DME company agreed to abide by Medicare
23 rules and regulations, including the Anti-Kickback Statute (42
24 U.S.C. § 1320a-7b(b)), which, among other things, prohibited the
25 payment of kickbacks or bribes for the referral of Medicare
26 beneficiaries for any item or service for which payment may be
27 made by the Medicare program.

28

1 8. If Medicare approved a provider's application, Medicare
2 assigned the provider a Medicare provider number, enabling the
3 provider (such as a DME company or physician) to submit claims to
4 Medicare for services and supplies provided to Medicare
5 beneficiaries.

6 9. To obtain and maintain their Medicare provider numbers
7 and billing privileges, DME suppliers had to meet Medicare
8 standards for participation. The Medicare contractor responsible
9 for evaluating and certifying DME suppliers' compliance with
10 these standards was Palmetto GBA ("Palmetto").

11 10. From in or about October 2006 through the date of this
12 information, Noridian Administrative Services ("Noridian")
13 processed and paid Medicare DME claims in Southern California.

14 11. Most Medicare providers, including the company owned
15 and operated by co-conspirator E.O., submitted their claims
16 electronically pursuant to an agreement with Medicare that they
17 would submit claims that were accurate, complete, and truthful.

18 12. Medicare paid DME providers only for DME that was
19 medically necessary to the treatment of a beneficiary's illness
20 or injury, was prescribed by a beneficiary's physician, and was
21 provided in accordance with Medicare regulations and guidelines
22 that governed whether a particular item or service would be paid
23 by Medicare.

24 13. To bill Medicare for DME provided to a beneficiary, a
25 DME supplier was required to submit a claim (Form 1500).
26 Medicare required claims to be truthful, complete, and not
27 misleading. In addition, when a claim was submitted, the DME
28

1 provider was required to certify that the DME or services covered
2 by the claim were medically necessary.

3 14. Medicare required a claim for payment to set forth,
4 among other things, the beneficiary's name and HICN, the type of
5 DME provided to the beneficiary, the date the DME was provided,
6 and the name and unique physician identification number ("UPIN")
7 of the physician who prescribed or ordered the DME.

8 15. Medicare had a co-payment requirement for DME.
9 Medicare reimbursed providers 80% of the allowed amount of a DME
10 claim and the beneficiary was ordinarily obligated to pay the
11 remaining 20%.

12 16. Defendant LING wrote medically unnecessary
13 prescriptions for power wheelchairs ("PWCs") and related
14 accessories that co-conspirator E.O. used as the basis to submit
15 false and fraudulent claims to Medicare.

16 17. Between in or around March 2010 and in or around
17 November 2010, co-conspirator E.O. submitted, or caused to be
18 submitted, to Medicare claims totaling approximately \$496,794 for
19 purported PWCs and other DME based on medically unnecessary
20 prescriptions and other documents written by defendant LING, and
21 Medicare paid approximately \$311,145 on those claims.

22 B. THE OBJECT OF THE CONSPIRACY

23 18. Beginning in or around March 2010, and continuing
24 through in or around November 2010, in Los Angeles County, within
25 the Central District of California, and elsewhere, defendant
26 LING, together with co-conspirator E.O. and others known and
27 unknown to the United States Attorney, knowingly combined,
28

1 conspired, and agreed to commit health care fraud, in violation
2 of Title 18, United States Code, Section 1347.

3 C. THE MANNER AND MEANS OF THE CONSPIRACY

4 19. The object of the conspiracy was carried out, and to be
5 carried out, in substance, as follows:

6 a. Defendant LING would use street-level marketers to
7 unlawfully recruit Medicare beneficiaries to obtain PWCs and
8 other DME that the beneficiaries did not need.

9 b. The marketers would take the Medicare
10 beneficiaries to visit defendant LING, and defendant LING would
11 write prescriptions for PWCs and other DME that he knew the
12 beneficiaries did not need.

13 c. Defendant LING would provide the prescriptions and
14 other supporting documents to marketers and others knowing that
15 the prescriptions and documents would be provided to a DME
16 company in Los Angeles, California, owned by co-conspirator E.O.,
17 and knowing that the prescriptions and documents would be used to
18 submit false and fraudulent claims to Medicare.

19 ///

20 ///

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23 ///

24 ///

25 ///

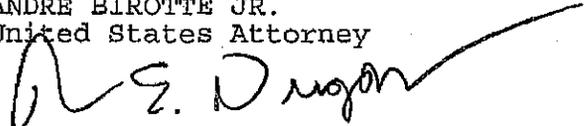
26 ///

27 ///

28 ///

1 d. After acquiring the false and fraudulent
2 prescriptions and supporting documents written by defendant LING,
3 co-conspirator E.O. would submit, or cause the submission of,
4 false and fraudulent claims to Medicare for medically unnecessary
5 PWCs and other DME.

6
7 ANDRÉ BIROTTE JR.
8 United States Attorney

9 
10 ROBERT E. DUGDALE
11 Assistant United States Attorney
12 Chief, Criminal Division

13 RICHARD E. ROBINSON
14 Assistant United States Attorney
15 Chief, Major Frauds Section

16 CONSUELO WOODHEAD
17 Assistant United States Attorney
18 Deputy Chief, Major Frauds Section

19 BEN CURTIS
20 Assistant Chief, Fraud Section
21 United States Department of Justice

22 ALEXANDER F. PORTER
23 Trial Attorney, Fraud Section
24 United States Department of Justice

United States District Court
Central District of California

UNITED STATES OF AMERICA vs.

Docket No.

CR 14-231-GW

JS-3

Defendant Jason C. Ling

Social Security No.

akas: _____

(Last 4 digits)

JUDGMENT AND PROBATION/COMMITMENT ORDER

In the presence of the attorney for the government, the defendant appeared in person on this date.

MONTH	DAY	YEAR
12	15	2014

COUNSEL Roseline Der Gregorian-Feral

(Name of Counsel)

PLEA **GUILTY**, and the court being satisfied that there is a factual basis for the plea. **NOLO** **NOT**
CONTENDERE **GUILTY**

FINDING There being a finding/verdict of **GUILTY**, defendant has been convicted as charged of the offense(s) of:
18 U.S.C. § 1349: CONSPIRACY TO COMMIT HEALTH CARE FRAUD as charged in the Information.

JUDGMENT AND PROB/ COMM ORDER The Court asked whether there was any reason why judgment should not be pronounced. Because no sufficient cause to the contrary was shown, or appeared to the Court, the Court adjudged the defendant guilty as charged and convicted and ordered that: Pursuant to the Sentencing Reform Act of 1984, it is the judgment of the Court that the defendant is hereby committed to the custody of the Bureau of Prisons to be imprisoned for a term of: **Twenty-two (22) months.**

Having considered the sentencing factors enumerated at 18 U.S.C. § 3553(a) including the advisory guideline range of 30 to 37 months based upon an offense level of 19 and a criminal history category of I, the Probation Officer respectfully recommends the following sentence.

It is ordered that the defendant shall pay to the United States a special assessment of \$100, which is due immediately. Any unpaid balance shall be due during the period of imprisonment, at the rate of not less than \$25 per quarter, and pursuant to the Bureau of Prisons' Inmate Financial Responsibility Program.

It is ordered that the defendant shall pay restitution in the total amount of \$311,145 pursuant to 18 U.S.C. § 3663A.

Defendant shall pay restitution in the total amount of \$311,145 to victims as set forth in a separate victim list prepared by the probation office which this Court adopts and which reflects the Court's determination of the amount of restitution due to each victim. The victim list, which shall be forwarded to the fiscal section of the clerk's office, shall remain confidential to protect the privacy interests of the victims.

The defendant shall comply with General Order No. 01-05.

All fines are waived as it is found that the defendant does not have the ability to pay a fine in addition to restitution.

Pursuant to the Sentencing Reform Act of 1984, it is the judgment of the Court that the defendant, Jason C. Ling, is hereby committed on the Single-Count Information to the custody of the Bureau of Prisons for a term of 22 months.

Upon release from imprisonment, the defendant shall be placed on supervised release for a term of three years under the following terms and conditions:

USA vs. **Jason C. Ling**

Docket No.: **CR 14-231-GW**

1. The defendant shall comply with the rules and regulations of the United States Probation Office, General Order 05-02, and General Order 01-05, including the three special conditions delineated in General Order 01-05.
2. During the period of community supervision, the defendant shall pay the special assessment and restitution in accordance with this judgment's orders pertaining to such payment.
3. The defendant shall cooperate in the collection of a DNA sample from the defendant.
4. The defendant shall apply all monies received from income tax refunds to the outstanding court-ordered financial obligation. In addition, the defendant shall apply all monies received from lottery winnings, inheritance, judgments and any anticipated or unexpected financial gains to the outstanding court-ordered financial obligation.

It is further ordered that the defendant surrender himself to the institution designated by the Bureau of Prisons on or before 12 noon on February 20, 2015. In the absence of such designation, the defendant shall report on or before the same date and time, to the United States Marshal located at the Roybal Federal Building, 255 East Temple Street, Los Angeles, California 90012. Bond is exonerated upon surrender.

The Court advises defendant of his rights to an appeal. The Court recommends, but does not order, that defendant serve his term at the federal facility in Taft, California or at a federal facility in Southern California.

In addition to the special conditions of supervision imposed above, it is hereby ordered that the Standard Conditions of Probation and Supervised Release within this judgment be imposed. The Court may change the conditions of supervision, reduce or extend the period of supervision, and at any time during the supervision period or within the maximum period permitted by law, may issue a warrant and revoke supervision for a violation occurring during the supervision period.

December 17, 2014
Date



GEORGE H. WU, U. S. District Judge

It is ordered that the Clerk deliver a copy of this Judgment and Probation/Commitment Order to the U.S. Marshal or other qualified officer.

Clerk, U.S. District Court

December 18, 2014
Filed Date

By /S/ Javier Gonzalez
Deputy Clerk

The defendant shall comply with the standard conditions that have been adopted by this court (set forth below).

STANDARD CONDITIONS OF PROBATION AND SUPERVISED RELEASE

While the defendant is on probation or supervised-release pursuant to this judgment:

USA vs. Jason C. LingDocket No.: CR 14-231-GW

1. The defendant shall not commit another Federal, state or local crime;
2. the defendant shall not leave the judicial district without the written permission of the court or probation officer;
3. the defendant shall report to the probation officer as directed by the court or probation officer and shall submit a truthful and complete written report within the first five days of each month;
4. the defendant shall answer truthfully all inquiries by the probation officer and follow the instructions of the probation officer;
5. the defendant shall support his or her dependents and meet other family responsibilities;
6. the defendant shall work regularly at a lawful occupation unless excused by the probation officer for schooling, training, or other acceptable reasons;
7. the defendant shall notify the probation officer at least 10 days prior to any change in residence or employment;
8. the defendant shall refrain from excessive use of alcohol and shall not purchase, possess, use, distribute, or administer any narcotic or other controlled substance, or any paraphernalia related to such substances, except as prescribed by a physician;
9. the defendant shall not frequent places where controlled substances are illegally sold, used, distributed or administered;
10. the defendant shall not associate with any persons engaged in criminal activity, and shall not associate with any person convicted of a felony unless granted permission to do so by the probation officer;
11. the defendant shall permit a probation officer to visit him or her at any time at home or elsewhere and shall permit confiscation of any contraband observed in plain view by the probation officer;
12. the defendant shall notify the probation officer within 72 hours of being arrested or questioned by a law enforcement officer;
13. the defendant shall not enter into any agreement to act as an informer or a special agent of a law enforcement agency without the permission of the court;
14. as directed by the probation officer, the defendant shall notify third parties of risks that may be occasioned by the defendant's criminal record or personal history or characteristics, and shall permit the probation officer to make such notifications and to conform the defendant's compliance with such notification requirement;
15. the defendant shall, upon release from any period of custody, report to the probation officer within 72 hours;
16. and, for felony cases only: not possess a firearm, destructive device, or any other dangerous weapon.



The defendant will also comply with the following special conditions pursuant to General Order 01-05 (set forth below).

STATUTORY PROVISIONS PERTAINING TO PAYMENT AND COLLECTION OF FINANCIAL SANCTIONS

The defendant shall pay interest on a fine or restitution of more than \$2,500, unless the court waives interest or unless the fine or restitution is paid in full before the fifteenth (15th) day after the date of the judgment pursuant to 18 U.S.C. §3612(f)(1). Payments may be subject to penalties for default and delinquency pursuant to 18 U.S.C. §3612(g). Interest and penalties pertaining to restitution, however, are not applicable for offenses completed prior to April 24, 1996.

If all or any portion of a fine or restitution ordered remains unpaid after the termination of supervision, the defendant shall pay the balance as directed by the United States Attorney's Office. 18 U.S.C. §3613.

The defendant shall notify the United States Attorney within thirty (30) days of any change in the defendant's mailing address or residence until all fines, restitution, costs, and special assessments are paid in full. 18 U.S.C. §3612(b)(1)(F).

The defendant shall notify the Court through the Probation Office, and notify the United States Attorney of any material change in the defendant's economic circumstances that might affect the defendant's ability to pay a fine or restitution, as required by 18 U.S.C. §3664(k). The Court may also accept such notification from the government or the victim, and may, on its own motion or that of a party or the victim, adjust the manner of payment of a fine or restitution-pursuant to 18 U.S.C. §3664(k). See also 18 U.S.C. §3572(d)(3) and for probation 18 U.S.C. §3563(a)(7).

Payments shall be applied in the following order:

1. Special assessments pursuant to 18 U.S.C. §3013;
2. Restitution, in this sequence:
 - Private victims (individual and corporate),
 - Providers of compensation to private victims,
 - The United States as victim;
3. Fine;
4. Community restitution, pursuant to 18 U.S.C. §3663(c); and
5. Other penalties and costs.

SPECIAL CONDITIONS FOR PROBATION AND SUPERVISED RELEASE

As directed by the Probation Officer, the defendant shall provide to the Probation Officer: (1) a signed release authorizing credit report inquiries; (2) federal and state income tax returns or a signed release authorizing their disclosure; and (3) an accurate financial statement, with supporting documentation as to all assets, income and expenses of the defendant. In addition, the defendant shall not apply for any loan or open any line of credit without prior approval of the Probation Officer.

The defendant shall maintain one personal checking account. All of defendant's income, "monetary gains," or other pecuniary proceeds shall be deposited into this account, which shall be used for payment of all personal expenses. Records of all other bank accounts, including any business accounts, shall be disclosed to the Probation Officer upon request.

The defendant shall not transfer, sell, give away, or otherwise convey any asset with a fair market value in excess of \$500 without approval of the Probation Officer until all financial obligations imposed by the Court have been satisfied in full.

These conditions are in addition to any other conditions imposed by this judgment.

USA vs. Jason C. Ling

Docket No.: CR 14-231-GW

RETURN

I have executed the within Judgment and Commitment as follows:

Defendant delivered on _____ to _____

Defendant noted on appeal on _____

Defendant released on _____

Mandate issued on _____

Defendant's appeal determined on _____

Defendant delivered on _____ to _____

at _____

the institution designated by the Bureau of Prisons, with a certified copy of the within Judgment and Commitment.

United States Marshal

By _____

_____ Date

Deputy Marshal

CERTIFICATE

I hereby attest and certify this date that the foregoing document is a full, true and correct copy of the original on file in my office, and in my legal custody.

Clerk, U.S. District Court

By _____

_____ Filed Date

Deputy Clerk

FOR U.S. PROBATION OFFICE USE ONLY

Upon a finding of violation of probation or supervised release, I understand that the court may (1) revoke supervision, (2) extend the term of supervision, and/or (3) modify the conditions of supervision.

These conditions have been read to me. I fully understand the conditions and have been provided a copy of them.

(Signed) _____

Defendant

_____ Date

_____ U. S. Probation Officer/Designated Witness

_____ Date

WESTERN,CLOSED

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA (Western Division - Los Angeles)
CRIMINAL DOCKET FOR CASE #: 2:14-cr-00231-GW-1**

Case title: USA v. Ling

Date Filed: 04/22/2014

Date Terminated: 12/18/2014

Assigned to: Judge George H. Wu

Defendant (1)**Jason C Ling***TERMINATED: 12/18/2014*represented by **Roseline Der Gregorian-Feral**

444 W C Street Ste 310

San Diego, CA 92101

619-232-1010

Fax: 619-231-2505

Email: roselineferal@gmail.com

LEAD ATTORNEY**ATTORNEY TO BE NOTICED***Designation: Retained***Pending Counts**

18:1349: Conspiracy to Commit Health
Care Fraud
(1)

Disposition

Defendant is hereby committed on the
Single Count Information to the custody
of Bureau of Prisons for a term of 22
months; Supervised Release 3 years;
Restitution 311,145; Special
Assessment 100; all fines are waived;
shall comply with the rules and
regulations of the United States
Probation Office, General Order 05-02,
and General Order 01-05

Highest Offense Level (Opening)

Felony

Terminated Counts

None

Disposition**Highest Offense Level (Terminated)**

None

Complaints

Disposition

None

Plaintiff

USA

represented by **Alexander F Porter**
 AUSA - Office of US Attorney
 Criminal Division - Major Frauds
 312 North Spring Street 11th Floor
 Los Angeles, CA 90012
 213-894-0813
 Fax: 213-894-6269
 Email: alexander.porter2@usdoj.gov
LEAD ATTORNEY
ATTORNEY TO BE NOTICED
Designation: Assistant US Attorney

Date Filed	#	Docket Text
04/22/2014	<u>1</u>	INFORMATION filed as to Jason C Ling (1) count(s) 1. Offense occurred in LA. (mhe) (Entered: 05/06/2014)
04/22/2014	<u>2</u>	CASE SUMMARY filed by AUSA Alexander Porter as to Defendant Jason C Ling; defendants Year of Birth: 1971 (mhe) (Entered: 05/06/2014)
04/22/2014	<u>3</u>	Government's Request for Issuance of Summons on Information Filed by Plaintiff USA as to Defendant Jason C Ling. (mhe) (Entered: 05/06/2014)
04/22/2014	<u>4</u>	ORDER by Judge Michael W. Fitzgerald: Granting <u>3</u> Ex Parte Application for Order as to Jason C Ling (1) (mhe) (Entered: 05/06/2014)
04/22/2014	<u>5</u>	EX PARTE APPLICATION to Seal Case Filed by Plaintiff USA as to Defendant Jason C Ling. (mhe) (Entered: 05/06/2014)
04/22/2014	<u>8</u>	ORDER by Judge Michael W. Fitzgerald: granting <u>5</u> Ex Parte Application to Seal Case as to Jason C Ling (1) (mhe) (Entered: 05/06/2014)
04/22/2014	<u>9</u>	ORDER by Judge Michael W. Fitzgerald: Granting <u>6</u> Exparte Application to Seal Document as to Jason C Ling (1) (mhe) (mhe). (Entered: 05/06/2014)
04/22/2014	<u>10</u>	MEMORANDUM filed by Plaintiff USA as to Defendant Jason C Ling. This criminal action, being filed on 4/18/14, was not pending in the U. S. Attorneys Office before the date on which Judge Michael W Fitzgerald and Judge Beverly Reid OConnell began receiving criminal matters. (mhe) (Entered: 05/06/2014)
04/22/2014	<u>11</u>	MEMORANDUM filed by Plaintiff USA as to Defendant Jason C Ling. Re Magistrate Judge Jacqueline Chooljian, Magistrate Judge Patrick J. Walsh, Magistrate Judge Sheri Pym, Magistrate Judge Michael Wilner, Magistrate Judge Jean Rosenbluth, Magistrate Judge Alka Sagar, Magistrate Judge Douglas McCormick(mhe) (Entered: 05/06/2014)

04/22/2014	<u>12</u>	NOTICE of Related Case(s) filed by Plaintiff USA as to Defendant Jason C Ling (mhe) (Entered: 05/06/2014)
04/22/2014	<u>22</u>	SEALED DOCUMENT(mhe) (Entered: 07/29/2014)
05/13/2014	<u>13</u>	MINUTES OF ARREST ON INDICTMENT HEARING held before Magistrate Judge Michael R. Wilner as to Defendant Jason C Ling. Defendant states true name as charged. Attorney: Roseline Der Gregorian-Feral for Jason C Ling, Retained, present.Court orders bail set as: Jason C Ling (1) \$10,000 Appearance bond, see attached bond for terms and conditions. Defendant remanded to the custody of the USM. PIA held, see separate minutes. RELEASE ORDER NO: SUMMONS Court Reporter: Miranda Algorri. (mhe) (Entered: 05/19/2014)
05/13/2014	<u>14</u>	WAIVER OF INDICTMENT by Defendant Jason C Ling before Magistrate Judge Michael R. Wilner (mhe) (Entered: 05/19/2014)
05/13/2014	<u>16</u>	DECLARATION RE: PASSPORT filed by Defendant Jason C Ling, declaring that My passport is in the possession of federal agents. If my passport is returned to me during the pendency of this case, I will immediately surrender it to the Clerk of the Court. I will not apply for the issuance of a passport during the pendency of this case. RE: Bond and Conditions (CR-1) <u>15</u> . (mhe) (Entered: 05/19/2014)
05/13/2014	<u>17</u>	STATEMENT OF CONSTITUTIONAL RIGHTS filed by Defendant Jason C Ling (mhe) (Entered: 05/19/2014)
05/13/2014	<u>18</u>	MINUTES OF POST-INDICTMENT ARRAIGNMENT: held before Magistrate Judge Michael R. Wilner as to Defendant Jason C Ling (1) Count 1. Defendant arraigned, states true name: As charged. Attorney: Roseline Der Gregorian-Feral, Retained present. Case assigned to Judge George H. Wu. Counsel are ordered to contact the court clerk regarding the setting of dates for the guilty plea and all further proceedings. Court Reporter: Miranda Algorri. (tba) (Entered: 05/19/2014).
05/14/2014	<u>15</u>	BOND AND CONDITIONS OF RELEASE filed as to Defendant Jason C Ling conditions of release: \$10,000 Appearance Bond, see attached for terms and conditions approved by Magistrate Judge Michael R. Wilner. (mhe) (Entered: 05/19/2014)
05/23/2014	<u>19</u>	TEXT ONLY ENTRY (IN CHAMBERS) by Judge George H. Wu; Pursuant to the request of counsel, a Change of Plea Hearing as to Defendant Jason C Ling is set for 6/9/2014 at 10:00 AM before Judge George H. Wu. THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY.(kss) TEXT ONLY ENTRY (Entered: 05/23/2014)
06/06/2014	<u>20</u>	TEXT ONLY ENTRY (IN CHAMBERS): by Judge George H. Wu; Due to a scheduling conflict, the time to appear at the Change of Plea Hearing as to Defendant Jason C Ling, presently set for June 9, 2014, has been ADVANCED from 10:00 to 8:00 a.m. THERE IS NO PDF DOCUMENT ASSOCIATED WITH THIS ENTRY.(jag) TEXT ONLY ENTRY (Entered: 06/06/2014)
06/09/2014	<u>21</u>	MINUTES OF Change of Plea Hearing held before Judge George H. Wu as to Defendant Jason C Ling. Defendant sworn. Defendant moves to Change plea to

		Count One of the Information. Defendant enters a new and different plea of Guilty to Count One of the Information. The Court questions the defendant regarding plea of Guilty and finds it knowledgeable and voluntary and orders the plea accepted and entered. The Court refers the defendant to the Probation Office for an investigation and report and continues the matter to December 15, 2014 at 8:00 a.m. for sentencing. Parties are to submit their sentencing positions by no later than December 8, 2014. The Court vacates the Court and/or Jury Trial date. Court Reporter: Katie Thibodeaux. (kss) (Entered: 06/10/2014)
12/08/2014	<u>25</u>	SENTENCING MEMORANDUM filed by Plaintiff USA as to Defendant Jason C Ling (Porter, Alexander) (Entered: 12/08/2014)
12/10/2014	<u>26</u>	SENTENCING MEMORANDUM filed by Defendant Jason C Ling (Attachments: # <u>1</u> Letter Letter in Support, # <u>2</u> Exhibit Proof of service) (Gregorian-Feral, Roseline) (Entered: 12/10/2014)
12/15/2014	<u>28</u>	MINUTES OF SENTENCING Hearing held before Judge George H. Wu as to Defendant Jason C Ling(1), Count(s) 1, Defendant is hereby committed on the Single Count Information to the custody of Bureau of Prisons for a term of 22 months; Supervised Release 3 years; Restitution 311,145; Special Assessment 100; all fines are waived; shall comply with the rules and regulations of the United States Probation Office, General Order 05-02, and General Order 01-05 Bond exonerated upon surrender. Defendant advised of right of appeal. Defendant to surrender not later than 2/20/2015. Bond is exonerated upon surrenderCourt Reporter: Katie Thibodeaux. (pj) (Entered: 12/22/2014)
12/18/2014	<u>29</u>	JUDGMENT AND COMMITMENT by Judge George H. Wu as to Defendant Jason C Ling (1), Count(s) 1, Defendant is hereby committed on the Single Count Information to the custody of Bureau of Prisons for a term of 22 months; Supervised Release 3 years; Restitution 311,145; Special Assessment 100; all fines are waived; shall comply with the rules and regulations of the United States Probation Office, General Order 05-02, and General Order 01-05 It is further ordered that the defendant surrender himself to the institution designated by the Bureau of Prisons on or before 12 noon on February 20, 2015. Bond is exonerated upon surrender (pj) (Entered: 12/22/2014)
03/24/2015	<u>31</u>	VERIFICATION OF SURRENDER as to Jason C Ling. The defendant was ordered to self-surrender to begin serving their sentence of imprisonment on 2/20/15. The bond may be exonerated pending the verification as to whether the defendant is being electronically monitored by the U.S. Probation Office; confined to the custody of the Bureau of Prisons; or completed their jail time. As of 3/24/2015, it was verified the defendant Voluntary Surrender to San Diego USMS on 2/20/2015. (pj) Modified on 3/24/2015 (pj). (Main Document 31 replaced on 3/24/2015) (pj). (Entered: 03/24/2015)

PACER Service Center	
Transaction Receipt	
04/30/2018 16:56:42	
Odlegal94612:2536794:0	

PACER Login:		Client Code:	
Description:	Docket Report	Search Criteria:	2:14-cr-00231-GW End date: 4/30/2018
Billable Pages:	4	Cost:	0.40



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

APR 20 2015

Jason Ling, #67742-12
MCC San Diego
808 Union Street
San Diego, CA 92101

**Re: Doctor of Osteopathy
License no. 20A9710
Provider No.: 1578666350**

Dear Dr. Ling:

The Deputy Director and Chief Counsel of the State Department of Health Services (Department) has been notified by the Director, Health Care Program Exclusions, Office of Counsel to the Inspector General, Department of Health and Human Services, that you have been excluded from participation in the Medicare, Medicaid, and all Federal health care programs, effective April 20, 2015. As a provider of health care services, you were granted certain permissions to participate in the Medi-Cal program by operation of law with or without applying for enrollment. Upon your exclusion from the Medicare program, you became ineligible to participate in the Medi-Cal program. The Department's Director is required to automatically suspend these permissions in certain cases, which means that the affected individual or entity is precluded from being eligible to receive payment from the Medi-Cal program directly or indirectly. (See 42 U.S.C. § 1320a-7(d)(3)(A); Welf. & Inst. Code, § 14123, subd. (b).)

Therefore, on behalf of the Director of the Department, you are hereby notified that you are suspended from being able to receive payment from the Medi-Cal program for an indefinite period of time, effective April 20, 2015. Your name will be posted on the "Medi-Cal Suspended and Ineligible Provider List," available on the Internet. During the period of your suspension, no person or entity, including an employer, may submit any claims to the Medi-Cal program for items or services rendered by you. If you are currently enrolled in Medi-Cal, that enrollment will be terminated. Any involvement by you directly or indirectly (i.e., as an office manager, administrator, billing clerk processing or preparing claims for payment, salesperson for medical equipment, etc., or utilizing any other provider number or group or clinic number for services rendered by you) will result in nonpayment of the claim(s) submitted. Any person who presents or causes to be presented a claim for equipment or services rendered by a person

Jason Ling
Page 2

APR 20 2015

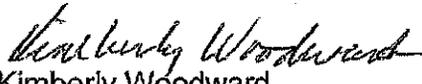
suspended from receiving Medi-Cal payment shall be subject to suspension from receiving payment, the assessment of civil money penalties, and/or criminal prosecution. (See Welf. & Inst. Code, §§ 14043.61, 14107, 14123.2; Cal. Code Regs., tit. 22, §§ 51458.1, 51484, 51485.1.) The Department will seek recoupment of any monies paid for claims presented to the Medi-Cal program for services or supplies provided by you during the duration of your suspension.

If your exclusion from participation in Medicare/Medicaid is reinstated by the Department of Health and Human Services in the future, and if no other circumstance(s) exist at that time that would preclude your being considered for reinstatement in the Medi-Cal program, you may then submit a written petition for reinstatement to participate in the Medi-Cal program. Reinstatement into the Medi-Cal program is not automatic. Only if your petition for reinstatement is granted will you be eligible to submit an application for enrollment in Medi-Cal.

If you have any questions about this action, or will be submitting a written petition for reinstatement (in accordance with the restrictions above), please submit your concerns or petition, in writing, to the Office of Legal Services, Mandatory Suspension Desk, at the address above.

Sincerely,

Eric Lazarus
Senior Attorney


Kimberly Woodward
Legal Analyst

cc: See next page.

Cliff Hamilton
Chief of Enforcement
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831

Charles M. Russo
Intelligence Analyst, Health Care Fraud
Federal Bureau of Investigations
4500 Orange Grove Avenue
Sacramento, CA 95841

Debbie Rielley
Bureau of Medi-Cal Fraud and Elder Abuse
Criminal Division
Office of Attorney General
1425 River Park Drive, Suite 300
Sacramento, CA 95815

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Audits & Investigations
Case Development Section, MS 2301
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Avril Singh
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Senior Management Auditor
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Office of Investigations
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Office of Inspector General
Office of Investigations
Department of Health and Human Services
600 City Parkway West, Suite 500
Orange, CA 92868-2946

FILED

NOV 20 2014

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

In the Matter of the First Amended Accusation
Against:

JASON LING, D.O.
4456 Vandever Avenue
San Diego, CA 92120

Osteopathic Physician's and Surgeon's
Certificate No. 20A9710

Respondent.

Case Nos. 00-2010-002765, 00-2011-003199,
and 00-2010-002723

OAH No. 2013050539

DECISION AND ORDER

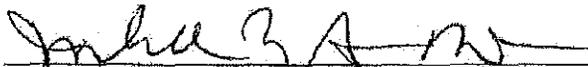
The attached Stipulated Revocation of License and Order is hereby adopted by the
Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in
this matter.

This Decision shall become effective on

12/5/2014

It is so ORDERED

11/20/2014


FOR THE OSTEOPATHIC MEDICAL BOARD OF
CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 ALEXANDRA M. ALVAREZ
Deputy Attorney General
4 State Bar No. 187442
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5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 645-3141
7 Facsimile: (619) 645-2061

8 *Attorneys for Complainant*

9
10 **BEFORE THE**
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
12 **STATE OF CALIFORNIA**

13 In the Matter of the First Amended Accusation
Against:

Case Nos. 00-2010-002765, 00-2011-003199,
and 00-2010-002723

14 **JASON LING, D.O.**
15 4456 Vandever Avenue
San Diego, CA 92120

OAH No. 2013050539

16 **Osteopathic Physician's and Surgeon's**
17 **Certificate No. 20A9710,**

**STIPULATED REVOCATION OF
LICENSE AND ORDER**

18 Respondent.

19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Angelina M. Burton (Complainant) is the Executive Director of the Osteopathic
24 Medical Board of California. She brought this action solely in her official capacity and is
25 represented in this matter by Kamala D. Harris, Attorney General of the State of California, by
26 Alexandra M. Alvarez, Deputy Attorney General.

27 ///

28 ///

1 cross-examine the witnesses against him; the right to present evidence and to testify on his own
2 behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the
3 production of
4 documents; the right to reconsideration and court review of an adverse decision; and all other
5 rights accorded by the California Administrative Procedure Act and other applicable laws.

6 8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently
7 waives and gives up each and every right set forth above.

8 CULPABILITY

9 9. Respondent admits the complete truth and accuracy of each and every charge and
10 allegation in the Tenth Cause for Discipline in First Amended Accusation Nos. 00-2010-002765,
11 00-2011-003199, and 00-2010-002723, and that he has thereby subjected his Osteopathic
12 Physician's and Surgeon's Certificate No. 20A9710 to disciplinary action. In addition,
13 respondent does not contest that, at an administrative hearing, complainant could establish a
14 *prima facie* case with respect to the charges and allegations in the First through Ninth Causes for
15 Discipline and in the Eleventh Causes for Discipline contained in First Amended Accusation Nos.
16 00-2010-002765, 00-2011-003199, and 00-2010-002723, and that he has thereby subjected his
17 Osteopathic Physician's and Surgeon's Certificate No. 20A9710 to further disciplinary action.

18 10. Respondent understands that by signing this stipulation he enables the Board to issue
19 an order revoking his Osteopathic Physician's and Surgeon's Certificate No. 20A9710 without
20 further process.

21 CONTINGENCY

22 11. The parties agree that this Stipulated Revocation of License and Order shall be
23 submitted to the Board for its consideration in the above-entitled matter and, further, that the
24 Board shall have a reasonable period of time in which to consider and act on this Stipulated
25 Revocation of License and Order after receiving it. By signing this stipulation, Respondent fully
26 understands and agrees that he may not withdraw his agreement or rescind this stipulation prior to
27 the time the Board considers and acts upon it.

28 ///

1 1. The revocation of Respondent's Osteopathic Physician's and Surgeon's Certificate
2 No. 20A9710 shall constitute the imposition of discipline against Jason Ling, D.O. This
3 stipulation constitutes a record of the discipline and shall become a part of Respondent's license
4 history with the Osteopathic Medical Board of California.

5 2. Respondent Jason Ling, D.O., shall lose all rights and privileges as an osteopathic
6 physician and surgeon in California as of the effective date of the Board's Decision and Order.

7 3. Respondent Jason Ling, D.O., shall cause to be delivered to the Board his pocket
8 license and, if one was issued, his wall certificate on or before the effective date of the Decision
9 and Order.

10 4. Pursuant to Business and Professions Code section 2273, subdivision (b), Respondent
11 Jason Ling, D.O., shall have his Osteopathic Physician's and Surgeon's Certificate No. 20A9710
12 revoked for a period of not less than ten (10) years from the effective date of the Decision and
13 Order. After the expiration of this ten-year period, Respondent may then apply for license
14 reinstatement pursuant to Business and Professions Code section 2307.

15 5. If respondent ever applies for licensure or petitions for reinstatement in the State of
16 California, the Board shall treat it as a new application for licensure. Respondent must comply
17 with all the laws, regulations and procedures for licensure in effect at the time the application or
18 petition is filed, and all of the charges and allegations contained in First Amended Accusation
19 Nos. 00-2010-002765, 00-2011-003199, and 00-2010-002723 shall be deemed to be true, correct
20 and admitted by Respondent when the Board determines whether to grant or deny the application
21 or petition.

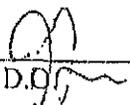
22 6. If Respondent should ever apply or reapply for a new license or certification, or
23 petition for reinstatement of a license, by any other health care licensing agency in the State of
24 California, all of the charges and allegations contained in First Amended Accusation Nos. 00-
25 2010-002765, 00-2011-003199, and 00-2010-002723 shall be deemed to be true, correct, and
26 fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding
27 seeking to deny or restrict licensure.

28 ///

1 ACCEPTANCE

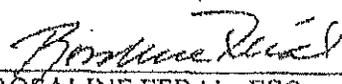
2 I have carefully read the above Stipulated Revocation of License and Order and have fully
3 discussed it with my attorney, Rosaline Feral, Esq. I understand the stipulation and the effect it
4 will have on my Osteopathic Physician's and Surgeon's Certificate No. 20A9710. I enter into
5 this Stipulated Revocation of License and Order voluntarily, knowingly, and intelligently, and
6 agree to be bound by the Decision and Order of the Osteopathic Medical Board of California.

7 DATED: 10-16-14


8 JASON LING, D.O.
Respondent

9 I have read and fully discussed with Respondent Jason Ling, D.O. the terms and conditions
10 and other matters contained in this Stipulated Revocation of License and Order. I approve its
11 form and content.

12 DATED: 10/16/14


13 ROSALINE FERAL, ESQ.
14 Attorney for Respondent

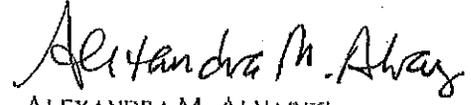
15 ENDORSEMENT

16 The foregoing Stipulated Revocation of License and Order is hereby respectfully submitted
17 for consideration by the Osteopathic Medical Board of California of the Department of Consumer
18 Affairs.

19 Dated: 10/17/14

Respectfully submitted,

20 KAMALA D. HARRIS
21 Attorney General of California
22 THOMAS S. LAZAR
Supervising Deputy Attorney General


23 ALEXANDRA M. ALVAREZ
24 Deputy Attorney General
25 Attorneys for Complainant

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Exhibit A

First Amended Accusation Nos. 00-2010-002765, 00-2011-003199, and 00-2010-002723

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 ALEXANDRA M. ALVAREZ
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8 *Attorneys for Complainant*

FILED

OCT 14 2014

**OSTEOPATHIC MEDICAL BOARD
OF CALIFORNIA**

9
10 **BEFORE THE**
11 **OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

13 In the Matter of the First Amended Accusation
14 Against:

Case Nos. 00-2010-002765, 00-2011-003199,
and 00-2010-002723

15 **JASON LING, D.O.**
4456 Vandever Avenue
16 San Diego, CA 92120

FIRST AMENDED ACCUSATION

17 **Osteopathic Physician's and Surgeon's
Certificate No. 20A9710**

18 Respondent.

19
20 Complainant alleges:

21 **PARTIES**

22 1. Angelina M. Burton (Complainant) brings this First Amended Accusation solely in
23 her official capacity as the Executive Director of the Osteopathic Medical Board of California,
24 Department of Consumer Affairs.

25 2. On or about September 1, 2006, the Osteopathic Medical Board of California issued
26 Osteopathic Physician's and Surgeon's Certificate No. 20A9710 to Jason Ling, D.O.

27 (Respondent). The Osteopathic Physician's and Surgeon's Certificate was in full force and effect.

28 ///

1 at all times relevant to the charges brought herein and will expire on October 31, 2014, unless
2 renewed.

3 JURISDICTION

4 3. This First Amended Accusation is brought before the Osteopathic Medical Board of
5 California (Board), Department of Consumer Affairs, under the authority of the following laws.

6 All section references are to the Business and Professions Code (Code) unless otherwise
7 indicated.

8 4. Section 3600 of the Code states that the law governing licentiates of the Osteopathic
9 Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2,
10 relating to medicine.

11 5. Section 3600-2 of the Code states:

12 "The Osteopathic Medical Board of California shall enforce those portions
13 of the Medical Practice Act identified as Article 12 (commencing with Section
14 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now
15 existing or hereafter amended, as to persons who hold certificates subject to the
16 jurisdiction of the Osteopathic Medical Board of California, however, persons who
17 elect to practice using the term or suffix "M.D." as provided in Section 2275 of the
18 Business and Professions Code, as now existing or hereafter amended, shall not be
19 subject to this section, and the Medical Board of California shall enforce the
20 provisions of the article as to persons who make the election. After making the
21 election, each person so electing shall apply for renewal of his or her certificate to
22 the Medical Board of California, and the Medical Board of California shall issue
23 renewal certificates in the same manner as other renewal certificates are issued by
24 it."

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

1 7. Section 2234 of the Code states:

2 "The Board shall take action against any licensee who is charged with
3 unprofessional conduct.¹ In addition to other provisions of this article,
4 unprofessional conduct includes, but is not limited to, the following:

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

7 "(b) Gross negligence.

8 "(c) Repeated negligent acts.

9 "(d) Incompetence.

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

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

15 "..."

16 8. Section 2238 of the Code provides that a violation of any federal statute or federal
17 regulation or any of the statutes or regulations of this state regulating dangerous drugs or
18 controlled substances constitutes unprofessional conduct.

19 9. Section 2241 of the Code provides:

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

24 "(b) A physician and surgeon may prescribe, dispense, or administer

25 _____
26 ¹ Unprofessional conduct under California Business and Professions Code section 2234 is
27 conduct which breaches the rules of ethical code of the medical profession, or conduct which is
28 unbecoming to a member in good standing of the medical profession, and which demonstrates an
unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564,
575.

1 prescription drugs or prescription controlled substances to an addict for purposes
2 of maintenance on, or detoxification from, prescription drugs or controlled
3 substances only as set forth in subdivision (c) or in Sections 11215, 11217,
4 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this
5 subdivision shall authorize a physician and surgeon to prescribe, dispense, or
6 administer dangerous drugs or controlled substances to a person he or she knows
7 or reasonably believes is using or will use the drugs or substances for a
8 nonmedical purpose.

9 "..."

10 10. Section 2242 of the Code provides:

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

14 "..."

15 11. Section 2261 of the Code provides that knowingly making or signing any certificate
16 or other document directly or indirectly related to the practice of medicine or podiatry which
17 falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional
18 conduct.

19 12. Section 2266 of the Code provides:

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

23 13. Section 725 of the Code states:

24 "(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing,
25 or administering of drugs or treatment, repeated acts of clearly excessive use of
26 diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or
27 treatment facilities as determined by the standard of the community of licensees is
28 unprofessional conduct for a physician and surgeon, dentist, podiatrist,

1 psychologist, physical therapist, chiropractor, optometrist, speech-language
2 pathologist, or audiologist.

3 “(b) Any person who engages in repeated acts of clearly excessive
4 prescribing or administering of drugs or treatment is guilty of a misdemeanor and
5 shall be punished by a fine of not less than one hundred dollars (\$100) nor more
6 than six hundred dollars (\$600), or by imprisonment for a term of not less than 60
7 days nor more than 180 days, or by both that fine and imprisonment.

8 “(c) A practitioner who has a medical basis for prescribing, furnishing,
9 dispensing, or administering dangerous drugs or prescription controlled substances
10 shall not be subject to disciplinary action or prosecution under this section.

11 “(d) No physician and surgeon shall be subject to disciplinary action
12 pursuant to this section for treating intractable pain in compliance with Section
13 2241.5.”

14 COST RECOVERY

15 14. Section 125.3 of the Code states, in pertinent part, that the Board may request the
16 administrative law judge to direct a licensee found to have committed a violation or violations of
17 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
18 enforcement of the case.

19 FIRST CAUSE FOR DISCIPLINE

20 (Gross Negligence)

21 15. Respondent has subjected his Osteopathic Physician's and Surgeon's Certificate No.
22 20A9710 to disciplinary action under sections 3600-2, 2227, and 2234, as defined by section
23 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of
24 patients C.J., J.C., C.C., Y.V., K.A., W.E., A.W., I.M., J.K., and S.H., as more particularly
25 alleged hereinafter:

26 A. In or about February 2009, the California of Justice, Bureau of
27 Narcotics Enforcement (BNE) received information that respondent was operating
28 as a mobile doctor and prescribing commonly abused Schedule III opiates and

1 Schedule V cough syrup to drug seeking Medi-Cal patients with no legitimate
2 ailments and without performing medical examinations.

3 **Patient C.J.**

4 B. On or about March 17, 2009, San Diego Police Department (SDPD)
5 Detective J.D., posing as patient C.J., accompanied a confidential informant (CI)
6 to respondent's clinic, Caring Hearts Medical Center. Patient C.J. was asked for
7 her Medi-Cal card and given a questionnaire to complete. The questionnaire asked
8 for personal information and no medical history. Approximately ten minutes later,
9 patient C.J. was taken back to see respondent in a small office. The office did not
10 contain an examination table.

11 C. Respondent asked patient C.J. what kind of pain she was having.
12 Patient C.J. told him that she was experiencing pain from menstrual cramps and
13 back pain. Respondent instructed his assistant to take patient C.J.'s blood pressure
14 and to give her a glaucoma eye test. The assistant told patient C.J. that her blood
15 pressure was high.²

16 D. Respondent asked patient C.J. what types of medications she used in the
17 past. Patient C.J. informed respondent that she had been given morphine for an
18 appendectomy along time ago. Respondent asked patient C.J. if she had any
19 swelling in her legs. Patient C.J. told him that her feet would swell after sitting for
20 long periods of time. Respondent asked her to show him her ankle. After quickly
21 looking at her right ankle, respondent stated, "That's swollen."³ No other history
22 was requested. Respondent never physically examined patient C.J.

23
24
25 ² Detective J.D. indicated in her operative report that she has never had high blood
26 pressure.

27 ³ Detective J.D. indicated in her operative report that neither of her legs were swollen and
28 she never had any problems with swelling in her legs.

1 E. Respondent prescribed patient C.J. Ultram,⁴ Patient C.J. asked
2 respondent to give her something else and he asked what she wanted. Patient C.J.
3 requested Vicodin⁵ and Oxycontin.⁶ Respondent replied, "I don't give oxy." He
4 gave her the prescription for 120 tablets of Ultram 50 mg and for 50 tablets
5 Hydrochlorothiazide⁷ 25 mg.

6 F. Patient C.J. left respondent's office and meet the CI outside. She
7 informed the CI that respondent did not give her a prescription for Vicodin. The
8 CI took the Ultram prescription and went to respondent's back door. The CI asked
9 respondent why he did not give patient C.J. a prescription for 60 tablets Vicodin
10 5/500 mg. Respondent responded that he did not think patient C.J. was in a lot of
11 pain; however, he gave the CI a prescription for patient C.J. for Vicodin.

12 G. On or about May 19, 2009, Detective J.D., posing as patient C.J., saw
13 respondent for a prescription of Vicodin. During the visit, patient C.J. offered to
14 bring patients to respondent with Medicare insurance. Respondent agreed and
15 instructed patient C.J. to call the day before she brought any new patients in order
16 for his office to verify their insurance benefits. Respondent provided patient C.J.
17 with prescriptions for 60 tablets of Vicodin 5/500 mg, 90 tablets of
18 Hydrochlorothiazide 25 mg, and 90 tables of Toprol 25 mg.

19
20
21 ⁴ Ultram is a brand name for tramadol, a narcotic-like pain reliever, and a dangerous drug
pursuant to Business and Professions Code section 4022.

22 ⁵ Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III
23 controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a
dangerous drug pursuant to Business and Professions Code section 4022.

24 ⁶ Oxycontin is a brand name for oxycodone, a Schedule II controlled substance pursuant
25 to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to
Business and Professions Code section 4022.

26 ⁷ Hydrochlorothiazide is a thiazide diuretic (water pill) that helps prevent your body from
27 absorbing too much salt, which can cause fluid retention. It can be used to treat high blood
pressure (hypertension).

1 H. Respondent committed gross negligence in his care and treatment of
2 patient C.J. which included, but was not limited to, the following:

3 1. Paragraphs 15A through 15G, above, are hereby incorporated by
4 reference as if fully set forth herein;

5 2. Failing to perform a complete history on patient C.J. on March 17, 2009
6 and May 19, 2009;

7 3. Failing to perform an adequate and pertinent physical examination on
8 patient C.J. prior to prescribing narcotic medications March 17, 2009 and May 19,
9 2009;

10 4. Creating diagnoses to fit the justification of narcotic prescriptions;

11 5. Prescribing medication without an appropriate medical indication;

12 6. Failing to establish treatment goals and to attempt any other treatments
13 in lieu of narcotic medications;

14 7. Prescribing controlled substances to patient C.J. without good faith
15 history, examination, or medical indication; and

16 8. Prescribing controlled substances to patient C.J. who exhibited potential
17 addiction/abuse and failing to counsel her on addictive properties of the controlled
18 substances.

19 **Patient J.C.**

20 I. On or about March 23, 2010, Department of Health Care Services
21 (DHCS) Investigator D.B. (Inv. D.B.) made recorded calls to set up appointments
22 with respondent at his C.D.O.V. clinic for three patients. The woman who
23 answered the telephone stated that respondent was not taking any new Medi-Cal
24 patients, but they would accept \$100 cash payment for an office visit. Investigator
25 D.B. scheduled three appointments for patients J.C., C.C., and Y.V. for March 25,
26 2010 with respondent.

27 J. On or about March 25, 2010, UCSD Police Detective M.B., posing as
28 patient J.C., went to his appointment with respondent. Patient J.C. signed in on a

1 pad of paper in the waiting room. A woman came into the room and called out his
2 name. She asked patient J.C. if he was a new patient and he stated yes. The
3 woman asked patient J.C. if he had insurance and he had Medi-Cal. Inv. D.B.,
4 posing as patient Y.V. told the woman that she had set up the appointments and
5 was told they took cash too. The woman told them it would be \$100.00 to be seen
6 by respondent and then took all three patients to see respondent.

7 K. Patients J.C., C.C., and Y.V. were taken to respondent's office.
8 Respondent asked them who had referred him. Patient D.B. stated that it had been
9 Ron and respondent asked if it was Ron K. Patient D.B. said yes. Respondent told
10 them that he would see each patient separately.

11 L. Patient J.C. saw respondent first. Respondent asked for patient J.C.'s
12 identification. Patient J.C. told respondent that he did not have any identification,
13 but gave him his Medi-Cal card. Respondent asked patient J.C. why he was there.
14 Patient J.C. stated, "Ron said you could hook it up for Vicodin." Respondent
15 asked him if he was paying cash because he no longer accepted Medi-Cal. He
16 asked patient J.C. for his social security number. Patient J.C. stated that he did not
17 know it.

18 M. While patient J.C. was talking to respondent, respondent's assistant took
19 patient J.C.'s blood pressure. He asked her if he needed to take off his sweatshirt,
20 but she said no. The assistant told patient J.C. to raise the sleeve of his sweatshirt
21 up past his elbow. She placed the arm cuff around his bare left forearm just below
22 the elbow. The blood pressure machine indicated a reading of 213/102.
23 Respondent asked patient J.C. if he felt his heart beating in his chest very fast.
24 Patient J.C. said no it felt normal. Respondent stated that they needed to slow the
25 heart beat down. He instructed his assistant to take patient J.C.'s blood pressure
26 again. According to the assistant, patient J.C.'s blood pressure was high.

27 N. Respondent asked if patient J.C. was taking any medication, including
28 blood pressure medicine. Patient J.C. said no. He asked patient J.C. if he drank or

1 smoked. Patient said no. Respondent asked patient J.C. why he took Vicodin.
2 Patient J.C. told him he had injured his back when he used to work. He told him
3 that he pulled a muscle. Respondent asked him if he had a muscle strain and
4 patient J.C. said yes. He told respondent that he ran out of Vicodin and needed
5 more. Respondent said he was going to prescribe patient J.C. blood pressure
6 medicine because of his high blood pressure.

7 O. During the office visit, respondent's assistant approached patient J.C.
8 with a hypodermic needle and patient J.C. asked her what it was. She stated that it
9 was a B-12 shot. Patient J.C. told her that he did not want a shot.

10 P. Respondent walked to where patient J.C. was seated and placed a
11 stethoscope on his chest on the right and left side for approximately 3-5 seconds.
12 He asked patient J.S. if he had any abdominal pain or back pain. Patient J.C.
13 stated he did not. Respondent told patient J.C. to bend over and touch his toes. He
14 stated that there was something wrong with patient J.C.'s back.⁸ Respondent
15 prescribed patient J.C. 60 tablets of Vicodin.

16 Q. Respondent fabricated a medical record for patient J.C. He documented
17 that patient J.C. saw respondent for hypertension. He noted that patient J.C. had a
18 history of degenerative joint disease (DJD) and hypertension. The note indicated
19 that a back exam was performed which showed paraspinal muscle pain/spasm,
20 when in fact patient J.C. reported a normal examination. Respondent noted that
21 patient J.C. was a smoker. Respondent documented that patient J.C. had anemia
22 and ordered a Vitamin B12 injection for anemia, when in fact patient J.C. declined
23 the Vitamin B12 injection. Respondent documented that patient had cerumen
24 impaction and that cerumen removal was performed.

25 R. Respondent committed gross negligence in his care and treatment of
26 patient J.C. which included, but was not limited to, the following:

27 ⁸ Detective M.B. indicated in his operative report that he has never had back issues.
28

- 1 1. Paragraphs 15H through 15Q, above, are hereby incorporated by
- 2 reference as if fully set forth herein;
- 3 2. Failing to perform a history on the patient J.C.;
- 4 3. Failing to perform a physical examination on patient J.C. prior to
- 5 prescribing narcotic medications;
- 6 4. Prescribing medication to patient J.C. without an appropriate medical
- 7 indication;
- 8 5. Failing to establish treatment goals and to attempt any other treatments
- 9 in lieu of narcotic medications;
- 10 6. Prescribing controlled substances to patient J.C. without good faith
- 11 history, examination, or medical indication;
- 12 7. Prescribing controlled substances to the J.C. who exhibited potential
- 13 addiction/abuse and failing to counsel him/her on addictive properties of the
- 14 controlled substances; and
- 15 8. Fabricating patient J.C.'s chart.

16 Patient C.C.

17 S. On or about March 25, 2010, Department of Health Cares Services
18 (DHCS) Investigator I.H. (Inv. I.H.), posing as patient C.C., went to her
19 appointment with respondent. Patient C.C. was seen by respondent after patient
20 J.C.'s appointment.

21 T. Patient C.C. was told by patient J.C. to go into respondent's office.
22 Respondent asked patient C.C. what insurance she had. She told him that she had
23 Medi-Cal insurance. Respondent's assistant told patient C.C. that it would be
24 \$100.00 cash to see respondent. Patient C.C. gave her the cash.

25 U. The assistant took patient C.C.'s blood pressure and respondent told
26 patient C.C. that her heart rate was "super fast" and blood pressure was too high.
27 He told her that he would give patient C.C. something for her blood pressure.
28 Respondent asked patient C.C. what else she needed. Patient C.C. told him that

1 she wanted Vicodin or Norco.⁹ He asked her why she was taking these medicines.
2 Patient C.C. said that she started using them two years prior because her friends
3 used them. He asked her if she was addicted to them. Patient C.C. did not respond
4 directly to his question.

5 V. Respondent asked patient C.C. for her date of birth, social security
6 number, address, and phone number. He continued to probe patient C.C. for
7 reasons to prescribe her Vicodin. Respondent asked patient C.C. if she had ever
8 been in a car accident and whether she had any abdominal pain. Patient told him
9 no. Respondent asked her to standup and then touched her back in various areas.
10 He asked patient C.C. if she had muscle spasms. He then said, "I guess we could
11 use that as your qualifying condition." Respondent asked patient C.C. to bend
12 over and touch her toes. He asked patient C.C. again why she was taking the
13 Vicodin. Patient C.C. told respondent because of her friends. Respondent said,
14 "So you're taking it for fun?" She answered, "I don't know, it's legal." When
15 patient C.C. was not able to give respondent a medical reason for the Vicodin,
16 respondent said, "We seriously have to find a reason for this." Patient C.C., "Well
17 what do you want me to say? I mean tell me what qualifies me and I can say it.
18 What qualifies me?" Respondent, "Injuries.,,[a]nything. You fell or something. I
19 need. I mean. You have some muscle spasms in your back." Patient said, "So
20 you're saying the muscle spasms from falling two years ago? Will that work?"
21 Respondent then asked patient C.C. again about her work history and she told him
22 that she had none. Respondent gave patient a prescription for 60 tablets of
23 Vicodin.

24 W. Respondent created a medical record for patient C.C. He documented
25 that patient C.C. saw respondent for tachycardia. He noted that patient C.C. had a

26
27 ⁹ Norco is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III
28 controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a
dangerous drug pursuant to Business and Professions Code section 4022.

1 history of DJD and elevated heart rate due to pain. The note indicated that patient
2 C.C. had been in a motor vehicle accident and sustained whiplash. The note
3 indicated that a back exam was performed which showed paraspinal muscle
4 pain/spasm, when in fact patient C.C. reported a normal examination. Respondent
5 noted that patient C.C. was a smoker and drank alcohol. Respondent documented
6 that patient C.C. had anemia and ordered a Vitamin B12 injection for anemia,
7 when in fact patient C.C. declined the Vitamin B12 injection. Respondent
8 documented that patient had cerumen impaction and that cerumen removal was
9 performed.

10 X. Respondent committed gross negligence in his care and treatment of
11 patient C.C. which included, but was not limited to, the following:

- 12 1. Paragraphs 15S through 15W, above, are hereby incorporated by
13 reference as if fully set forth herein;
- 14 2. Failing to perform a history on the C.C.;
- 15 3. Failing to perform a physical examination on patient C.C. prior to
16 prescribing narcotic medications;
- 17 4. Prescribing medication to patient C.C. without an appropriate medical
18 indication;
- 19 5. Failing to establish treatment goals and to attempt any other treatments
20 in lieu of narcotic medications;
- 21 6. Prescribing controlled substances to patient C.C. without a good faith
22 history, examination, or medical indication;
- 23 7. Prescribing controlled substances to the C.C. who exhibited potential
24 addiction/abuse and failing to counsel him/her on addictive properties of the
25 controlled substances; and
- 26 8. Fabricating patient C.C.'s chart.

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1 Patient Y.V.

2 Y. On or about March 25, 2010, Inv. D.B., posing as patient Y.V., went to
3 her appointment with respondent. Patient Y.V. was seen by respondent after
4 patient C.C.'s appointment. Respondent's assistant asked patient Y.V. for her
5 identification. Patient Y.V. said she did not have any. Respondent told patient
6 Y.V. that he needed some type of card and patient Y.V. gave him her Medi-Cal
7 insurance card.

8 Z. Respondent asked patient Y.V. why she was there. She stated that Ron
9 told her respondent could hook her up. Respondent said that patient C.C. did not
10 have any reason for taking medicine. He asked her again if she had a reason to
11 take medicine. Patient Y.V. told respondent that she has taken Vicodin before and
12 that she likes it. Respondent asked her if she had any injuries. Patient Y.V. said
13 she did not and that Ron had told her to come to him because he was "straight."
14 Respondent told patient Y.V. that he was straight, but she had to have a reason to
15 take Vicodin. He asked patient Y.V. if she had been involved in a car accident.
16 Patient Y.V. told respondent she had been in a car accident when she was 8 years
17 old, but if that worked for the paperwork that would be a reason. Respondent told
18 patient Y.V. he did not know what Ron told her, but Ron had a condition that
19 qualified him for the medication that he was taking. Patient Y.V. again told
20 respondent that Ron told her that respondent could hook her up.

21 AA. Respondent told patient Y.V. that he did not take Medi-Cal patients
22 and asked her if she was a cash patient. Patient Y.V. said she had cash.
23 Respondent instructed his assistant to check patient Y.V. out. The assistant
24 removed the arm section from patient Y.V.'s sweater and placed the monitor's
25 band on the lower section of her left arm. She asked patient Y.V. what she did for
26 a living. Patient Y.V. told her that she did not work. Respondent told patient Y.V.
27 that her heart rate was "super fast" and asked her if she was "on anything" such as
28 recreational drugs. Patient Y.V. told respondent that she drank a double shot. He

1 told patient Y.V. that her heart rate was 134 and that if she did not slow down she
2 would have a heart attack.

3 BB. Respondent asked patient Y.V. if she was on any medications.
4 Patient Y.V. said that she took Vicodin when she had some. Respondent asked
5 patient Y.V. if she had any drug allergies, surgeries in the past, and drank or
6 smoked. Patient Y.V. said no.

7 CC. Respondent used his stethoscope to listen to patient Y.V.'s heart for a
8 few seconds. He asked patient Y.V. if she could feel her heart pounding. Patient
9 Y.V. stated that she could feel her heart pounding whenever she drank caffeinated
10 drinks. Respondent told patient Y.V. to try not to drink those types of drinks.
11 Respondent then looked at patient Y.V.'s back. He asked patient Y.V. if she felt
12 pain or muscle spasms. Patient Y.V. told respondent that she did not have any
13 pain. Respondent told patient Y.V. to bend forward and touch her toes. Patient
14 Y.V. bent down and touched the ground. Respondent told her that was good.

15 DD. Respondent asked patient Y.V. if started taking pills when she had
16 her car accident. Patient Y.V. told respondent that it was long time ago.
17 Respondent told patient Y.V. he had to have a reason to prescribe the Vicodin.
18 Patient Y.V. again stated that Ron told her that respondent would just give it to
19 her. Respondent told patient Y.V. again that Ron had a reason for taking the
20 medication. Patient Y.V. told respondent to put down whatever he needed.
21 Respondent prescribed patient Y.V. 60 tablets of Vicodin.

22 EE. Respondent committed gross negligence in his care and treatment of
23 patient Y.V. which included, but was not limited to, the following:

- 24 1. Paragraphs 15Y through 15DD, above, are hereby incorporated by
25 reference as if fully set forth herein;
- 26 2. Failing to perform a history on the Y.V.;
- 27 3. Failing to perform a physical examination on patient Y.V. prior to
28 prescribing narcotic medications;

1 4. Prescribing medication to patient Y.V. without an appropriate medical
2 indication;

3 5. Failing to establish treatment goals and to attempt any other treatments
4 in lieu of narcotic medications;

5 6. Prescribing controlled substances to patient Y.V. without a good faith
6 history, examination, or medical indication; and

7 7. Prescribing controlled substances to patient Y.V. who exhibited
8 potential addiction/abuse and failing to counsel him/her on addictive properties of
9 the controlled substances.

10 **Patient K.A.**

11 FF. On or about July 27, 2008, patient K.A. saw respondent for lower back
12 pain and hypertension. Respondent noted lower extremity edema and weight gain.
13 Respondent diagnosed patient K.A. with hypertension, low back pain, and anemia.
14 There are no history or exam findings documented related to the diagnoses of back
15 pain, anemia, and the cerumen disimpaction. Respondent gave patient K.A. a
16 Vitamin B12 injection for anemia, although there is no history or physical on this
17 visit corresponding to anemia. Respondent ordered blood work which resulted in
18 normal lab results and no anemia. He ordered cerumen disimpaction, although
19 there was no history or exam corresponding to cerumen impaction. Respondent
20 prescribed patient K.A. Hydrochlorothiazide for blood pressure elevation and
21 Vicodin for her low back pain. Portions of patient K.A.'s progress note are
22 illegible.

23 GG. On or about August 28, 2008, patient K.A. saw respondent for
24 hypertension, lower back pain, and asthma. Respondent noted a history of asthma
25 and ordered a spirometer. There is no history or exam finding documented related
26 to the diagnoses of back pain, anemia, and lung function. Respondent gave
27 patient K.A. a Vitamin B12 injection for anemia, although there is no history or
28 physical on this visit corresponding to anemia. Respondent prescribed patient

1 K.A. Vicodin for her low back pain. Portions of patient K.A.'s progress note are
2 illegible.

3 HH. On or about September 28, 2009, patient K.A. saw respondent for
4 low back pain after a motor vehicle accident. Respondent prescribed patient K.A.
5 Norco for her low back pain. There is no history or exam finding documented
6 related to the diagnoses of back pain and anemia. Portions of patient K.A.'s
7 progress note are illegible.

8 II. From or about October 26, 2009, through March 12, 2010, patient K.A.
9 saw respondent on nine separate visits for hypertension, musculoskeletal pain, and
10 anemia. Respondent prescribed controlled substances to patient K.A. at each visit.
11 There are no history or exam findings documented relating to the diagnoses. At
12 each visit, respondent gave patient K.A. a Vitamin B12 injection for anemia,
13 although there is no history or physical on this visit corresponding to anemia. For
14 each visit, portions of patient K.A.'s progress note are illegible.

15 JJ. On or about March 29, 2010, patient K.A. saw respondent. He
16 diagnosed her with hypothyroidism and prescribed her Synthroid. There is no
17 indication how the diagnosis of hypothyroidism was determined. Portions of
18 patient K.A.'s progress note are illegible.

19 KK. From or about April 12, 2010, through September 21, 2010, patient
20 K.A. saw respondent on ten separate visits. Respondent prescribed controlled
21 substances to patient K.A. at each visit. There are no history or exam findings
22 documented relating to these diagnoses. At each visit, respondent gave patient
23 K.A. a Vitamin B12 injection for anemia, although there is no history or physical
24 on each of these visits corresponding to anemia. For each visit, portions of patient
25 K.A.'s progress note are illegible.

26 LL. On or about October 20, 2010, patient K.A. saw respondent.
27 Respondent noted that she had abdominal pain and diagnosed patient K.A. with

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1 peptic ulcer disease. He referred patient K.A. for an upper GI study. Respondent
2 also noted a diagnosis of alcohol abuse. There is no plan noted regarding patient
3 K.A.'s alcohol abuse problem. Respondent also diagnosed patient K.A. with
4 pancreatitis. There are no history or exam findings documented relating to the
5 diagnoses of alcohol abuse and pancreatitis. Portions of patient K.A.'s progress
6 note are illegible.

7 MM. From on or about November 8, 2010, through December 24, 2010,
8 patient K.A. saw respondent. In each visit, respondent continued to prescribe
9 patient K.A. controlled substances, even though she was diagnosed with alcohol
10 abuse. There are no history or exam findings documented relating to the
11 diagnoses. At each visit, respondent gave patient K.A. a Vitamin B12 injection for
12 anemia, although there is no history or physical on this visit corresponding to
13 anemia. For each visit, portions of patient K.A.'s progress note are illegible.

14 NN. From on or about July 28, 2008, through December 24, 2010,
15 respondent only treated patient K.A.'s musculoskeletal pain with narcotic
16 medication. He never referred patient K.A. for physical therapy. Respondent
17 never ordered any image studies and did not refer her for orthopedics consultation.
18 He diagnosed patient K.A. with anemia, but did not perform a diagnostic workup
19 for anemia. On or about May 25, 2010, patient K.A.'s blood work indicated an
20 elevated level of vitamin B 12, but respondent continued to provide Vitamin B12
21 injections to patient K.A.

22 OO. Respondent committed gross negligence in his care and treatment of
23 patient K.A. which included, but was not limited to, the following:

24 1. Paragraphs 15FF through 15NN, above, are hereby incorporated by
25 reference as if fully set forth herein;

26 2. Failing to perform an adequate or reasonable history on patient K.A. on
27 multiple visits from July 27, 2008, through December 24, 2010;

28 ///

1 3. Failing to perform an adequate or pertinent physical exam on patient
2 K.A. on multiple visits from July 27, 2008, through December 24, 2010;

3 4. Prescribing and administering treatment to patient K.A. without medical
4 indication on multiple visits from July 27, 2008, through December 24, 2010;

5 5. Failing to establish treatment goals and failing to attempt any other
6 nonpharmaceutical treatments in lieu of narcotic medications on a multiple and
7 consistent basis from July 27, 2008, through December 24, 2010;

8 6. Prescribed controlled substances to patient K.A. without a good faith
9 history, examination, or medical indication on multiple visits from July 27, 2008,
10 through December 24, 2010; and

11 7. Prescribed controlled substances to individuals who exhibited potential
12 addiction/abuse and by failing to appropriately counsel on addictive properties.

13 **Patient W.E.**

14 PP. On or about April 1, 2010, patient W.E. saw respondent for complaints
15 of degenerative joint disorder (DJD) in his neck. Respondent noted that patient
16 W.E. had decreased range of motion and had "cervical treatments" in the past.
17 Respondent prescribed patient W.E. Norco and Soma¹⁰ for patient W.E.'s neck
18 DJD. Respondent diagnosed patient W.E. with anemia. Respondent ordered a
19 Vitamin B12 injection for anemia, although there is no history or physical on this
20 visit corresponding to anemia. Patient W.E.'s systolic blood pressure was 145 and
21 was not addressed by respondent. The majority of the physical exam recordings
22 are illegible.

23 QQ. On or about May 3, 2010, patient W.E. saw respondent for an office
24 visit. Respondent noted a history of shortness of breath and wheezing. He noted
25 patient W.E.'s paraspinal muscle was tender on back exam. Respondent

26 ¹⁰ Soma is a brand name for carisoprodol, a muscle relaxer that works by blocking pain sensations
27 between the nerves and the brain, and a dangerous drug pursuant to Business and Professions
28 Code section 4022.

1 recommended that patient W.E. stop smoking and prescribed him Proair.
2 Respondent also prescribed patient W.E. Norco and Soma for patient W.E.'s low
3 back pain. Portions of patient W.E.'s progress note are illegible.

4 RR. On or about June 3, 2012, patient W.E. saw respondent for an office
5 visit. Respondent ordered a Vitamin B12 injection for anemia, although there is
6 no history or physical on this visit corresponding to anemia. Respondent
7 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
8 was 156 and was not addressed by respondent. There is no documented history,
9 exam, plan, or assessment in patient W.E.'s progress note. Portions of patient
10 W.E.'s progress note are illegible.

11 SS. On or about July 5, 2012, patient W.E. saw respondent for an office
12 visit. Respondent ordered a Vitamin B12 injection for anemia, although there is
13 no history or physical on this visit corresponding to anemia. Respondent
14 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
15 was 163 and was not addressed by respondent. There is no documented history,
16 exam, plan, or assessment in patient W.E.'s progress note. Portions of patient
17 W.E.'s progress note are illegible.

18 TT. On or about August 5, 2010, patient W.E. saw respondent for an office
19 visit. Respondent ordered a Vitamin B12 injection for anemia, although there is
20 no history or physical on this visit corresponding to anemia. Respondent
21 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
22 was 163. Respondent prescribed patient W.E. anti-hypertensive medications
23 Lisinopril and Norvasc. There is no documented history, exam, plan, or
24 assessment in patient W.E.'s progress note. Portions of patient W.E.'s progress
25 note are illegible.

26 UU. On or about September 5, 2010, patient W.E. saw respondent for an
27 office visit. Respondent ordered a Vitamin B12 injection for anemia, although
28 there is no history or physical on this visit corresponding to anemia. There is no

1 documented history, exam, plan, or assessment in patient W.E.'s progress note.
2 Portions of patient W.E.'s progress note are illegible.

3 VV. On or about October 5, 2010, patient W.E. saw respondent for an
4 office visit. Respondent ordered a Vitamin B12 injection for anemia, although
5 there is no history or physical on this visit corresponding to anemia. Respondent
6 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
7 was 168. Respondent prescribed patient W.E. two anti-hypertensive medications
8 Lisinopril and Norvasc. There is no documented history, exam, plan, or
9 assessment in patient W.E.'s progress note. Portions of patient W.E.'s progress
10 note are illegible.

11 WW. On or about November 5, 2010, patient W.E. saw respondent for an
12 office visit. Respondent ordered a Vitamin B12 injection for anemia, although
13 there is no history or physical on this visit corresponding to anemia. Respondent
14 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
15 was 157. Respondent prescribed patient W.E. anti-hypertensive medications
16 Lisinopril and Norvasc. There is no documented history, exam, plan, or
17 assessment in patient W.E.'s progress note. Portions of patient W.E.'s progress
18 note are illegible.

19 XX. On or about December 5, 2010, patient W.E. saw respondent for an
20 office visit. Respondent ordered a Vitamin B12 injection for anemia, although
21 there is no history or physical on this visit corresponding to anemia. Respondent
22 prescribed patient W.E. Norco and Soma. Patient W.E.'s systolic blood pressure
23 was 158. Respondent prescribed patient W.E. anti-hypertensive medications
24 Lisinopril and Norvasc. There is no documented history, exam, plan, or
25 assessment in patient W.E.'s progress note. Respondent never requested a
26 diagnostic workup for anemia. Portions of patient W.E.'s progress note are
27 illegible.

28 ///

1 YY. Respondent committed gross negligence in his care and treatment of
2 patient W.E. which included, but was not limited to, the following:

3 1. Paragraphs 15PP through 15XX, above, are hereby incorporated by
4 reference as if fully set forth herein;

5 2. Failing to perform an adequate or reasonable history on patient W.E. on
6 multiple occasions;

7 3. Failing to perform an adequate or pertinent physical exam on patient
8 W.E. on multiple occasions;

9 4. Failing to perform an adequate or appropriate assessment and plan on
10 patient W.E. on multiple occasions;

11 5. Prescribing and administering treatment to patient W.E. without medical
12 indication on several occasions;

13 6. Failing to establish treatment goals and failed to attempt any other
14 nonpharmaceutical treatments in lieu of narcotic medications on a multiple and
15 consistent basis; and

16 7. Prescribing controlled substances to patient W.E. without a good faith
17 history, examination, or medical indication on multiple instances.

18 **Patient A.W.**

19 ZZ. On or about January 14, 2008, patient A.W. saw respondent for
20 hypertension and tachycardia. Respondent noted that patient A.W. previously
21 been on Hydrochlorothiazide, but had run out of his medications. Patient A.W.
22 complained of heart palpitations and respondent noted tachycardia upon exam.
23 Respondent also noted paraspinal muscle spasms. Patient A.W.'s blood pressure
24 was 174/96. Respondent prescribed patient A.W. Hydrochlorothiazide for
25 hypertension and Toprol for the tachycardia. Respondent diagnosed patient A.W.
26 with anemia. Respondent gave patient A.W. a Vitamin B12 injection for anemia,
27 although there is no history or physical on this visit corresponding to anemia. He
28 ordered cerumen disimpaction, although there was no history or exam

1 corresponding to cerumen impaction. Respondent prescribe patient A.W. Tylenol
2 #3 for his back pain. Portions of patient A.W.'s progress note are illegible.

3 AAA. On or about March 5, 2008, patient A.W. saw respondent for
4 hypertension. Respondent noted that patient A.W. was on Zocor. He prescribed
5 patient A.W. Neurontin¹¹ and Norco for low back pain. Respondent gave patient
6 A.W. a Vitamin B12 injection for anemia, although there is no history or physical
7 on this visit corresponding to anemia. Portions of patient A.W.'s progress note are
8 illegible.

9 BBB. On or about July 2, 2008, patient A.W. saw respondent for an office
10 visit. Respondent prescribed patient A.W. Valium and Norco. Respondent gave
11 patient A.W. a Vitamin B12 injection for anemia, although there is no history or
12 physical on this visit corresponding to anemia. Portions of patient A.W.'s
13 progress note are illegible.

14 CCC. On or about July 30, 2008, patient A.W. saw respondent for
15 complaints after a motor vehicle accident. Respondent noted 7/10 pain and that
16 patient A.W. was taking Norco. He also noted that patient A.W. had insomnia and
17 prescribed him some type of medication which was illegible. Respondent
18 prescribed patient A.W. Valium and Norco. Respondent gave patient A.W. a
19 Vitamin B12 injection for anemia, although there is no history or physical on this
20 visit corresponding to anemia. Portions of patient A.W.'s progress note are
21 illegible.

22 DDD. On or about August 28, 2008, patient A.W. saw respondent for
23 complaints of wheezing. Respondent diagnosed patient A.W. with tachycardia.
24 There is no history or exam supporting the diagnosis of tachycardia. Respondent
25 prescribed patient A.W. Valium and Norco. Respondent gave patient A.W. a

26
27 ¹¹ Neurontin is a brand name for gabapentin, an anti-epileptic medication, and a dangerous drug
28 pursuant to Business and Professions Code section 4022..

1 Vitamin B12 injection for anemia, although there is no history or physical on this
2 visit corresponding to anemia. Portions of patient A.W.'s progress note are
3 illegible.

4 EEE. On or about September 22, 2008, patient A.W. saw respondent for
5 an office visit. Respondent diagnosed patient A.W. with scoliosis and tachycardia.
6 There is no history or exam supporting either diagnosis. Respondent gave patient
7 A.W. a Vitamin B12 injection for anemia, although there is no history or physical
8 on this visit corresponding to anemia. Portions of patient A.W.'s progress note are
9 illegible.

10 FFF. On or about October 16, 2009, patient A.W. saw respondent for
11 anemia and fatigue. Respondent prescribed patient A.W. Neurontin and Valium¹²
12 for his low back pain. Respondent gave patient A.W. a Vitamin B12 injection for
13 anemia, although there is no history or physical on this visit corresponding to
14 anemia. Portions of patient A.W.'s progress note are illegible.

15 GGG. On or about November 2, 2009, patient A.W. saw respondent for an
16 office visit. Respondent noted a MRI showing scoliosis, degenerative disc disease,
17 and severe foraminal stenosis. He prescribed patient A.W. Vicodin and Neurontin.
18 Respondent noted peripheral neuropathy on assessment. There is no history or
19 exam to support the diagnosis of peripheral neuropathy. Respondent gave patient
20 A.W. a Vitamin B12 injection for anemia, although there is no history or physical
21 on this visit corresponding to anemia. Portions of patient A.W.'s progress note are
22 illegible.

23 HHH. On or about November 24, 2009, patient A.W. saw respondent for
24 an office visit. Respondent noted for the first time that patient A.W. had diabetes
25 and was on insulin. Respondent gave patient A.W. a Vitamin B12 injection for

26 ¹² Valium is a brand name for diazepam, a Schedule IV controlled substance pursuant to
27 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
28 Business and Professions Code section 4022.

1 anemia, although there is no history or physical on this visit corresponding to
2 anemia. Portions of patient A.W.'s progress note are illegible.

3 III. On or about January 4, 2012, patient A.W. saw respondent for
4 diabetes. Respondent gave patient A.W. a Vitamin B12 injection for anemia,
5 although there is no history or physical on this visit corresponding to anemia. He
6 ordered cerumen disimpaction, although there was no history or exam
7 corresponding to cerumen impaction. Portions of patient A.W.'s progress note are
8 illegible.

9 JJJ. On or about January 15, 2010, patient A.W. saw respondent for
10 hypoglycemia and dizziness. Respondent recommended Lantus at 30 units before
11 bed. Portions of patient A.W.'s progress note are illegible.

12 KKK. On or about January 29, 2010, patient A.W. saw respondent for
13 diabetes. Respondent prescribed patient A.W. Lantus and Norco. Respondent
14 gave patient A.W. a Vitamin B12 injection for anemia, although there is no history
15 or physical on this visit corresponding to anemia. Portions of patient A.W.'s
16 progress note are illegible.

17 LLL. From or about February 11, 2010, through August 12, 2010, patient
18 A.W. saw respondent for various complaints. At each visit, respondent gave
19 patient A.W. a Vitamin B12 injection for anemia, although there is no history or
20 physical on this visit corresponding to anemia. For each visit, portions of patient
21 A.W.'s progress notes are illegible.

22 MMM. On or about September 6, 2010, patient A.W. saw respondent for
23 lower back pain. Respondent noted that patient had a motor vehicle accident with
24 pain of 6/10 severity. He prescribed patient A.W. Valium for his lower back pain.
25 Respondent gave patient A.W. a Vitamin B12 injection for anemia, although there
26 is no history or physical on this visit corresponding to anemia. Portions of patient
27 A.W.'s progress note are illegible.

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1 NNN. On or about September 20, 2010, through December 15, 2010,
2 patient A.W. saw respondent for various complaints. At each visit, respondent
3 gave patient A.W. a Vitamin B12 injection for anemia, although there is no history
4 or physical on this visit corresponding to anemia. At the December 15, 2010, visit
5 respondent ordered cerumen disimpaction, although there was no history or exam
6 corresponding to cerumen impaction. For each visit, portions of patient A.W.'s
7 progress notes are illegible.

8 OOO. On or about January, 2011, patient A.W. saw respondent for
9 hypertension. Respondent gave patient A.W. a Vitamin B12 injection for anemia,
10 although there is no history or physical on this visit corresponding to anemia.
11 There is no documented history, exam, plan, or assessment in patient A.W.'s
12 progress note. Respondent never referred patient A.W. for physical therapy.
13 Respondent never ordered any image studies and did not refer him for orthopedics
14 consultation. He diagnosed patient A.W. with anemia, but did not perform a
15 diagnostic workup for anemia.

16 PPP. Respondent committed gross negligence in his care and treatment of
17 patient W.E. which included, but was not limited to, the following:

- 18 1. Paragraphs 15ZZ through 15OOO, above, are hereby incorporated by
19 reference as if fully set forth herein;
- 20 2. Failing to perform an adequate or reasonable history on patient A.W. on
21 multiple occasions;
- 22 3. Failing to perform an adequate or pertinent physical exam on patient
23 A.W. on multiple occasions;
- 24 4. Failing to perform an adequate or appropriate assessment and plan on
25 patient A.W. on multiple occasions;
- 26 5. Prescribing and administering treatment to patient A.W. without
27 medical indication on several occasions; and

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1 6. Failed to establish treatment goals and failed to attempt any other
2 nonpharmaceutical treatments in lieu of narcotic medications on a multiple and
3 consistent basis.

4 **Patient I.M.**

5 QQQ. On or about February 16, 2008, patient I.M. saw respondent for
6 right arm pain and hypertension. Respondent noted that patient I.M. had a long
7 standing history of degenerative joint disease. Patient reported taking Norco and
8 requested an injection. Respondent gave patient I.M. an injection, but did not
9 document the medication requested and given. Respondent diagnosed patient I.M.
10 with degenerative joint disease and prescribed her Norco, Soma, and Lidoderm
11 patches. Respondent diagnosed patient I.M. with anemia. Respondent gave
12 patient I.M. a Vitamin B12 injection for anemia, although there is no history or
13 physical on this visit corresponding to anemia. He ordered cerumen disimpaction,
14 although there was no history or exam corresponding to cerumen impaction.
15 Respondent diagnosed patient I.M. with bronchitis, although there is no history
16 and exam corresponding to Bronchitis. Portions of patient I.M.'s progress note are
17 illegible.

18 RRR. On or about April 9, 2008, patient I.M. saw respondent for DJD.
19 Respondent noted patient I.M. had 7/10 pain and was overweight. Patient I.M.
20 requested an injection. Respondent gave patient I.M. an injection, but did not
21 document medication requested and given. Respondent prescribed patient I.M.
22 Norco and Lidoderm patches. Portions of patient I.M.'s progress note are
23 illegible.

24 SSS. On or about April 23, 2008, patient I.M. saw respondent for anemia.
25 Respondent gave patient I.M. a Vitamin B12 injection for anemia, although there
26 is no history or physical on this visit corresponding to anemia. Respondent noted
27 that patient I.M.'s DJD had improved. Portions of patient I.M.'s progress note are
28 illegible.

1 TTT. On or about June 8, 2008, patient I.M. saw respondent for COPD.
2 Respondent noted that patient I.M. had wheezing and sputum production. He
3 noted paraspinal muscle pain. Respondent prescribed patient I.M. Proair for the
4 COPD and Vicodin for low back pain. Respondent gave patient I.M. a Vitamin
5 B12 injection for anemia, although there is no history or physical on this visit
6 corresponding to anemia. Portions of patient I.M.'s progress note are illegible.

7 UUU. On or about June 23, 2008, patient I.M. saw respondent for
8 "uncontrolled hypertension." Respondent noted that patient I.M.'s blood pressure
9 was normal on exam. It was noted that patient I.M. had a history of stroke in the
10 past and continued to eat salty foods. Respondent prescribe patient I.M. Norco for
11 low back pain. There is no history on this visit corresponding to low back pain.
12 Portions of patient I.M.'s progress note are illegible.

13 VVV. On or about July 20, 2008, patient I.M. saw respondent for facial
14 swelling and increased blood pressure. Respondent noted facial edema on exam.
15 He recommended that patient I.M. take Benadryl and prescribed her Norco for low
16 back pain. There is no history on this visit correspondent low back pain.
17 Respondent gave patient I.M. a Vitamin B12 injection for anemia, although there
18 is no history or physical on this visit corresponding to anemia. Portions of patient
19 I.M.'s progress note are illegible.

20 WWW. On or about August 13, 2008, patient I.M. saw respondent for low
21 back pain. Respondent noted that patient I.M. had 8/10 pain. He prescribed her
22 Norco and Soma for low back pain. Respondent gave patient I.M. a Vitamin B12
23 injection for anemia, although there is no history or physical on this visit
24 corresponding to anemia. Portions of patient I.M.'s progress note are illegible.

25 XXX. On or about September 16, 2009, patient I.M. saw respondent for
26 acid reflux. Respondent noted that patient I.M. was taking Prilosec. He prescribed
27 patient I.M. Norco and Soma for low back pain. There is no history on this visit
28 corresponding low back pain. Respondent gave patient I.M. a Vitamin B12

1 injection for anemia, although there is no history or physical on this visit
2 corresponding to anemia. Portions of patient I.M.'s progress note are illegible.

3 YYY. On or about October 21, 2009, patient I.M. saw respondent for
4 stenosis. Respondent noted that patient I.M. had 8/10 pain. There is no plan
5 related to back pain documented. Respondent gave patient I.M. a Vitamin B12
6 injection for anemia, although there is no history or physical on this visit
7 corresponding to anemia. Portions of patient I.M.'s progress note are illegible.

8 ZZZ. On or about November 25, 2009, patient I.M. saw respondent for low
9 back pain, hypertension, GERD, and anemia. Respondent prescribed patient
10 Tylenol #3¹³ and Soma. Respondent gave patient I.M. a Vitamin B12 injection for
11 anemia, although there is no history or physical on this visit corresponding to
12 anemia. Portions of patient I.M.'s progress note are illegible.

13 AAAA. On or about December 22, 2009, patient I.M. saw respondent for
14 sinus infection, hypertension, anemia, and low back pain. The remaining history is
15 illegible. Respondent gave patient I.M. a Vitamin B12 injection for anemia,
16 although there is no history or physical on this visit corresponding to anemia.
17 Portions of patient I.M.'s progress note are illegible.

18 BBBB. On or about January 19, 2010, patient I.M. saw respondent for
19 hypertension and GERD. Respondent prescribed patient I.M. Prilosec, Lisinopril,
20 and Nifedipine. He also prescribed her Soma and Tylenol #3. Respondent noted
21 that patient I.M. had low back pain and anemia. There is no history on this visit
22 corresponding to low back pain and anemia. Respondent gave patient I.M. a
23 Vitamin B12 injection for anemia, although there is no history or physical on this
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25 ¹³ Tylenol #3 is a brand name for acetaminophen and not more than 1.8 grams of Codeine
26 per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, non-
27 narcotic ingredients in recognized therapeutic amounts, is a Schedule III controlled substance
28 pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug
pursuant to Business and Professions Code section 4022.

1 visit corresponding to anemia. Portions of patient I.M.'s progress note are
2 illegible.

3 CCCC. On or about February 15, 2010, patient I.M. saw respondent for
4 tachycardia and hypertension. Respondent noted that patient I.M. was non-
5 compliant. Respondent noted that patient I.M. had insomnia, low back pain, and
6 anemia. There is no history on this visit corresponding to insomnia, low back pain
7 and anemia. Respondent prescribed patient I.M. Ambien,¹⁴ Soma and Tylenol #3.
8 Respondent gave patient I.M. a Vitamin B12 injection for anemia, although there
9 is no history or physical on this visit corresponding to anemia. Portions of patient
10 I.M.'s progress note are illegible.

11 DDDD. On or about March 15, 2010, patient I.M. saw respondent for
12 hypertension. Respondent noted that patient I.M. had COPD, DJD, and anemia.
13 There is no history on this visit corresponding to COPD, DJD, and anemia.
14 Respondent prescribed patient I.M. Soma and Tylenol #3. Respondent gave
15 patient I.M. a Vitamin B12 injection for anemia, although there is no history or
16 physical on this visit corresponding to anemia. Portions of patient I.M.'s progress
17 note are illegible.

18 EEEE. On or about April 13, 2010, patient I.M. saw respondent for GERD.
19 Respondent noted that patient I.M. had DJD and anemia. There is no history on
20 this visit corresponding to DJD and anemia. Respondent prescribed patient I.M.
21 Soma and Tylenol #3. Respondent gave patient I.M. a Vitamin B12 injection for
22 anemia, although there is no history or physical on this visit corresponding to
23 anemia. Portions of patient I.M.'s progress note are illegible.

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26 ¹⁴ Ambien is a brand name for zolpidem, a Schedule IV controlled substance pursuant to
27 Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to
28 Business and Professions Code section 4022. It is a sedative used for the short-term treatment of
insomnia.

1 FFFF. On or about May 12, 2010, patient I.M. saw respondent for DJD.
2 Respondent noted that patient I.M. had a history of lumbar hernia. The rest of the
3 history is illegible. Respondent gave patient I.M. a Vitamin B12 injection for
4 anemia, although there is no history or physical on this visit corresponding to
5 anemia. Portions of patient I.M.'s progress note are illegible.

6 GGGG. On or about June 19, 2010, patient I.M. saw respondent for
7 hypertension. Respondent gave patient I.M. a Vitamin B12 injection for anemia,
8 although there is no history or physical on this visit corresponding to anemia. The
9 progress note is illegible.

10 HHHH. On or about July 5, 2010, patient I.M. saw respondent for GERD.
11 Respondent noted that patient I.M. had DJD and anemia. There is no history on
12 this visit corresponding to DJD and anemia. Respondent prescribed patient I.M.
13 Soma and Tylenol #3. Respondent gave patient I.M. a Vitamin B12 injection for
14 anemia, although there is no history or physical on this visit corresponding to
15 anemia. The progress note is illegible.

16 III. On or about August 4, 2010, patient I.M. saw respondent for
17 hypertension. The remaining history is illegible. Respondent prescribed patient
18 I.M. Soma and Tylenol #4.¹⁵ Respondent gave patient I.M. a Vitamin B12
19 injection for anemia, although there is no history or physical on this visit
20 corresponding to anemia. Portions of patient I.M.'s progress note are illegible.

21 JJJ. On or about September 2, 2010, patient I.M. saw respondent for
22 GERD. Respondent noted that patient had DJD and anemia. There is no history
23 on this visit corresponding to DJD and anemia. Respondent prescribed patient
24 I.M. Soma and Tylenol #4. Respondent gave patient I.M. a Vitamin B12 injection

25 ¹⁵ Tylenol #4 is **Error! Main Document Only.** a brand name for acetaminophen and not
26 more than 1.8 grams of Codeine per 100 milliliters or not more than 90 milligrams per dosage
27 unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts, is a
28 Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision
(e), and a dangerous drug pursuant to Business and Professions Code section 4022.

1 for anemia, although there is no history or physical on this visit corresponding to
2 anemia. Portions of patient I.M.'s progress note are illegible.

3 KKKK. On or about September 27, 2010, patient I.M. saw respondent for
4 hypertension. Respondent noted that patient had DJD. There is no history on this
5 visit corresponding to DJD. Respondent prescribed patient I.M. Tylenol #4.
6 Respondent gave patient I.M. a Vitamin B12 injection for anemia, although there
7 is no history or physical on this visit corresponding to anemia. Portions of patient
8 I.M.'s progress note are illegible.

9 LLLL. On or about October 26, 2010, patient I.M. saw respondent for
10 DJD. Respondent noted that patient I.M. had low back pain with lower extremity
11 radiation. He noted recent trauma, but there is no description documented.
12 Respondent prescribed patient I.M. Tylenol #4. Respondent gave patient I.M. a
13 Vitamin B12 injection for anemia, although there is no history or physical on this
14 visit corresponding to anemia. Portions of patient I.M.'s progress note are
15 illegible.

16 MMMM. On or about November 15, 2010, patient I.M. saw respondent
17 for anemia. Respondent noted that patient I.M. had fatigue, but there is no other
18 relevant history is documented. He also noted that patient I.M. had DJD, GERD,
19 and hypertension. There is no history documented for this visit corresponding to
20 DJD, GERD, and hypertension. Respondent prescribed patient I.M. Soma and
21 Tylenol #4. Respondent gave patient I.M. a Vitamin B12 injection for anemia,
22 although there is no history or physical on this visit corresponding to anemia.
23 Portions of patient I.M.'s progress note are illegible.

24 NNNN. On or about December 16, 2010, patient I.M. saw respondent for
25 hypertension after having a stroke. The remaining history is illegible. Respondent
26 prescribed patient I.M. Soma and Tylenol #4. Respondent gave patient I.M. a
27 Vitamin B12 injection for anemia, although there is no history or physical on this

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1 visit corresponding to anemia. Portions of patient I.M.'s progress note are
2 illegible.

3 OOOO. On or about December 27, 2010, patient I.M. saw respondent for
4 hypertension and bronchitis. Respondent noted that patient I.M. had a cough and
5 mild fever. Respondent prescribed patient I.M. Doxycycline for bronchitis. He
6 noted that patient I.M. had DJD, but there is no plan, history, or physical exam
7 documented o this visit corresponding to DJD. Respondent never referred patient
8 I.M. for physical therapy. Respondent never ordered any image studies and did
9 not refer her for orthopedics consultation. He diagnosed patient I.M. with anemia,
10 but did not perform a diagnostic workup for anemia. Portions of patient I.M.'s
11 progress note are illegible.

12 PPPP. Respondent committed gross negligence in his care and treatment of
13 patient W.E. which included, but was not limited to, the following:

- 14 1. Paragraphs 15QQQ through 15OOOO, above, are hereby incorporated
15 by reference as if fully set forth herein;
- 16 2. Failing to perform an adequate or reasonable history on patient I.M. on
17 multiple occasions;
- 18 3. Failing to perform an adequate or pertinent physical exam on patient
19 I.M. on multiple occasions;
- 20 4. Failing to establish treatment goals and failing to attempt any other
21 nonpharmaceutical treatments in lieu of narcotic medications on a multiple and
22 consistent basis; and
- 23 5. Prescribing controlled substances to patient I.M. without a good faith
24 history, examination, or medical indication on multiple occasions.

25 **Patient J.K.**

26 QQQQ. On or about July 20, 2008, patient J.K. saw respondent for low
27 back pain and whiplash resulting from a motor vehicle accident. Respondent
28 noted that patient J.K. had bilateral lower extremity radiation and paraspinal

1 muscular spasm on exam. Respondent diagnosed patient J.K. with anemia.
2 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is
3 no history or physical on this visit corresponding to anemia. He ordered cerumen
4 disimpaction, although there was no history or exam corresponding to cerumen
5 impaction. Respondent prescribed patient J.K. Norco for low back pain and
6 Neurontin for peripheral neuropathy. There is no history or exam documented
7 corresponding to peripheral neuropathy. Portions of patient J.K.'s progress note
8 are illegible.

9 RRRR. On or about July 28, 2008, patient J.K. saw respondent for a L
10 orbital fracture after being assaulted by his roommate. Respondent noted that
11 patient J.K. had 8/10 pain severity. Respondent prescribed patient J.K. Norco for
12 chronic pain. He made a referral for patient J.K.'s L orbital fracture, but the
13 referral is illegible. Portions of patient J.K.'s progress note are illegible.

14 SSSS. On or about September 12, 2008, patient J.K. saw respondent for
15 bronchitis. Respondent prescribed patient J.K. Norco for chronic pain.
16 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is
17 no history or physical on this visit corresponding to anemia. The remainder of the
18 progress note is illegible.

19 TTTT. On or about October 7, 2008, patient J.K. saw respondent for
20 chronic pain. Respondent prescribed patient J.K. Norco for chronic pain.
21 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is
22 no history or physical on this visit corresponding to anemia. The remainder of the
23 progress note is illegible.

24 UUUU. On or about October 21, 2008, patient J.K. saw respondent for
25 COPD, tachycardia, and anxiety. There is no history or physical documented
26 corresponding to the diagnosis of chronic pain, but chronic pain is listed in the
27 assessment. Respondent prescribed patient J.K. Norco for chronic pain.
28 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is

1 no history or physical on this visit corresponding to anemia. Respondent
2 prescribed patient J.K. Restoril for insomnia. There is no history or physical on
3 this visit documented corresponding to insomnia. Portions of patient J.K.'s
4 progress note are illegible.

5 VVVV. On or about November 6, 2008, patient J.K. saw respondent for
6 low back pain. Respondent noted that patient J.K. was taking Norco for his pain.
7 Patient J.K. reported having tachycardia. Respondent prescribed patient J.K.
8 Norco and Cymbalta¹⁶ for chronic pain. Respondent gave patient J.K. a Vitamin
9 B12 injection for anemia, although there is no history or physical on this visit
10 corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

11 WWW. On or about January 24, 2009, patient J.K. had his blood drawn
12 for blood work. The lab results indicated that patient J.K.'s labs were normal, and
13 there was no evidence of anemia or vitamin B12 deficiency on the lab report.

14 XXXX. On or about November 27, 2009, a year after his last visit, patient
15 J.K. saw respondent for tachycardia. Respondent noted that patient J.K. was on
16 Toprol and his pulse was within normal range. Respondent prescribed patient J.K.
17 Norco and Cymbalta for chronic pain, although there is no interval history
18 documented corresponding to patient J.K.'s chronic pain. Respondent gave patient
19 J.K. a Vitamin B12 injection for anemia, although there is no history or physical
20 on this visit corresponding to anemia. Portions of patient J.K.'s progress note are
21 illegible.

22 YYYY. On or about December 27, 2009, patient J.K. saw respondent for
23 insomnia. As of this visit, respondent did not order lab work for insomnia, such a
24 TSH. There is no documentation of patient J.K.'s sleep hygiene changes.
25 Respondent prescribed patient J.K. Ambien for insomnia and Norco chronic pain.

26
27 ¹⁶ Cymbalta is a brand name for duloxetine, a selective serotonin and norepinephrine
28 reuptake inhibitor antidepressant, and a dangerous drug pursuant to Business and Professions
Code section 4022.

1 There is no history or exam documented corresponding to chronic pain.
2 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is
3 no history or physical on this visit corresponding to anemia. Portions of patient
4 J.K.'s progress note are illegible.

5 ZZZZ. On or about January 20, 2010, patient J.K. saw respondent for
6 chronic pain. Respondent noted that patient J.K. had a L orbital fracture. He did
7 not document why patient J.K. still had pain for his L orbital fracture that occurred
8 over one and half years prior. Respondent prescribed patient J.K. Norco for
9 chronic pain. He prescribed patient J.K. Klonopin for "ALOC," with ALOC
10 undefined in the progress note. There is no history or exam documented
11 corresponding to ALOC. Respondent gave patient J.K. a Vitamin B12 injection
12 for anemia, although there is no history or physical on this visit corresponding to
13 anemia. Portions of patient J.K.'s progress note are illegible.

14 AAAAA. On or about February 12, 2009, patient J.K. saw respondent for
15 peripheral neuropathy with lower extremity radiculopathy. Patient J.K. reported
16 that his symptoms were improving with the Neurontin. Respondent prescribed
17 patient J.K. Neurontin and Cymbalta for neuropathy and Percocet¹⁷ for chronic
18 pain. There is no documentation regarding the change of Norco for Percocet to
19 treat patient J.K.'s chronic pain. Respondent gave patient J.K. a Vitamin B12
20 injection for anemia, although there is no history or physical on this visit
21 corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

22 BBBBB. On March 15, 2010, patient J.K. saw respondent for chronic pain.
23 Respondent noted that patient J.K. had a L orbital fracture. Patient J.K. reported
24 that Norco no longer worked to treat his pain and exhibited 8/10 pain severity.
25

26 ¹⁷ Percocet is a brand name for oxycodone and acetaminophen, a Schedule II controlled
27 substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous
28 drug pursuant to Business and Professions Code section 4022.

1 Respondent prescribed patient J.K. Percocet and Klonopin¹⁸ for chronic pain.
2 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is
3 no history or physical on this visit corresponding to anemia. Portions of patient
4 J.K.'s progress note are illegible.

5 CCCCC. On or about April 1, 2010, patient J.K. saw respondent for
6 hyperlipidemia. Respondent noted that patient J.K. was on Zocor and not
7 suffering from any muscle pain. Contrary to the history in the progress note,
8 respondent then noted that patient J.K. had paraspinal muscle spasms. Respondent
9 prescribed patient J.K. Norco and Soma for DJD. He also prescribed patient J.K.
10 Ambien for insomnia, although there is no history documented corresponding to
11 insomnia. Respondent gave patient J.K. a Vitamin B12 injection for anemia,
12 although there is no history or physical on this visit corresponding to anemia.
13 Portions of patient J.K.'s progress note are illegible.

14 DDDDD. On or about April 12, 2010, patient J.K. saw respondent for
15 tachycardia. Respondent noted that patient J.K. had been in the hospital for
16 increased pain due to left orbital fracture. Respondent prescribed patient J.K.
17 Lortab¹⁹ for pain. Respondent gave patient J.K. a Vitamin B12 injection for
18 anemia, although there is no history or physical on this visit corresponding to
19 anemia. He ordered cerumen disimpaction, although there was no history or exam
20 corresponding to cerumen impaction. Respondent prescribed patient J.K. Ativan,
21 but did not document the rationale in prescribing patient J.K. this medication.
22 Portions of patient J.K.'s progress note are illegible.

23
24 ¹⁸ Klonopin is a brand name for clonazepam which is in a group of drugs called
25 benzodiazepines. 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.

26 ¹⁹ Lortab is a brand name for hydrocodone, a Schedule III controlled substance pursuant to
27 Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to
28 Business and Professions Code section 4022.

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EEEE. On or about May 12, 2010, patient J.K. saw respondent.
Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. The remainder of the progress note is illegible.

FFFF. On or about June 3, 2010, patient J.K. saw respondent for tachycardia. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. The remainder of the progress note is illegible.

GGGG. On or about July 2, 2010, patient J.K. saw respondent for bronchitis. Respondent prescribed patient J.K. Amoxicillin to treat the bronchitis. He diagnosed patient J.K. with attention deficit with hyperactivity (ADHD) and prescribed him Adderall.²⁰ There is no history, present or past, related to attention deficit documented in patient J.K.'s progress note. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

HHHH. On or about July 30, 2010, patient J.K. saw respondent for ADHD. Respondent noted that patient J.K. had a history of hyperactivity without poor concentration. Patient J.K. reported to have an improvement of his ADHD with Adderall. Respondent prescribed patient J.K. Klonopin, but did not document the rationale in prescribing patient J.K. this medication. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

²⁰ Adderall is a brand name for dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salts used for attention-deficit hyperactivity disorder and narcolepsy.

1 IIIII. On or about August 13, 2010, patient J.K. saw respondent for
2 chronic pain. Respondent noted that Norco was no longer effective to treat patient
3 J.K.'s pain. Patient J.K. reported persistent pain. Respondent noted that patient
4 J.K.'s L orbit had edema and to be tender to the touch. This is the first exam
5 noting any pain on orbit in the progress notes. Respondent prescribed patient J.K.
6 Percocet for pain. Respondent gave patient J.K. a Vitamin B12 injection for
7 anemia, although there is no history or physical on this visit corresponding to
8 anemia. Portions of patient J.K.'s progress note are illegible.

9 JJJJ. On or about August 27, 2010, patient J.K. saw respondent for
10 nausea. Patient J.K. reported that the Percocet was "too strong" and caused him to
11 vomit. Respondent switched patient J.K.'s medication to Tylenol #4. The
12 remainder of the progress note is illegible.

13 KKKKK. On or about September 6, 2010, patient J.K. saw respondent for
14 neuropathy and lower back pain, with bilateral lower extremity radiation and
15 numbness. Patient J.K. reported that his symptoms were improved with Cymbalta
16 use. Respondent prescribed patient J.K. Adderall for ADHD, although there is no
17 history documented corresponding to ADHD. He also prescribed patient J.K.
18 Norco for pain. Respondent gave patient J.K. a Vitamin B12 injection for anemia,
19 although there is no history or physical on this visit corresponding to anemia.
20 Portions of patient J.K.'s progress note are illegible.

21 LLLLL. On or about September 20, 2010, patient J.K. saw respondent for
22 constipation. Respondent prescribed patient J.K. Norco for pain, even though
23 narcotics can often cause constipation. Respondent gave patient J.K. a Vitamin
24 B12 injection for anemia, although there is no history or physical on this visit
25 corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

26 MMMMM. On or about October 17, 2010, patient J.K. saw respondent for
27 neuropathy. Respondent prescribed patient J.K. Cymbalta and Neurontin.
28 Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is

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no history or physical on this visit corresponding to anemia. The remainder of the progress note is illegible.

NNNNN. On or about November 8, 2010, patient J.K. saw respondent for a urinary tract infection. Respondent prescribed patient J.K. Flomax for benign prostatic hypertrophy. There is no prostate exam documented in the progress note. Respondent did not order a PSA exam or urinalysis. Respondent prescribed patient J.K. Levaquin for the urinary tract infection and Cymbalta and Neurontin for neuropathy. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

OOOOO. On or about November 23, 2010, patient J.K. saw respondent for neuropathy and low back pain. Respondent prescribed patient J.K. Cymbalta and Neurontin for neuropathy and Norco for pain. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. Portions of patient J.K.'s progress note are illegible.

PPPPP. On or about December 13, 2010, patient J.K. saw respondent for diarrhea. Respondent noted that patient J.K. had rectal pain and hemorrhoids. He prescribed patient J.K. Flagyl for the diarrhea. Respondent gave patient J.K. a Vitamin B12 injection for anemia, although there is no history or physical on this visit corresponding to anemia. Respondent never referred patient J.K. for physical therapy. Respondent never ordered any image studies and did not refer him for orthopedics consultation. He diagnosed patient J.K. with anemia, but did not perform a diagnostic workup for anemia. Portions of patient J.K.'s progress note are illegible.

QQQQQ. Respondent committed gross negligence in his care and treatment of patient J.K. which included, but was not limited to, the following:

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1 1. Paragraphs 15QQQQ through 15PPPPP, above, are hereby incorporated
2 by reference as if fully set forth herein;

3 2. Failing to perform an adequate or reasonable history on patient J.K. on
4 multiple occasions;

5 3. Failing to perform an adequate or pertinent physical exam on patient
6 J.K. on multiple occasions;

7 4. Failing to establish treatment goals and failed to attempt any other
8 nonpharmaceutical treatments in lieu of narcotic medications on a multiple and
9 consistent basis; and

10 5. Prescribing controlled substances to patient J.K. without a good faith
11 history, examination, or medical indication on multiple instances.

12 **Patient S.H.**

13 RRRRR. On or about May 19, 2008, patient S.H. saw respondent for
14 hypertension and GERD. Respondent noted that patient S.H. had nausea. He did
15 not perform an abdominal exam on patient S.H., despite complaints of GERD.
16 Respondent noted in progress note that patient S.H. has GERD, CVA
17 (cerebrovascular accident), insomnia, anemia, and cerumen disimpaction. There
18 are no history or exam findings documented corresponding to the diagnoses of
19 CVA, insomnia, anemia, and cerumen disimpaction. Respondent gave patient S.H.
20 a Vitamin B12 injection for anemia, although there is no history or physical on this
21 visit corresponding to anemia. He ordered cerumen disimpaction, although there
22 was no history or exam corresponding to cerumen impaction. Portions of patient
23 S.H.'s progress note are illegible.

24 SSSSS. On or about July 16, 2008, patient S.H. saw respondent for
25 complaints of tachycardia with a pulse of 98. Respondent prescribed patient S.H.
26 metoprolol for tachycardia. There is no history or examination regarding
27 tachycardia, anemia, or asthma documented in patient S.H.'s progress note.
28 Respondent performed a spirometry test on patient S.H., but the results were not

1 noted in the progress note. He diagnosed patient S.H. with tachycardia,
2 hypertension, anemia, and asthma. Respondent gave patient S.H. a Vitamin B12
3 injection for anemia, although there is no history or physical on this visit
4 corresponding to anemia. Portions of patient S.H.'s progress note are illegible.

5 TTTTT. On or about September 25, 2008, patient S.H. saw respondent for
6 tuberculosis (TB) testing. Respondent order a PPD test, but results of the PPD test
7 were not documented. He diagnosed patient S.H. with anemia. Respondent gave
8 patient S.H. a Vitamin B12 injection for anemia, although there is no history or
9 physical on this visit corresponding to anemia. Respondent also diagnosed patient
10 S.H. with "ALOC," which normally stands for "acute loss of consciousness;"
11 however, in his interview with Medical Board, he stated that he meant this to mean
12 schizophrenia. There is no history or exam finding to indicate how respondent
13 came to the diagnosis of schizophrenia. Portions of patient S.H.'s progress note are
14 illegible.

15 UUUUU. On or about October 28, 2009, patient S.H. saw respondent for
16 hypertension and degenerative joint disease (DJD). Respondent noted that patient
17 S.H. requested a cortisone injection. He noted that patient S.H.'s shoulder showed
18 a "decreased range of motion, especially with abduction." In his interview,
19 respondent stated that he gave patient S.H. a steroid injection with Lidocaine and
20 prescribed him Ultram. The progress note does not contain any pertinent history
21 regarding shoulder pain. Respondent did not order physical therapy or imaging for
22 patient S.H. Portions of patient S.H.'s progress note are illegible.

23 VVVVV. On or about December 18, 2009, patient S.H. saw respondent for
24 insomnia and peripheral neuropathy. Respondent did not perform a neurological
25 exam on patient S.H. or order labs for a peripheral neuropathy workup.
26 Respondent prescribed patient S.H. Tylenol with Codeine after diagnosing him
27 with cough. The progress note does not contain history or exam findings related to
28 a diagnosis of cough. Respondent gave patient S.H. a Vitamin B12 injection for

1 anemia, although there is no history or physical on this visit corresponding to
2 anemia. Portions of patient S.H.'s progress note are illegible.

3 WWWWW. On or about January 15, 2009, patient S.H. saw respondent
4 for DJD and was given another intraarticular injection. Respondent did not order
5 physical therapy or imaging for patient S.H. He diagnosed patient S.H. with a
6 cough. The progress note does not contain history or exam findings related to a
7 diagnosis of cough. Respondent gave patient S.H. a Vitamin B12 injection for
8 anemia, although there is no history or physical on this visit corresponding to
9 anemia. Portions of patient S.H.'s progress note are illegible.

10 XXXXX. On or about February 21, 2010, patient S.H. saw respondent for
11 a sinus infection. Respondent gave patient S.H. a Vitamin B12 injection for
12 anemia, although there is no history or physical on this visit corresponding to
13 anemia. He prescribed patient S.H. Tylenol #3 for DJD. Portions of patient S.H.'s
14 progress note are illegible.

15 YYYYY. On or about April 22, June 21, August 22, November 10, and
16 December 8, 2012, patient S.H. saw respondent for DJD, anemia, insomnia,
17 ALOC, and peripheral neuropathy. Respondent did not document in the progress
18 notes for each of these visits a history, exam findings, assessment, or plan.
19 Respondent gave patient S.H. a Vitamin B12 injection for anemia at each visit,
20 although there is no history or physical on this visit corresponding to anemia.
21 Portions of patient S.H.'s progress notes were illegible for each visit.

22 ZZZZZ. Respondent committed gross negligence in his care and treatment
23 of patient S.H. which included, but was not limited to, the following:

24 1. Paragraphs 15RRRRR through 15YYYYY, above, are hereby
25 incorporated by reference as if fully set forth herein;

26 2. Developing diagnosis for patient S.H. without justifiable history or
27 examination findings on May 18, 2008, July 16, 2008; September 25, 2008;
28 December 18, 2009; and January 15, 2009; and

- 1 A. Failing to maintain adequate and accurate records for patient J.K.; and
2 B. Prescribing and administering cerumen disimpaction without medical
3 indication.

4 22. Respondent has committed repeated negligent acts in his care and treatment of patient
5 S.H., which included, but was not limited to, the following:

6 A. Failing to perform and record an adequate history on patient S.H. on
7 May 19, 2008; July 16, 2008; September 25, 2008; October 28, 2009; December
8 18, 2009; and January 15, 2009;

9 B. Failing to perform and record an adequate and pertinent physical exam
10 on patient S.H. on May 9, 2008; July 16, 2008; September 25, 2008; December 18,
11 2009; and January 15, 2008;

12 C. Failing to perform a neurological examination for a diagnosis of
13 peripheral neuropathy;

14 D. Failing to maintain adequate and accurate records for patient S.H.; and

15 E. Providing intraarticular injection to patient S.H. without performing
16 prerequisite steps of referring patient S.H. for physical therapy or ordering
17 imaging.

18 23. Respondent has committed repeated negligent acts in his care and treatment of patient
19 C.A., which included, but was not limited to, the following:

20 A. On or about August 30, 2008, patient C.A. saw respondent for her
21 Chronic Obstructive Pulmonary Disorder (COPD). Respondent noted that patient
22 C.A. had "ALOC," which indicates altered level of consciousness. He also noted
23 that patient C.C. was a smoker and had complaints of cough and sputum
24 production. She has normal cardiac, pulmonary, abdominal, extremities upon
25 examination. Respondent noted cerumen impaction and performed a cerumen
26 disimpaction. He prescribed patient C.A. Seroquel and Zyprexa and advised her
27 to stop smoking.

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1 B. On or about September 25, 2008, patient C.A. saw respondent for
2 COPD. Respondent noted that patient C.A. had a cough and sputum. She had
3 tachycardia and a pulse of 101. Patient C.A. indicated that she experienced
4 palpitations when not smoking. Respondent advised patient C.A. to quit smoking
5 and ordered spirometry. He prescribed her Robutussin for cough and gave her a
6 flu vaccine.

7 C. On or about October 8, 2008, patient C.A. saw respondent for a
8 complaint of tremors. Respondent noted that patient C.A. had tremors, which had
9 been treated with and responsive to Neurontin. While there is no history noted
10 regarding glaucoma, respondent checked patient C.A.'s eyes with a tonometer, and
11 found to have normal results. Her blood pressure was noted to be elevated at
12 157/93, with a plan to recheck her blood pressure again at the next visit.

13 D. On or about December 9, 2010, patient C.A. saw respondent for a
14 complaint of anemia. The subjective and plan sections of the medical record are
15 illegible. Respondent noted that was no melena. He ordered cerumen
16 disimpaction, although there was no history or exam corresponding to cerumen
17 impaction.

18 E. On or about December 27, 2010, patient C.A. saw respondent for
19 hypothyroidism. Patient C.A. was noted to be on Synthroid. There are no weight
20 changes noted in the medical record. Respondent gave patient C.A. a Vitamin B12
21 injection for anemia, although there is no history or physical on this visit
22 corresponding to anemia.

23 F. On or about February 1, 2011, patient C.A. saw respondent for
24 hypothyroidism. She reported interval improvement of her energy level.
25 Respondent noted that patient C.A. did not to have chest pain, weight loss or
26 constipation. Respondent ordered thyroid labs. Respondent gave patient C.A. a
27 Vitamin B12 injection for anemia, although there is no history or physical on this
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1 visit corresponding to anemia. Respondent prescribed patient C.A. Toprol for
2 hypertension because her blood pressure was noted to be elevated at 142/83.

3 G. Respondent committed repeated negligent acts in his care and treatment
4 of patient C.A. which included, but was not limited to, the following:

5 1. Paragraph 23, above, is hereby incorporated by reference as if fully set
6 forth herein;

7 2. Failing to match an action plan to a corresponding history or exam on
8 December 9, 2010, December 27, 2010, and February 1, 2011;

9 3. Failing to maintain adequate and accurate records for patient C.A.

10 **THIRD CAUSE FOR DISCIPLINE**

11 **(Repeated Acts of Clearly Excessive Prescribing)**

12 24. Respondent has further subjected his Osteopathic Physician's and Surgeon's
13 Certificate No. 20A9710 to disciplinary action under section 725 of the Code, in the he engaged
14 in repeated acts of clearly excessive prescribing or administrating of drugs or treatment as
15 determined by the community of licenses in his care and treatment of patients C.J., J.C., C.C.,
16 Y.V., K.A., W.E., A.W., I.M., J.K. and S.H., as more particularly alleged in paragraphs 15
17 through 22, above, and which are hereby incorporated by reference as if fully set forth.

18 **FOURTH CAUSE FOR DISCIPLINE**

19 **(Prescribing Narcotics to a Drug Addict)**

20 25. Respondent has further subjected his Osteopathic Physician's and Surgeon's
21 Certificate No. 20A9710 to disciplinary action under section 3600-2, 2227 and 2234, as defined
22 by section 2241, of the Code, in that he prescribed narcotics to patients C.J., J.C., C.C., and Y.V.,
23 as more particularly alleged in paragraph 15, above, and which is hereby incorporated by
24 reference as if fully set forth.

25 **FIFTH CAUSE FOR DISCIPLINE**

26 **(Prescribing Without a Good Faith Prior Examination)**

27 26. Respondent has further subjected his Osteopathic Physician's and Surgeon's
28 Certificate No. 20A9710 to disciplinary action under section 3600-2, 2227 and 2234, as defined

1 by section 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs as
2 defined in section 4022 without an appropriate prior examination and a medical indication, in his
3 care and treatment of patients C.J., J.C., C.C., Y.V., K.A., W.E., A.W., I.M., J.K., S.H., and C.A.,
4 as more particularly alleged in paragraphs 15 through 23, above, and which are hereby
5 incorporated by reference as if fully set forth.

6 **SIXTH CAUSE FOR DISCIPLINE**

7 **(Violation of State Statutes Regulating Dangerous Drugs or Controlled Substances)**

8 27. Respondent has further subjected his Osteopathic Physician's and Surgeon's
9 Certificate No. 20A9710 to disciplinary action under section 3600-2, 2227 and 2234, as defined
10 by section 2238, of the Code, in that he violated state statutes regulating dangerous drugs or
11 controlled substances in his care and treatment of patients C.J., J.C., C.C., Y.V., K.A., W.E.,
12 A.W., I.M., J.K., S.H., and C.A., as more particularly alleged in paragraphs 15 through 23, above,
13 and which are hereby incorporated by reference as if fully set forth.

14 **SEVENTH CAUSE FOR DISCIPLINE**

15 **(Making or Signing False Document Directly Related to the Practice of Medicine)**

16 28. Respondent has further subjected his Osteopathic Physician's and Surgeon's
17 Certificate No. 20A9710 to disciplinary action under section 3600-2, 2227 and 2234, as defined
18 by section 2261, of the Code, in that he knowingly made or signed documents directly related to
19 the practice of medicine which falsely represents the existence or non-existence of a state of facts,
20 as more particularly alleged in paragraph 15, above, and which is hereby incorporated by
21 reference as if fully set forth.

22 **EIGHTH CAUSE FOR DISCIPLINE**

23 **(Dishonesty or Corruption)**

24 29. Respondent has further subjected his Osteopathic Surgeon Certificate No.
25 20A9710 to disciplinary action under sections 3600-2, 2227 and 2234, as defined by
26 section 2234, subdivision (e), of the Code, in that he has committed acts of dishonesty or
27 corruption, as more particularly alleged in paragraphs 15 and 28, above, which is hereby
28 incorporated by reference as if fully set forth herein.

1 **NINTH CAUSE FOR DISCIPLINE**

2 **(Failure to Maintain Adequate and Accurate Records)**

3 30. Respondent has further subjected his Osteopathic Physician's and Surgeon's
4 Certificate No. 20A9710 to disciplinary action under sections 3600-2, 2227 and 2234, as defined
5 by section 2266, of the Code, in that failed to maintain adequate and accurate records regarding
6 his care and treatment of patients C.J., J.C., C.C., Y.V., K.A., W.E., A.W., I.M., J.K., S.H., and
7 C.A., as more particularly alleged in paragraphs 15 through 23, above, which are hereby
8 incorporated by reference as if fully set forth herein.

9 **TENTH CAUSE FOR DISCIPLINE**

10 **(Conviction of Crimes Substantially Related)**

11 31. Respondent has subjected his Osteopathic Physician's and Surgeon's Certificate No.
12 20A9710 to disciplinary action under sections 2227 and 2234, as defined by 2236, of the Code, in
13 that he was convicted of crimes substantially related to the qualifications, functions, or duties of a
14 physician and surgeon. The circumstances are as follows:

15 **Superior Court Case No. SCD246456**

16 A. On or about February 26, 2013, a criminal complaint was filed against respondent in
17 the case entitled *The People of the State of California vs. Jason Ling*, Superior Court of the State
18 of California, County of San Diego, Case No. SCD246456, charging respondent with the
19 following counts:

20 Count 1 - Unlawful Controlled Substance Prescription, to wit: Vicodin ES
21 (Hydrocodone 7.5), in violation of Health and Safety Code section 11153(a) - On or
22 about March 17, 2010, Respondent knowingly and unlawfully issued a prescription
for a controlled substance for other than a legitimate medical purpose;

23 Count 2 - Unlawful Controlled Substance Prescription, to wit: Vicodin ES
24 (Hydrocodone 5/500mg). On or about March 25, 2010, Respondent knowingly and
unlawfully issued a prescription for a controlled substance for other than a legitimate
25 medical purpose, in violation of Health and Safety Code section 11153(a);

26 Count 3 - Unlawful Controlled Substance Prescription, to wit: Hydrocodone
27 5/500mg). On or about March 25, 2010, Respondent knowingly and unlawfully
issued a prescription for a controlled substance for other than a legitimate medical
28 purpose, in violation of Health and Safety Code section 11153(a);

Count 4 - Unlawful Controlled Substance Prescription, to wit: Hydrocodone
5/500mg. On or about March 25, 2010, Respondent knowingly and unlawfully issued

1 a prescription for a controlled substance for other than a legitimate medical purpose,
in violation of Health and Safety Code section 11153(a);

2 Count 5 - Unlawful Controlled Substance Prescription, to wit: Tylenol with
Codeine #4. On or about May 11, 2010, Respondent knowingly and unlawfully
3 issued a prescription for a controlled substance for other than a legitimate medical
purpose, in violation of Health and Safety Code section 11153(a);

4 Count 6 - Unlawful Controlled Substance Prescription, to wit: Valium 10mg.
5 On or about May 11, 2010, Respondent knowingly and unlawfully issued a
prescription for a controlled substance for other than a legitimate medical purpose, in
6 violation of Health and Safety Code section 11153(a);

7 Count 7 - Unlawful Controlled Substance Prescription, to wit: Tylenol with
Codeine #4. On or about June 15, 2010, Respondent knowingly and unlawfully
8 issued a prescription for a controlled substance for other than a legitimate medical
purpose, in violation of Health and Safety Code section 11153(a);

9 Count 8 - Unlawful Controlled Substance Prescription, to wit: Valium 10mg.
10 On or about June 15, 2010, Respondent knowingly and unlawfully issued a
prescription for a controlled substance for other than a legitimate medical purpose, in
11 violation of Health and Safety Code section 11153(a);

12 Count 9 - Unlawful Controlled Substance Prescription, to wit: Norco
(Hydrocodone 10mg). On or about July 29, 2010, Respondent knowingly and
13 unlawfully issued a prescription for a controlled substance for other than a legitimate
medical purpose, in violation of Health and Safety Code section 11153(a);

14 Count 10 - Unlawful Controlled Substance Prescription, to wit: Xanax 2mg.
15 On or about July 29, 2010, Respondent knowingly and unlawfully issued a
prescription for a controlled substance for other than a legitimate medical purpose, in
16 violation of Health and Safety Code section 11153(a);

17 Count 11 - Unlawful Controlled Substance Prescription, to wit: Norco
(Hydrocodone 10mg). On or about August 12, 2010, Respondent knowingly and
18 unlawfully issued a prescription for a controlled substance for other than a legitimate
medical purpose, in violation of Health and Safety Code section 11153(a);

19 Count 12 - Unlawful Controlled Substance Prescription, to wit: Xanax 2mg.
20 On or about August 12, 2010, Respondent knowingly and unlawfully issued a
prescription for a controlled substance for other than a legitimate medical purpose, in
21 violation of Health and Safety Code section 11153(a);

22 Count 13 - Unlawful Controlled Substance Prescription, to wit: Vicodin ES
(Hydrocodone 7.5mg). On or about September 8, 2010, Respondent knowingly and
23 unlawfully issued a prescription for a controlled substance for other than a legitimate
medical purpose, in violation of Health and Safety Code section 11153(a);

24 Count 14 - Unlawful Controlled Substance Prescription, to wit: Valium
25 10mg. On or about September 8, 2010, Respondent knowingly and unlawfully issued
a prescription for a controlled substance for other than a legitimate medical purpose,
26 in violation of Health and Safety Code section 11153(a);

27 Count 15 - Unlawful Controlled Substance Prescription, to wit: Norco
(Hydrocodone 10mg). On or about October 14, 2010, Respondent knowingly and
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1 unlawfully issued a prescription for a controlled substance for other than a legitimate
2 medical purpose, in violation of Health and Safety Code section 11153(a);

3 Count 16 - Unlawful Controlled Substance Prescription, to wit: Xanax 2mg.
4 On or about October 14, 2010, Respondent knowingly and unlawfully issued a
5 prescription for a controlled substance for other than a legitimate medical purpose, in
6 violation of Health and Safety Code section 11153(a).

7 B. On or about May 15, 2014, respondent pled guilty to Counts 2, 9, 13, and 15,
8 violating Health and Safety Code section 11153(a), a felony. Respondent entered into a
9 stipulation settlement to four years of state prison to run concurrent with Superior Court Case
10 Nos. SCD251366 and SCD24404, and Federal Case No. CR14-0231.²¹

11 **Superior Court Case No. SCD251366**

12 C. On or about October 9, 2013, a felony complaint was filed against respondent in the
13 case entitled *The People of the State of California vs. Jason Ling*, Superior Court of California,
14 County of San Diego, Case No. CD251366, charging respondent with the following:

15 Count 1 – Insurance Fraud (Medicare) - Beginning on or after November 8,
16 2012 and continuing through October 7, 2013, Respondent did knowingly make or
17 cause to be made fraudulent claims for payment of a health care benefit, to wit,
18 Medicare, in violation of Penal Code section 550(a)(6);

19 Count 2 – Grand Theft – Beginning on or about November 8, 2012, and
20 continuing through October 7, 2013, Respondent did willfully and unlawfully take
21 from the United States Government and/or its contracted agents money in excess of
22 \$950, in violation of Penal Code section 550(a)(6);

23 Special Allegations:

24 Felony While Released on Bail - Penal Code section 12022.1 – It is further
25 alleged that at the time of the commission of Counts 1 and 2 charged above,
26 Respondent was released from custody on bail in Case No. CD244404 with the
27 meaning of Penal Code section 12022.1;

28 Loss Over \$65,000 - Penal Code section 12022.6(a)(1) – It is further alleged
that in the commission of Counts 1 and 2 charged above, Respondent, with the intent
to do so, did cause the loss of or did take property of a value in excess of \$200,000,
within the meaning of Penal Code section 12022.6(a)(2);

Loss Over \$200,000 - Penal Code section 12022.6(a)(2) – It is further alleged
that in the commission of Counts 1 and 2 charged above, Respondent, with the intent
to do so, did cause the loss of or did take property of a value in excess of \$200,000,
within the meaning of Penal Code section 12022.6(a)(2);

²¹ Sentencing is scheduled for December 17, 2014.

1 Aggravated White Collar Crime Enhancement within the meaning of Penal
2 Code section 186.11(a)(1) -- It is further alleged that the crimes Respondent is
3 charged with in Counts 1 and 2 charged above, are related felonies, a material
4 element of which is fraud, and that the resulting loss exceeded more than \$100,000,
5 within the meaning of Penal Code section 186.11(a)(1);

6 Probation Limitation – Penal Code section 1203.045 – It is further alleged that
7 in the commission of Counts 1 and 2 charged above, that Respondent with the intent
8 to do so, took in excess of \$100,000, within the meaning of the Penal Code section
9 1203.045, thereby requiring Respondent be denied probation.

10 D. On or about May 15, 2014, respondent pled guilty to Count 1, violating Penal Code
11 section 550(a)(6), felony. Respondent entered into a stipulation settlement to two years of state
12 prison to run concurrent with Case No. SCD246456 and SCD244404, and Federal Case No.
13 CR14-0231.

14 **Superior Court Case No. SCD244404**

15 E. On or about February 27, 2013, a first amended complaint was filed against
16 respondent in the case entitled *The People of the State of California vs. Jason Ling*, Superior
17 Court of the State of California, County of San Diego, Central District, Case No. CD2444046,
18 charging respondent with the following:

19 Count 1 – Insurance Fraud (Medicare) – Beginning on or about November 1,
20 2007 and continuing through July 21, 2012, Respondent did knowingly make or cause
21 to be made fraudulent claims for payment of a health care benefit under Medicare, in
22 violation of Penal Code section 550(a)(6), a felony;

23 Count 2 – Insurance Fraud (Medi-Cal) – Beginning on or about January 6, 2011
24 and continuing through August 29, 2011, Respondent did knowingly make or cause to
25 be made fraudulent claims for payment of a health care benefit under Medi-Cal, in
26 violation of Penal Code section 550(a)(6), a felony;

27 Count 3 – Insurance Fraud (Tricare) – Beginning on or about October 1, 2009,
28 and continuing on through or after November 31, 2010, Respondent did knowingly
make or cause to be made fraudulent claims for payment of a health care benefit
under Tricare, in violation of Penal Code section 550(a)(6), a felony;

Count 4 – Grand Theft (US Government) – Beginning on or about November 1,
2007, and continuing through July 21, 2012, Respondent did willfully and unlawfully
take from the United States Government and/or its contracted agents money in excess
of \$950, in violation of Penal Code section 487(a), a felony;

Count 5 – Grand Theft (State of California) – Beginning on or about January 6,
2011, and continuing on through August 29, 2011, Respondent did willfully and
unlawfully take from the State of California money in excess of \$950, in violation of
Penal Code section 487(a), a felony;

1 Count 6 – Tax Evasion (Personal) – Beginning on or about April 15, 2009,
2 Respondent did willfully and unlawfully make and subscribe a personal income tax
3 return that contained, or was verified by written declaration that it was made under
penalty of perjury, which he did not believe to be true and correct as to every material
matter, in violation of Revenue and Tax Code section 19705(a)(1), a felony;

4 Count 7 - Tax Evasion (Personal) – Beginning on or about April 15, 2010,
5 Respondent did willfully and unlawfully make and subscribe a personal income tax
6 return that contained, or was verified by written declaration that it was made under
penalty of perjury, which he did not believe to be true and correct as to every material
matter, in violation of Revenue and Tax Code section 19705(a)(1), a felony;

7 Count 8 - Beginning on or about October 17, 2011, Respondent did willfully
8 and unlawfully make and subscribe a personal income tax return that contained, or
was verified by written declaration that it was made under penalty of perjury, which
9 he did not believe to be true and correct as to every material matter, in violation of
Revenue and Tax Code section 19705(a)(1), a felony;

10 Count 9 - - Beginning on or about October 15, 2012, Respondent did willfully
11 and unlawfully make and subscribe a personal income tax return that contained, or
was verified by written declaration that it was made under penalty of perjury, which
12 he did not believe to be true and correct as to every material matter, in violation of
Revenue and Tax Code (RT) section 19705(a)(1), a felony;

13 Special Allegation: Loss Over \$65,000 - In the commission of Counts 1 through
14 5 above, Respondent with the intent to do so, did cause the loss of or take property of
a value in excess of \$65,000 within the meaning of Penal Code section 12022.6(a)(1);

15 Special Allegation – Loss Over \$65,000 - In the commission of Counts 1
16 through 5 above, Respondent with the intent to do so, did cause the loss of or take
property of a value in excess of \$200,000 within the meaning of Penal Code section
17 12022.6(a)(1);

18 Special Allegation – Aggravated White Collar Crime Enhancement – In the
19 crimes charged in Counts 1 through 5 committed by Respondent are related felonies,
a material element of which is fraud and that the resulting loss exceeded more than
\$100,000, within the meaning of Penal Code section 186.11(a)(1);

20 Special Allegation – Aggravated White Collar Crime Enhancement – In the
21 crimes charged in Counts 1 through 5 committed by Respondent are related felonies a
material element of which is fraud and that the resulting loss exceeded more than
22 \$500,000 within the meaning of Penal Code section 186.119(a)(2); and

23 Special Allegation – Probation Limitation – In the commission of Counts 1
24 through 5, Respondent, with the intent to do so, took in excess of \$100,000, within
the meaning of the Penal Code section 1203.045, thereby requiring Respondent be
denied probation.

25
26 F. On or about May 15, 2014, respondent pled guilty to Count 1, violating Penal Code
27 section 550(a)(6), and admitted the allegation enhancement -Penal Code section 186.11(a)(2));
28 Count 2 – violating Penal Code section 550(a)(6); and Count 9 – violating RT 19705(a)(1).

1 Respondent entered into a stipulation settlement to four years of state prison to run concurrent
2 with SCD251366 and SCD246456 and pending Federal Case No. CR14-0231.

3 **Federal Court Case No. CR14-0231**

4 G. On or about April 22, 2014, an Information was filed in the United States District
5 Court, Central District of California, in the case entitled *United States of America v. Jason C.*
6 *Ling*, Case No. Cr-140231, charging respondent with Count One - 8 U.S.C. section 1349 –
7 Conspiracy to Commit Health Care Fraud. The Information alleged that beginning in or around
8 March 2010 and continuing through in or around November 2010, in Los Angeles County,
9 respondent together with a co-conspirator and other known and unknown to the United States
10 Attorney, conspired and agreed to commit health care fraud in violation of Title 18, United States
11 Code section 1347, as follows:

12 Respondent used street-level marketers to unlawfully recruit Medicare
13 beneficiaries to obtain power wheelchairs (PWS) and other durable medical
14 equipment (DME) that the beneficiaries did not need. The marketers took the
15 Medicare beneficiaries to visit respondent who would write prescriptions for PWCs
16 and other DME that respondent knew the beneficiaries would need. Respondent
17 would provide the prescriptions and other supporting documents to marketers and
18 others knowing that the prescriptions and documents would be provided to a DME
19 company, owned by a co-conspirator, knowing that the prescriptions and documents
20 would be used to submit false and fraudulent claims to Medicare. After acquiring the
21 false and fraudulent prescriptions and supporting documents written by respondent,
22 the co-conspirator would submit or cause the submission of false and fraudulent
23 claims to Medicare for medically unnecessary PWCs and other DME.

24 H. On or about June 9, 2014, respondent pled guilty and was convicted of Count One of
25 the Information.²²

26
27
28 ²² Sentencing is scheduled for December 15, 2014.

1 **ELEVENTH CAUSE FOR DISCIPLINE**

2 **(Unprofessional Conduct)**

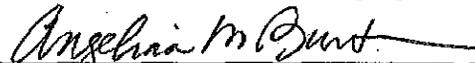
3 32. Respondent has further subjected his Osteopathic Physician's and Surgeon's
4 Certificate No. 20A9710 to disciplinary action under sections 3600-2, 2227 and 2234, of the
5 Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical
6 profession, or conduct which is unbecoming to a member in good standing of the medical
7 profession, and which demonstrates an unfitness to practice medicine, as more particularly
8 alleged in paragraphs 15 through 31, above, which are hereby incorporated by reference as if fully
9 set forth herein.

10 **PRAYER**

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

- 13 1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate NO.
14 20A9710, issued to respondent Jason Ling, D.O.;
- 15 2. If placed on probation, ordering respondent Jason Ling, D.O. to pay probation
16 monitoring costs;
- 17 3. Ordering respondent Jason Ling, D.O. to pay the Osteopathic Medical Board of
18 California the reasonable costs of the investigation and enforcement of this case, pursuant to
19 Business and Professions Code section 125.3; and
- 20 4. Taking such other and further action as deemed necessary and proper.

21 DATED: October 14, 2014



22 ANGELINA M. BURTON
23 Executive Director
24 Osteopathic Medical Board of California
25 Department of Consumer Affairs
26 State of California
27 Complainant

28 SD2012703866

DECLARATION OF SERVICE BY MAIL

**In the Matter of the First Amended Accusation
Against:**

**Jason Ling, D.O.
Case No: 00-2010-2723**

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

**DECISION AND ORDER
STIPULATED REVOCATION AND DISCIPLINARY ORDER**

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

NAME AND ADDRESS

CERT NO.

Jason Ling, D.O
4456 Vandever Avenue
San Diego, CA 92120

91 7199 9991 7034 8923 8598

Rosaline Feral, Esq
Columbia Court Office Building
444 West C Street, Suite 310
San Diego, CA 92101

91 7199 9991 7034 8923 8581

Each said envelope was then, on November 20, 2014 sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid, and return receipt requested.

Executed on November 20, 2014 at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Steve Ly

Typed Name



Signature

cc: Alexandra M. Alvarez, Deputy Attorney General