Exhibit A

Decision and Order

Medical Board of California Case No. 06-2007-181358

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

In the Matter of the Accusation Against: GUVEN UZUN, M.D. Physician's and Surgeon's Certificate No. A 72928 Respondent.	)	File No. 06-2007-181358

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby accepted and adopted as the Decision and Order by the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 22, 2011.

DATED March 24, 2011

MEDICAL BOARD OF CALIFORNIA

Hedy Chang
Chair, Panel B

KAMALA D. HARRIS
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GUVEN UZUN, M.D.** **P.O. Box 12843** **Marina Del Rey, California 90295** **Physician and Surgeon's Certificate No. A72928** Respondent.	Case No. 06-2007-181358 OAH No. 2010030350 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Colleen M. McGurrin, Deputy Attorney General.

2. Guven Uzun, M.D. (Respondent) is represented in this proceeding by attorney Thomas A. Mesereau, Jr. and Susan C. Yu, whose address is: Mesereau & Yu, LLP, 10390 Santa Monica Boulevard, Suite 220, Los Angeles, California 90025.

3. On or about August 24, 2000, the Board issued Physician's and Surgeon's Certificate No. A 72928 to Guven Uzun, M.D. The Physician's and Surgeon's Certificate was in full force

and effect at all times relevant to the charges brought in Accusation No. 06-2007-181358 and will expire on March 31, 2012, unless renewed.

JURISDICTION

4. Accusation No. 06-2007-181358 was filed before the Medical Board of California, Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 21, 2010. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 06-2007-181358 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 06-2007-181358. Respondent has also carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order and the effects it will have on his physician's and surgeon's certificate.

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

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

CULPABILITY

8. Respondent admits the truth of the charges and allegations alleged in Accusation No. 06-2007-181358 the following: First Cause for Discipline, paragraph 69 C and D; Second Cause for Discipline, paragraph 72 C, D, F, G, H, and I; Ninth Cause for Discipline, paragraph 105 B and C; Fourteenth Cause for Discipline, paragraph 125 A; and Fifteenth Cause for Discipline, paragraph 128 A, B, F, G and H, as charged and alleged in the Accusation. As to the remainder

of the allegations in the Accusation, Respondent agrees not to contest them for the purposes of this settlement.

Further, if Respondent ever petitions to modify or terminate any term or condition set forth herein, including but not limited to probation, or should the Board or any other regulatory agency in California or elsewhere hereinafter institute any other action against Respondent, including, but not limited to, an Accusation and/or Petition to Revoke Probation, the allegations and facts set forth in the Accusation shall be deemed admitted for all purposes.

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

CONTINGENCY

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

11. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 72928 issued to Respondent Guven Uzun, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for eight (8) years on the following terms and conditions.

1. ACTUAL SUSPENSION As part of probation, respondent is suspended from the practice of medicine for six (6) months beginning the sixteenth (16th) day after the effective date of this decision.

2. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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

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

3. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

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

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

4. ETHICS COURSE Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

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

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

5. CLINICAL TRAINING PROGRAM Within 60 calendar days of the effective date of this Decision, respondent shall enroll in the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical

education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

6. MONITORING – PRACTICE AND BILLING Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as practice and billing monitors, the names and qualifications of two or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are American Board of Medical Specialties (ABMS) certified. The monitors shall have no prior or current business or personal relationship with respondent, or other relationships that could reasonably be expected to compromise the ability of the monitors to render fair and unbiased reports to the Division, including, but not limited to, any form of bartering, shall be in respondent's field of

practice, and must agree to serve as respondent's monitors. Respondent shall pay all monitoring costs.

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

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

The monitors shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and billing, and whether respondent is practicing medicine safely, and billing appropriately.

It shall be the sole responsibility of respondent to ensure that the monitors submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor(s) resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor(s) who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3

calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

7. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

9. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

10. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. PROBATION UNIT COMPLIANCE Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence.

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

12. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

13. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

14. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

15. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

16. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. LICENSE SURRENDER Following the effective date of this Decision, if

respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorneys, Thomas A. Mesereau and Susan C. Yu. I fully understand the stipulation and the effects it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order freely, voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 1/26/11

GÖKVEN UZUN, M.D.
Respondent

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We have read and fully discussed with Respondent Guven Uzun, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. We approve its form and content.

DATED: 1/26/11

Thomas A. Mesereau, Jr.
Attorney for Respondent

Susan C. Xu
Attorney for Respondent

ENDORSEMENT

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

Dated: January 26, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

COLLEEN M. MCGURRIN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 06-2007-181358

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO January 21 2010
BY [illegible] ANALYST

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

In the Matter of the Accusation Against: GUVEN UZUN, M.D. P.O. Box 12843 Marina Del Rey, California 90295 Physician's and Surgeon's Certificate No. A 72928 Respondent.	Case No. 06-2007-181358 ACCUSATION

Complainant alleges:

PARTIES

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

2. On or about August 24, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 72928 to GUVEN UZUN, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2012, unless renewed.

JURISDICTION

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

4. Section 2234 of the Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

5. Section 2261 of the Code states: "Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Bus. & Prof. Code § 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

6. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 810 of the Code states, in pertinent part:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) . . . .

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

"(b) . . . (d)."

9. Section 725 of the Code states, in pertinent part:

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

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

(c) . . . (d)."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patient C.C.[2])

10. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient C.C. The circumstances are as follows:

11. On or about June 3, 2004, patient C.C., a then 43-year-old female, presented to respondent with a history of chronic daily headaches, neck pain, and intermittent spasms radiating into her shoulders and occasional numbness in her hands. Respondent's diagnostic impression of the patient's condition was mild carpal tunnel syndrome[3], intractable migraine/rebound headaches, cervical radiculopathy[4] and cervical spasm.

12. On or about August 2, 2004, respondent saw the patient again. Respondent ordered that the patient undergo an upper extremity Electromyography[5] (EMG)/Nerve Conduction Velocity[6] (NCV) study to access her continuing complaints. Initially, patch electrodes[7] were utilized; however, the patient was unable to tolerate the electrical stimulation generated, and asked that it be stopped. The patch electrodes were removed and respondent then utilized

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[2] For privacy, the patients in the Accusation will be identified by their first and last initial. The full name will be disclosed to Respondent upon timely request for discovery pursuant to Government Code section 11507.6. In addition, all references to the care and treatment respondent rendered to the patients identified in the Accusation are from the certified records respondent produced to the Board, unless otherwise indicated.

[3] Carpal tunnel is a passageway in the wrist, created by bones and ligaments of the wrist, through which the median nerve (which runs through the wrist and into the hand) passes. Carpal tunnel syndrome is a disorder caused by compression at the wrist of the median nerve supplying the hand, causing pain and burning, or numbness and tingling paresthesias in the fingers and hand, sometimes extending to the elbow.

[4] Radiculopathy is a term for the disease of the nerve root. Sometimes referred to as a pinched nerve, it refers to compression of the nerve root – the part of a nerve between the vertebrae. This compression causes pain to be perceived in areas to which the nerve leads.

[5] Electromyography (commonly referred to as EMG) is a type of test in which a nerve's function is tested by stimulating a nerve with electricity, and then measuring the speed and strength of the corresponding muscle's response.

[6] Nerve conduction velocity test (commonly referred to as NCV) is a test that measures the time it takes a nerve impulse to travel a specific distance over the nerve after electronic stimulation.

[7] An electrode is a conductor or medium by which an electric current is conducted to or from any medium, such as a cell, body, solution, or apparatus. A needle electrode is a thin, cylindrical electrode with an outer shaft beveled to a sharp point, enclosing a wire or series of wires. A patch electrode is a tiny electrode with a blunt tip that is used in studies of membrane potentials.

monopolar disposable needle electrodes on various muscles to complete the test. Respondent summarized, interpreted and signed the report findings noting, inter alia, that "the bilateral median motor and sensory nerves revealed prolonged distal latency,[8] normal amplitude and decreased conduction velocity.[9] The bilateral median sensory nerves revealed prolonged distal latency, amplitude and decreased conduction velocity. The bilateral ulnar and median F-wave[10] latencies were normal." However, respondent's findings are not supported by a review of the actual data listed in the study.

13. On or about December 8, 2004, respondent saw the patient again and performed a cervical and thoracic facet joint[11] block injection. However, there was no Magnetic Resonance Imaging (MRI)[12] or Computed tomography (CT) scan[13] of the cervical or thoracic spine showing facet joint disease, nor had the patient been diagnosed with facet joint disease. In addition, respondent failed to utilize fluoroscopy[14] during the procedure.

14. On or about January 7, 2005, respondent saw the patient again who complained of

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[8] Distal latency (in electoneuromyography) is the interval between the stimulation of a compound muscle and the observed response. Normal nerve conduction velocity is above 40 m/sec in the lower extremities and above 50 m/sec in the upper extremities, but age, muscle disease, temperature, and other factors can influence the velocity.

[9] Conduction velocity is the speed with which an electrical impulse can be transmitted through excitable tissue.

[10] F-wave is a waveform recorded in electroneuromyographic and nerve conduction tests. It appears on supramaximal stimulation of a motor nerve and is caused by antidromic (relating to the propagation of an impulse along an axon in a direction that is the reverse of normal) transmission of a stimulus. The F wave is used in studies of motor nerve function in the arms and legs.

[11] The facet joint (or zygapophyseal) is a synovial joint (the most common and most moveable type of joints in the body) between the superior articular process of one (lower) vertebra and the inferior articular process of the adjacent (higher) vertebra. A facet joint block is both a test and a type of treatment. A local anesthetic medication is injected into the facet joint or the small nerve branches going to the facet joint. The physician watches on a fluoroscope as the needle is inserted to make sure it goes into the proper location. The medication numbs the area around the facet joint, and if the pain goes away, the physician can assume that the facet joint is contributing to the problem.

[12] Magnetic resonance imaging (commonly referred to as MRI) is a nonintrusive method using nuclear magnetic resonance to render images of the inside of an object. It is primarily used in medical imaging to demonstrate pathological or other physiological alteration of living tissues.

[13] Computed tomography (originally known as computed axial tomography), commonly referred to as CAT or CT scan is a medical imaging method employing tomography (any of several techniques for making detailed x-rays of a plane section of a solid object, such as the body, while blurring out the images of the other planes) where digital geometry processing is used to generate a three-dimensional image of the internals of an object from a large series of two-dimensional x-ray images taken around a single axis of rotation.

[14] Fluoroscopy is an imaging (x-ray) technique commonly used by physicians that makes it possible to obtain real-time images of the internal structures of a patient. Fluoroscopy uses x-ray to produce real-time video images. After the x-rays pass through the patient, instead of using film, they are captured by a device called an image intensifier and converted into light. The light is then captured by a TV camera and displayed on a video monitor.

worsening back pain, among other things. Respondent diagnosed the patient with lumbar radiculopathy with acute lumbar spasm, and administered a lumbar facet joint injection. However, there was no MRI or CT scan of the lumbar spine showing that the patient suffered from facet joint disease, nor had the patient been diagnosed with this condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

15. Also on or about January 7, 2005, respondent claims he performed a needle EMG/NCV of the lower extremity, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

16. Concerning the January 7, 2005 patient visit, the Motion Picture Industry Pension & Health Plans (hereinafter referred to as MPI), patient C.C.'s insurance company, received copies of the patient's medical records, on or about May 9, 2006, in support of respondent's claim for payment. Respondent also produced certified records of the patient's medical records to the Board on or about April 9, 2008. In comparing the two sets of records it is apparent that the records have been altered, modified, fabricated, and created as follows, inter alia: the MPI lumbar injection record is on different paper, contains a different procedure description and narrative than the record produced to the Board; the signed EMG/NCV report sent to MPI contains a different chief complaint, different values for some of the nerves tested, and a different impression than the record produced to the Board. In addition, the EMG/NCV report produced to the Board contains additional handwritten entries that are not contained in the record received by MPI. These additional handwritten entries are not dated, initialed, signed, or explained. Further, respondent's signature is different on both records.

17. On or about February 12, 2005, respondent saw the patient again and complained of continuing neck and back pain. Respondent claims he performed another needle EMG/NCV of the upper and lower extremities, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the

electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

18. Concerning the February 12, 2005 patient visit, the EMG/NCV report received by MPI does not contain the additional handwritten entries under the impression portion of the report that are contained in the record produced to the Board. These additional handwritten entries are not dated, initialed, or explained.

19. Patient C.C. saw respondent again on or about March 18, 2005. Respondent performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

20. On or about May 27, 2005, respondent saw the patient again and claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, only patch electrodes were used, but the patient was unable to tolerate the electrical stimulation generated, and requested that the study be stopped, and it was never completed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

21. Concerning the May 27, 2005 patient visit, the signed EMG/NCV report received by MPI in support of respondent claim for payment reflects that the lower extremities were tested on this date. However, the EMG/NCV report produced to the Board reflects that the upper extremities were tested. In addition, the typewritten neurological follow up note produced to the Board also notes that an upper extremity EMG/NCV was conducted. This typewritten note was not sent to MPI. Further, the handwritten neurological attending note sent to MPI does not contain some of the additional handwritten entries in the records produced to the Board. These additional handwritten entries are not dated, initialed, signed, or explained.

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22. On or about August 13, 2005, respondent saw the patient again and performed an Electroencephalogram (EEG)[15] to further evaluate the patient's complaints. Respondent interpreted the results as abnormal, signed the report, and recorded in the follow up neurological note that the EEG was consistent only with mild slowing. However, this statement contradicts the findings.

23. Concerning the August 13, 2005 patient visit, the medical records received MPI from respondent, in or about February 2007, in support of his claim for payment are different from the records produced to the Board in April 2008. In the EEG report received by MPI the clinical impression is different and does not reflect the changes respondent made to the record produced to the Board. In addition, there are handwritten entries in the EEG report and the handwritten neurological consultation follow-up note produced to the Board which are not contained in the records received by MPI. These additional handwritten entries are not dated, initialed, signed, or explained.

24. On or about September 17, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

25. Also, on or about September 17, 2005, respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease. Nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

26. On or about October 19, 2005, patient C.C. saw respondent again. Respondent reports in the follow up neurological note that an EEG was completed and the results are "without significant changes." However, there is no evidence that an EEG was ever performed on this visit.

[15] An Electroencephalogram (commonly referred to as EEG) is a record of the tiny electrical impulses produced by the brain's activity. By measuring the characteristic wave patterns, the EEG can help diagnose certain conditions of the brain.

27. On or about November 4, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

28. Regarding the November 4, 2005 patient visit, the signed EMG/NCV report sent to MPI notes additional information under the impression, and does not contain the additional handwritten entries that are in the record produced to the Board. These additional handwritten entries are not dated, initialed, signed, or explained.

29. On or about November 15, 2005, patient C.C. saw respondent again. Respondent ordered that the patient receive an infusion of Intravenous Immunoglobulin (IVIG)[16]. However, there was no indication in the EMG/NCV studies that the patient suffered from Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)[17], nor had she been diagnosed with this condition.

30. On or about December 5, 2005, respondent saw the patient, and claims to have performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

31. Regarding the December 5, 2005 patient visit, MPI received medical records from respondent, on or about May 4, 2006, in support of his claim for payment which are different from the records produced to the Board in April 2008. The signed EMG/NCV report received by MPI does not contain the additional handwritten entries that are in the record produced to the

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[16] IVIG refers to intravenous immunoglobulin. Immunoglobulins (also known as antibodies) are proteins that are found in blood or other bodily fluids of vertebrates, and are used by the immune system to identify and neutralize foreign objects, such as bacteria and viruses.

[17] Chronic inflammatory demyelinating polyneuropathy (CIDP) is an acquired immunomediated inflammatory disorder of the peripheral nervous system. The pathologic hallmark of the disease is loss of the myelin sheath (the fatty covering that wraps around and protects nerve fibers) of the peripheral nerves. Polyneuropathy is a condition in which many peripheral nerves are afflicted with a disorder.

Board. These additional handwritten entries are not dated, initialed, or explained. In addition, respondent's signature is different in both records.

32. On or about December 27, 2005, C.C. saw respondent again who claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

33. Concerning the December 27, 2005 patient visit, the Neurological consultation note sent to MPI is completely blank with the exception of the patient's name and date. However, the record produced to the Board is on different letterhead, and has been filled out. In addition, the cervical facet joint injection procedure note sent to MPI states, inter alia, that the "patient complained of feeling lightheaded immediately following the procedure…." However, the record produced to the Board states that the patient had no complaints following the procedure. In addition, the report produced to the Board notes that the patient "also received kineret subQ injection without any complication." This information is not contained in the record sent to MPI.

34. Patient C.C. saw respondent again on or about January 19, 2006. Respondent claims that he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

35. Also, on or about January 19, 2006, respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease; nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

36. On or about February 7, 2006, respondent saw patient C.C. who denied experiencing

any palpitations, chest pains or loss of consciousness. Nevertheless, respondent ordered that the patient undergo a Transthoracic Echocardiogram[18] (ECHO), which was performed by a technician who reported the preliminary findings. However, the results were not interpreted by a cardiologist, consistent with the standard of practice. Respondent also ordered that the patient undergo a Transcarotid Duplex[19] study even though the patient did not display any risk factors for carotid artery disease or carotid artery dissection, and there was no clinical evidence of vascular pathology involving the anterior circulation.

37. The patient saw respondent again on or about February 24, 2006. Respondent claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

38. Concerning the February 24, 2006 patient visit, the signed EMG/NCV report received by MPI in support of respondent's claim for payment contains two additional sentences under the impression portion of the report that are not in the record produced to the Board. In addition, the EMG/NCV report and the neurological consultation follow-up note sent to MPI do not contain the additional handwritten entries reflected in the records produced to the Board. These additional handwritten entries are not dated, initialed, signed, nor explained. In addition, respondent's signature is different on both EMG/NCV reports.

39. On or about March 11, 2006, C. C. saw respondent again and denied experiencing any palpitations, chest pains, shortness of breath, or loss of consciousness. Nevertheless,

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[18] A Transthoracic (across or though the thoracic cavity or chest wall) Echocardiogram is a diagnostic test that uses ultrasound waves to create an image of the heart muscle and may show such abnormalities as poorly functioning heart valves or damage to the heart tissue from a past heart attack.

[19] A Transcarotid duplex study is a procedure that uses ultrasound to look for blood clots, plaque buildup, and other blood flow problems in the carotid arteries which are located in the neck and supply blood to the brain.

respondent ordered another ECHO even though this study had been performed a month earlier. However, there is no evidence that a cardiologist ever reviewed or interpreted the technician's preliminary findings, consistent with the standard of practice, and respondent did not refer the patient to a cardiologist for further evaluation. In addition, respondent reports, in the signed typewritten follow up neurological note that an "EEG was completed with no evidence of seizures." However, there is no evidence that an EEG was ever performed on this visit.

40. On or about March 26, 2006, respondent saw the patient again. Respondent claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent performed another lumbar facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

41. Regarding the March 26, 2006 patient visit, the facet joint injection procedure note sent to MPI describes the procedure as a "Cervical Facet Joint Injection." However, the record produced to the Board describes the procedure as a "Lumbar Facet Steroid Injection" and is on different letterhead. In addition, the EMG/NCV report sent to MPI lists a different chief complaint, and reports different values for some of the nerves tested in the study than are contained in the record produced to the Board.

42. On or about April 14, 2006, patient C.C. saw respondent again who ordered another EEG. Respondent interpreted the results as abnormal with diffuse slowing and localized spike-and-wave activity in the left hemisphere. However, the body of the report does not support respondent's interpretation as it does not mention that the activity was localized only to the left hemisphere.

43. On or about April 28, 2006, the patient saw respondent again and claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study

had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

44. Concerning the April 28, 2006 patient visit, MPI received medical records from respondent, on or about November 3, 2006, in support of his claim for payment which are different than the records produced to the Board in April 2008. The signed EMG/NCV report received by MPI reflects that a lower extremity study was performed. However, the records produced to the Board reflect that an upper extremity study was performed. In addition, the EMG/NCV report received by MPI contains a different chief complaint, a different impression, and is on different letterhead than the records produced to the Board. Further, the records received by MPI include a lumbar epidural injection record which was not produced to the Board, nor is this procedure referenced in the typewritten follow up neurological visit note signed by respondent.

45. On or about May 10, 2006, respondent saw the patient. Respondent performed another cervical and lumbar facet joint block injections without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

46. On or about May 25, 2006, patient C.C. saw respondent again and claims he performed another needle EMG/NCV of the lower extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

47. Concerning the May 25, 2006 patient visit, MPI received medical records from respondent, on or about January 17, 2007, in support of his claim for payment which included a handwritten signed follow up neurological consultation note, dated 5/25/06, which was not produced to the Board in April 2008.

48. On or about May 26, 2006, respondent saw the patient and ordered that she undergo another EEG, as well as another Carotid duplex study despite no risk factors for carotid artery disease or carotid artery dissection, and no clinical evidence of vascular pathology involving the

anterior circulation. In addition, although the patient denied experiencing any palpitations, chest pains or loss of consciousness, respondent ordered that she undergo another ECHO. The ECHO was performed by a technician who reported the preliminary findings. However, the results were not interpreted by a cardiologist, consistent with the standard of practice, nor did respondent refer the patient to a cardiologist for a consultation or evaluation.

49. Concerning the May 26, 2006 patient visit, MPI received medical records from respondent, on or about November 3, 2006 and on or about January 17, 2007, in support of his claim for payment which are different from the records produced to the Board. The signed follow up neurological consultation note received by MPI is almost completely blank except for the patient's name, date of visit, and impression/plan portion of the record. However, the note produced to the Board has been filled out and does not include the same handwritten entries in the record received by MPI. In addition, the signed "Transcarotid Duplex" report received by MPI reports "irregular calcific plaquing" and that the "degree of stenosis is 20-30 percent in the internal carotid artery." However, these findings are not present in the "Carotid Duplex" report produced to the Board which reports "no clarific plaquing" and "no stenosis."

50. On or about June 19, 2006, the patient saw respondent again who claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent also ordered that the patient receive another infusion of IVIG despite no clinical diagnosis nor any EMG/NCV or other neurophysiological findings indicating that the patient suffers from CIDP. Further, respondent performed another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

51. Concerning the June 19, 2006 patient visit, the signed EMG/NCV report sent to MPI does not contain all of the impressions noted in the record produced to the Board, contains a different summary of findings, and respondent's signature is different. An additional follow up

neurological consultation note was sent to MPI that was not produced to the Board. In addition, the IVIG record sent to MPI is on different letterhead, reflects different start and end times, temperatures, pulse and blood pressure readings, inter alia, than what is contained in the record produced to the Board.

52. On or about July 27, 2006, respondent saw the patient again. Respondent ordered that the patient undergo a fourth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study at this time.

53. Respondent saw patient C.C. again on or about October 18, 2006. Respondent claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

54. C.C. saw respondent again on or about November 7, 2006. However, it is unclear what the patient complained of as there are two separate records for this visit reflecting different complaints. Respondent ordered a third Carotid duplex study despite the patient having no risk factors for carotid artery disease or carotid artery dissection, and no clinical evidence of vascular pathology involving the anterior circulation. Respondent also ordered a fifth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study.

55. Concerning the November 7, 2006 patient visit, the "Transcarotid Duplex" report received by MPI, in or about February 2007, in support of respondent's claim for payment reports "irregular calcific plaquing" and that the "degree of stenosis is 20-30 percent in the internal carotid artery." However, these findings are not present in the Carotid Duplex" report sent to the Board which reports "no" or "regular calcific plaquing" and no "evidence of stenosis." In addition, the report sent to MPI lists a technician and date of birth which are not included in the record produced to the Board. Further, the handwritten follow up note received by MPI does not contain the additional handwritten impression, inter alia, which is in the record produced to the Board.

56. On or about December 5, 2006, respondent saw the patient again. Respondent

ordered the patient undergo a fourth Carotid duplex study. This study was not necessary and had been performed less than a month earlier with completely different findings[20]. Respondent also claims he performed another needle EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

57. On or about December 29, 2006, the patient saw respondent again who administered another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

58. On or about January 26, 2007, respondent saw the patient again and claims he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent administered another cervical facet joint block injection without any evidence or diagnostic imaging showing that the patient suffered from facet joint disease, nor had she been diagnosed with that condition. In addition, respondent failed to utilize fluoroscopy during the procedure.

59. On or about February 8, 2007, patient C. C. saw respondent again who ordered the patient undergo a sixth EEG despite no new physical findings or symptoms severe enough to warrant a repeat of this study at this time.

60. On or about February 16, 2007, respondent saw the patient again and ordered the patient undergo a seventh EEG even though this same study had been performed a week earlier, and there were no new physical findings or symptoms severe enough to warrant a repeat of this study at this time. In addition, respondent reports in the follow up neurological visit notes that an EMG/NCV of the upper extremities was "completed and showing worsening of cervical

[20] Interestingly, this study records the "irregular calcific plaquing" and the" 20-30 percent" degree of stenosis reported in the May 26, 2006 and November 7, 2006 studies sent to MPI.

Radiculopathy." However, there is no evidence that an EMG/NCV study was ever performed on this visit.

61. On or about February 23, 2007, a MRI of the patient's cervical spine was performed at ProHealth Advanced Imaging which revealed that all the facet joints were normal, and there was no evidence of canal stenosis or facet joint disease. Additionally, the patient underwent an MRI of the brain, with and without contrast, which was reported as normal.

62. On or about February 26, 2007, respondent saw the patient again for a follow-up visit. There is a conflict in the neurological findings as respondent notes that "sensation diminished to lateral aspects forearm and diminished in lower extremities" in the neurological examination. However, he also notes that "sensation was intact to touch and pinprick in upper and lower extremities," which is inconsistent. In addition, he ordered a fifth Carotid duplex, which was not necessary.

63. On or about February 28, 2007, C.C. saw respondent again who performed another cervical facet joint injection despite the MRI findings, five days earlier, showing no facet joint pathology. Respondent also claims that he performed another needle EMG/NCV of the upper extremity. Respondent interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

64. On or about April 14, 2007, the patient saw respondent who performed another unnecessary cervical facet join. Respondent also ordered the ninth EEG, which was not necessary.

65. On or about April 24, 2007, respondent saw the patient again for a follow up visit. Respondent performed another unnecessary cervical facet join injection. Respondent also claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

66. Patient C. C. saw respondent again on or about May 2, 2007. Respondent ordered a

tenth EEG. However, this study was not necessary and had been performed less than a month earlier.

67. On or about May 11, 2007, the patient saw respondent again who performed another unnecessary cervical facet injection. Respondent also claims he performed another needle EMG/NCV of the upper extremity, which he interpreted, summarized, and signed the report. However, this study was not performed. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study.

68. On or about June 25, 2007, patient C.C. was last seen by respondent who performed another unnecessary cervical facet block injection. In addition, there is a discrepancy in the records as the cervical facet joint injection procedure note sent to MPI is on different letterhead, contains, inter alia, a different narrative and procedure description than the record produced to the Board.

69. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting gross negligence as follows:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred;

B. By fabricating the administration of and creating carotid duplex study reports which never occurred;

C. By prescribing facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

D. By failing to dispense and administer facet joint block injections utilizing fluoroscopy; and

E. By altering and modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient C.C.)

70. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and

treatment of patient C.C. The circumstances are as follows:

71. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

72. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated negligent acts:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred;

B. By fabricating the administration of and creating carotid duplex study reports which never occurred;

C. By prescribing facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

D. By failing to dispense and administer facet joint block injections utilizing fluoroscopy;

E. By altering and modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

F. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, non transient ischemic attack;

G. By failing to interpret the electroencephalogram (EEG) studies properly;

H. By prescribing and administering Immunoglobulin (IVIG) without any clinical diagnosis, EMG/NCV or neurological findings showing that the patient suffered from chronic inflammatory demylinating polyneuropathy (CIDP); and

I. By failing to refer the patient to a cardiologist for evaluation and review of echocardiographic (ECHO) studies, and to pursue additional diagnostic testing to evaluate the patient's condition.

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THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing of Treatment and Use of Diagnostic Procedures)

(Patient C.C.)

73. Respondent is subject to disciplinary action under section Business and Professions Code section 725, subdivision (a), in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment and use of diagnostic procedures in his care and treatment of patient C.C. The circumstances are as follows:

74. Paragraphs 11 through 68, inclusive, above are incorporated herein by reference as if fully set forth.

75. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated acts of clearly excessive prescribing and administering drugs and treatment, and use of diagnostic procedures:

A. By prescribing, administering and utilizing repeated electromyography/nerve conduction velocity (EMG/NCV) studies with no new symptoms, findings or circumstances justifying the repeat study;

B. By prescribing, dispensing, and administering facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis;

C. By prescribing, administering, and utilizing repeated electroencephalogram (EEG) studies with no new symptoms, findings or circumstances justifying the repeat study;

D. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, nor transient ischemic attack;

E. By prescribing and utilizing repeated echocardiogram (ECHO) studies with no new symptoms, findings or circumstances justifying the repeat study; and

F. By prescribing, furnishing, dispensing, and administering infusions of Immunoglobulin (IVIG) without a diagnosis of chronic inflammatory demylinating polyneuropathy (CIDP).

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FOURTH CAUSE FOR DISCIPLINE

(Fraud – Patient C.C.)

76. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient C.C. The circumstances are as follows:

77. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

78. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting fraud:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By knowingly preparing, making and/or subscribing different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim; and

C. By knowingly subscribing carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient C.C.)

79. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient C.C. The circumstances are as follows:

80. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

81. Respondent committed acts in the care and treatment of patient C.C constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By knowingly preparing, making and/or subscribing different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

C. By knowingly subscribing carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim.

D. By prescribing, dispensing, and administering facet joint block injections when the diagnostic imaging showed no anatomic evidence of facet joint disease or canal stenosis;

E. By prescribing, administering, and utilizing repeated electroencephalogram (EEG) studies with no new symptoms, findings or circumstances justifying the repeat study;

E. By prescribing and administering carotid duplex studies with no clinical evidence of vascular pathology involving the anterior circulation or symptoms consistent with a dissection involving any of the anterior or posterior neck vessels, nor transient ischemic attack;

G. By prescribing and utilizing repeated echocardiogram (ECHO) studies with no new symptoms, findings or circumstances justifying the repeat study; and

H. By prescribing, furnishing, dispensing, and administering infusions of Immunoglobulin (IVIG) without a diagnosis of chronic inflammatory detnylinating polyneuropathy.

SIXTH CAUSE FOR DISCIPLINE

(False Representations – Patient C.C.)

82. Respondent is subject to disciplinary action under Business and Professions Code

section 2261 in that he knowingly made or signed a document directly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient C.C. The circumstances are as follows

83. Paragraphs 11 though 68, inclusive, above are incorporated herein by reference as if fully set forth.

84. Respondent committed acts where he knowingly made and or signed documents directly related to the practice of medicine in the care and treatment of patient C.C which falsely represented the existence or nonexistence of facts constituting false representations:

A. By knowingly making and subscribing numerous needle EMG/NCV report studies, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly making and subscribing different facet joint injection block procedure notes, and falsely reporting the findings; and

C. By knowingly subscribing carotid duplex report studies for the same date reflecting markedly different findings.

SEVENTH CAUSE FOR DISCIPLINE

(Altering or Modifying Medical Records or Creating False Medical Records – Patient C.C.)

85. Respondent is subject to disciplinary action under Business and Professions Code section 2262, in that he altered or modified the medical record of any person, with fraudulent intent, or created any false medical record, with fraudulent intent, in his care and treatment of patient C.C. The circumstances are as follows:

86. Paragraphs 10 though 67, inclusive, above are incorporated herein by reference as if fully set forth.

87. Respondent altered and modified, and created false medical records, with fraudulent intent, in the care and treatment of patient C.C.:

A. By creating and subscribing needle EMG/NCV report studies, which were not performed, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

B. By creating different facet joint injection block procedure notes for the same date reflecting different information, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim;

C. By creating, altering or modifying carotid duplex report studies for the same date with different findings, with the intent to present, use, or to allow the studies to be presented or used in support of a false or fraudulent claim; and

D. By altering and or modifying the medical records of the patient with no medical justifications, explanations, dates, or initials.

EIGHT CAUSE FOR DISCIPLINE

(Gross Negligence – Patient M.E.)

88. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient M.E. The circumstances are as follows:

89. On or about March 6, 2006, patient M.E., a then 29-year-old female, presented to respondent with complaints of increased weakness, tingling and numbness in both legs and left arm. Physical examination revealed, among other things, proximal motor weakness in the lower and upper extremities, although there is a discrepancy between the handwritten and typewritten note regarding the severity of the weakness. Respondent claims he performed an EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. However, only patch electrodes were used during the study. Even if this study had been performed, respondent's summary of the findings would not be supported by a review of the actual data listed in the study. Respondent's clinical impression was that the patient suffered from chronic inflammatory demylinating neuropathy[21]. However, there were insufficient findings to support this diagnosis. The patient's weight was not recorded on this visit.

90. On or about March 27, 2006, respondent saw patient M.E. again and did not record her weight. Respondent ordered that she be administered 42 grams of IVIG. Respondent did this

[21] Neuropathy is a functional disturbance or pathological change in the peripheral nervous system, sometimes limited to noninflammatory lesions as opposed to those of neuritis.

without knowing her weight which was necessary to determine the proper dosage. In addition, the entire dosage, which was administered in two hours, should have been administered daily in smaller dosages for a period of time for a number of series over a period of several weeks.

91. On or about April 3, 2006, respondent saw patient M.E. again and did not record her weight. He ordered that she be administered 42 grams of IVIG, which was administered over a three hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

92. On or about April 17, 2006, respondent saw patient M.E., and again did not record her weight. He ordered that she be administered an unknown dosage of IVIG over what appears to be a five-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

93. Respondent saw patient M.E. on or about May 1, 2006, and did not records her weight. He ordered that she be administered 42 grams of IVIG, which was administered in less than a three-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

94. On or about May 10, 2006, patient M.E. was seen by respondent and her weight was again not recorded. Respondent ordered that she be administered 50 grams of IVIG, which was administered over an unknown period of time as no end time is reflection in the record. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

95. On or about June 21, 2006, patient M.E. was again seen by respondent who again failed to record her weight. Respondent ordered that she be administered 62 grams of IVIG, which was administered over a two-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

96. On or about June 28, 2006, respondent saw patient M.E. again and failed to record her weight. Respondent ordered that she be administered another 62 grams of IVIG, which was administered over a five-hour period. However, the dosage should have been based on the patient's weight, which was unknown, and the entire dosage should have been administered over a longer period of time in smaller dosages.

97. Patient M.E. saw respondent on or about July 17, 2006, for an office visit. However, respondent billed the Motion Picture Industry Pension & Health Plans (hereinafter referred to as MPI), patient M.E.'s insurance company, for an office visit and needle EMG/NCV he claims he performed on this day. However, this study never occurred, and there are no medical records for this date.

98. On or about July 19, 2006, respondent claims he saw patient M.E. and performed another needle EMG/NCV of the upper and lower extremities. Respondent interpreted, summarized, and signed the report. In addition, respondent claims the patient was administered 36 grams of IVIG, over an unknown amount of time. However, this visit did not occur.

99. MPI received medical records from respondent, in or about 2007, in support of his claim for payment. Included in those records was an Immune Globulin IV Human Infusion (IVIG) record, and a two page patient visit note dated August 21, 2006, which was not produced to the Board on or about April 9, 2008. However, this visit never occurred. Respondent nevertheless billed MPI over $10,000.00 for this visit.

100. Respondent claims he saw patient M.E. for an office visit on or about September 11, 2006. However, this visit never occurred and there are no medical records for this date. Nevertheless respondent billed MPI for an office visit.

101. Respondent claims he saw patient M.E. for an office visit on or about October 17, 2006. However, this visit never occurred and there are no medical records for this date. Nevertheless respondent billed MPI for an office visit and various medical procedures which were never performed.

102. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting gross negligence by fabricating the administration of and creating a needle

electromyography/nerve conduction velocity (EMG/NCV) report for a study which never occurred.

NINTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient M.E.)

103. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient M.E. The circumstances are as follows:

104. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

105. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting repeated negligent acts:

A. By fabricating the administration of and creating needle electromyography/nerve conduction velocity (EMG/NCV) study reports which never occurred.

B. By diagnosing the patient with chronic inflammatory demyelinating polyneuropathy without sufficient diagnostic or neurophysiological findings supporting such a diagnosis;

C. By prescribing, dispensing and administering Immunoglobulin (IVIG) without knowing and utilizing the patient's weight to determine the proper dosage; and dispensing and administering the infusions outside of the recommended schedule.

TENTH CAUSE FOR DISCIPLINE

(Fraud – Patient M.E.)

106. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient M.E. The circumstances are as follows:

107. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

108. Respondent committed acts and omissions in the care and treatment of patient M.E. constituting fraud:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim; and

B. By knowingly preparing, making and/or subscribing IVIG records for services and treatment not rendered on August 21, 2006, with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim.

ELEVENTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient M.E.)

109. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient M.E. The circumstances are as follows:

110. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

111. Respondent committed acts in the care and treatment of patient M.E. constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim; and

B. By knowingly preparing, making and/or subscribing IVIG records for services and treatment not rendered on August 21, 2006, with the intent to present, use, or to allow them to be presented or used in support of any false or fraudulent claim; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered with the intent to present, use, or to allow them to be presented or used in support of

any false or fraudulent claim.

TWELFTH CAUSE FOR DISCIPLINE

(False Representations — Patient M.E.)

112. Respondent is subject to disciplinary action under section Business and Professions Code section 2261 in that he knowingly made or signed a document directly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient M.E. The circumstances are as follows:

113. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

114. Respondent knowingly made and/or signed documents directly related to the practice of medicine in the care and treatment of patient M.E which falsely represented the existence or nonexistence of facts constituting false representations:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly preparing and/or making patient visit notes and FVIG records for services and treatment not rendered on August 21, 2006; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered.

THIRTEENTH CAUSE FOR DISCIPLINE

(Creating False Medical Records – Patient M.E.)

115. Respondent is subject to disciplinary action under section Business and Professions Code section 2262, in that he created false medical records, with fraudulent intent, in his care and treatment of patient M.E. The circumstances are as follows:

116. Paragraphs 89 through 101, inclusive, above are incorporated herein by reference as if fully set forth.

117. Respondent committed acts of fraudulently creating false medical records in the care and treatment of patient M.E.:

A. By knowingly preparing, making and/or subscribing needle EMG/NCV study reports, which were not performed, and summarizing the findings which are not supported by the data listed in the study;

B. By knowingly preparing and/or making patient visit notes and IVIG records for services and treatment not rendered on August 21, 2006; and

C. By knowingly preparing, making and/or subscribing bills for services and treatment not rendered.

FOURTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence—Patient C.P.)

118. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of patient C.P.. The circumstances are as follows:

119. On or about September 7, 2006, patient C.P., a then seventy-five-year-old female, presented to respondent with complaints of nervousness, anxiety and neck pain radiating into her shoulders. An EMG/NCV of the patient's upper extremities was performed indicating the patient presents with numbness, tingling in the bilateral upper and lower extremities. However, the patient had no complains related to her lower extremities on this visit. Respondent summarized and interpreted the EMG/NCV findings and signed the report indicating, inter alia, that the "bilateral....tibial and peroneal motor nerves revealed prolonged distal latency," and the "bilateral H-reflexes were normal." However, the H-reflexes, and the tibial and peroneal nerves are not tested in an upper extremity study, as they are lower extremity nerves. Respondent also prescribed the patient Marinol[22] even though the patient was not anorexic, receiving chemotherapy nor having problems with nausea and vomiting.

120. On or about September 14, 2006, patient C.P. saw respondent for a follow-up visit. Although she had no complaints of dizziness or vertigo, and no symptoms consistent with anterior-circulation ischemic symptomatology, respondent nevertheless ordered that the patient

[22] Marinol is a trademark for the drug dronabinol, which is one of the major active substances in cannabis, used as an antiemetic for cancer chemotherapy to control nausea and vomiting and anorexia and weight loss.

undergo a Transcarotid duplex study for dizziness/vertigo. The study, performed by technician German Elenes, revealed "irregular calcific plaquing", but no evidence of stenosis. Respondent signed the report.

121. On or about September 25, 2006, respondent's office faxed patient C.P. a copy of her medical records. Included in the records was a signed EMG/NCV report, dated 9/7/2006, which describes the chief complaint as "numbness and tingling, neck pain radiating to the bilateral upper extremities and hands." However, this report is markedly different from the one produced to the Board on or about October 24, 2007, in that it contains different: chief complaints; findings; and impressions, inter alia. In addition, this report is also markedly different from the one faxed to the patient in December 2006 as further discussed below.

122. In addition, concerning the September 25, 2006 fax, the Transcarotid duplex report, dated 9/7/2006, notes the technician as German Elenes and revealed 20-30 percent degree of stenosis in the right and left Doppler findings, "an abnormal, low amplitude Doppler signal" in "the proximal and distal vertebral artery." However, this report is markedly different from the report faxed to the patient in December 2006, as further discussed below. Further, this report was not produced to the Board in October 2007.

123. On or about December 11, 2006, respondent's office faxed the patient an additional copy of her medical records. Included in the records was a signed EMG/NCV report, dated 9/7/2006, which reflects a different chief complaint than the report faxed to the patient in September 2006, and contains an additional impression that is not contained in the record produced to the Board.

124. In addition, concerning the December 11, 2006 fax, the Transcarotid duplex report, dated 9/14/2006, lists the technician as Annalee, and notes the correct patient date of birth. This report indicates that no stensosis or any abnormal calcific plaquing was revealed, and reports that "a normal Doppler signal" was "detected in the proximal and distal vertebral artery." However, this report is markedly different from the report faxed to the patient in September 2006 which contains different findings, descriptions, and technicians. In addition, this report was not included in the records produced to the Board in October 2007. However, the transcarotid duplex report

produced to the Board notes a different technician who reports "irregular calcific plaquing in the internal carotid" arteries.

125. Respondent committed acts and omissions in the care and treatment of patient C.R. constituting gross negligence as follows:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

FIFTEENTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient C.P.)

126. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient C.P. The circumstances are as follows:

127. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

128. Respondent committed acts and omissions in the care and treatment of patient C.C. constituting repeated negligent acts:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

E. By failing to take an inadequate initial history and physical examination on the initial

patient visit;

E. By failing to formulate an adequate patient management plan;

G. By prescribing, administering and utilizing carotid ultrasounds despite no patient symptoms for cerebrovascular disease; and

H. By prescribing Marinol when there was no indication that the patient was anorexic or had nausea or vomiting.

SIXTEENTH CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing of Treatment and Use of Diagnostic Procedures)

(Patient C.P.)

129. Respondent is subject to disciplinary action under Business and Professions Code section 725, subdivision (a), in that he engaged in repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment and use of diagnostic procedures in his care and treatment of patient C.P. The circumstances are as follows:

130. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

131. Respondent committed acts in the care and treatment of patient C.P. constituting repeated acts of clearly excessive use of diagnostic procedures by ordering the patient undergo carotid duplex studies with no patient symptoms for cerebravascular disease.

SEVENTEENTH CAUSE FOR DISCIPLINE

(Fraud – Patient C.P.)

132. Respondent is subject to disciplinary action under Business and Professions Code section 810, subdivision (a)(2), in that he knowingly prepared, made or subscribed writings with the intent to present, use, or to allow it to be presented or used in support of any false or fraudulent claim in his care and treatment of patient C.P. The circumstances are as follows:

133. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

134. Respondent committed acts and omissions in the care and treatment of patient C.P. constituting fraud:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption – Patient C.P.)

135. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts involving dishonesty or corruption which are substantially related to the qualifications, functions, and duties of a physician in his care and treatment of patient C.P. The circumstances are as follows:

136. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

137. Respondent committed acts in the care and treatment of patient C.P. constituting dishonesty and corruption substantially related to the qualifications, functions and duties of a physician:

A. By fabricating and creating carotid duplex study reports with different findings;

B. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

C. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

NINETEENTH CAUSE FOR DISCIPLINE

(False Representations – Patient C.P.)

138. Respondent is subject to disciplinary action under Business and Professions Code section 2261 in that he knowingly made or signed a document directly related to the practice of

medicine which falsely represents the existence or nonexistence of a state of facts in his care and treatment of patient C.P. The circumstances are as follows:

139. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

140. Respondent knowingly made and signed documents directly related to the practice of medicine in the care and treatment of patient C.P which falsely represented the existence or nonexistence of facts constituting false representations:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity (EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

TWENTIETH CAUSE FOR DISCIPLINE

(Altering or Modifying Medical Records or Creating False Medical Records—Patient C.P.)

141. Respondent is subject to disciplinary action under Business and Professions Code section 2262, in that he altered or modified the medical record of any person, with fraudulent intent, or created any false medical record, with fraudulent intent, in his care and treatment of patient C.P. The circumstances are as follows:

142. Paragraphs 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

143. Respondent altered and modified, and created false medical records, with fraudulent intent, in the care and treatment of patient C.P.:

A. By failing to properly interpret and summarize the findings in the electromyography/nerve conduction velocity (EMG/NCV) study;

B. By fabricating and creating carotid duplex study reports with different findings;

C. By fabricating and creating electromyography/nerve conduction velocity

(EMG/NCV) reports with different findings, chief complaints, inter alia; and

D. By altering and modifying the patient's medical records of the patient with no medical justifications, explanations, dates, or initials.

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records – All Patients)

144. Respondent is subject to disciplinary action under section Business and Professions Code section 2261 in that he failed to maintain adequate and accurate medical records in his care and treatment of patients C.C., M.E. and C.P. The circumstances are as follows:

145. Paragraphs 11 through 68, 89 through 101, and 119 through 124, inclusive, above are incorporated herein by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 72928, issued to respondent, GUVEN UZUN, M.D.

Revoking, suspending or denying approval of respondent's authority to supervise physician assistants, pursuant to section 3527 of the Code;

2. Ordering respondent to pay the Medical Board of California the reasonable costs of probation monitoring, if placed on probation; and

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

DATED: January 21, 2010

BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 5 20 15
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: GUVEN UZUN, M.D. Post Office Box 12843 Marina Del Rey, California 90295 Physician's and Surgeon's Certificate Number A 72928, Respondent.	Case No. 800-2014-008477 ACCUSATION AND PETITION TO REVOKE PROBATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California ("Board").

2. On August 24, 2000, the Board issued Physician's and Surgeon's Certificate Number A 72928 to Guven Uzun, M.D. ("Respondent"). That license was in effect at all times relevant to the charges brought herein, but subject to the prior disciplinary order below, and will expire on March 31, 2016, unless renewed.

3. In a disciplinary action entitled *In the Matter of Accusation Against Guven Uzun, M.D.*, Case No. 06-2007-181358, the Board issued a decision on March 24, 2011 (effective April

22, 2011), in which Respondent's Physician's and Surgeon's Certificate was revoked. However, the revocation was stayed and Respondent's Physician's and Surgeon's Certificate was suspended for six months, and placed on probation for a period of eight years on numerous terms and conditions. A copy of that decision is attached hereto as Exhibit A and is incorporated herein by reference.

4. Respondent's prior disciplinary history with the Board is described in the Discipline Considerations below.

JURISDICTION

5. This Accusation and Petition to Revoke Probation is brought before the Board under the authority of the following laws and in accordance with the Board's decision *In the Matter of Accusation Against Guven Uzun, M.D.*, Case No. 06-2007-181358. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2004 of the Code provides, in pertinent part:

"The board shall have the responsibility for the following:

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

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

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

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

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

"(f) . . . (i)."

7. Section 2229, subdivision (a), of the Code states, in pertinent part "Protection of the public shall be the highest priority for the Division of Medical Quality[1] . . . and administrative

[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practices Act (Bus. & Prof. Code § 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

8. Section 2227 of the Code states, in pertinent part:

(a) "A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code . . . , or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:

(1) Have his . . . license revoked upon order of the division.

(2) Have his . . . right to practice suspended for a period not to exceed one year upon order of the division.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

(4) . . . ."

(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper."

"(b) Any matter heard pursuant to subdivision (a) . . . is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

9. Section 2234 of the Code, provides, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) - (h)."

10. Section 725, subdivision (a) of the Code states that repeated acts of clearly excessive use of diagnostic procedures is unprofessional conduct for a physician and surgeon.

11. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

GENERIC FACTS

12. The Probation Inspector assigned to Respondent is Inspector K.M.

13. The Supervising Probation Inspector I is Supervising Inspector R.L.

14. PACE refers to the University of California at San Diego (UCSD) Physician Assessment and Clinical Education Program.

15. The PACE case manager assigned to Respondent is PACE manager P.R.

16. PACE PEP refers to the PACE Program's Professional Enhancement Program.

17. The PACE PEP Faculty Mentor assigned to Respondent is PEP mentor S.E. or Dr. S.E.[2]

18. Respondent's Billing and Practice monitor is P&B monitor R.Y. or Dr. R.Y.

19. CPEP refers to the Center for Personalized Education for Physicians (CPEP)

[2] Dr. S.E. is a neurologist and Associate Clinical Professor of Neurosciences at the University of California, San Diego (UCSD). He was also one of Respondent's Phase I & II PACE evaluators.

Program.

20. The Quality Review Coordinator for CPEP is CPEP Coordinator J.S.

21. The Program Services Director for CPEP is CPEP Director M.M.

FIRST CAUSE TO REVOKE PROBATION

(Failure to Successfully Participate in and Complete Professional Enhancement Program)

22. Paragraphs 12 through 21, inclusive, above are incorporated by reference as if fully set forth herein.

23. At all times after the effective date of Respondent's probation, Condition 5 states, in pertinent part:

CLINICAL TRAINING PROGRAM After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

24. Respondent's probation is subject to revocation because he failed to comply with Probation Condition 5, referenced above. The facts and circumstances regarding this violation are as follows:

25. On or about January 5, 2012, PEP mentor S.E. reported his review of seven charts from Respondent's practice from November 2011, pursuant to Condition 5 of Respondent's probation. Six of the charts submitted failed to meet the standard, and many of the chart notes had "quite limited descriptions of the patient's clinical presentation and past medical history" and "frequently [Respondent's] documentation of the neurologic examination does not follow his own template's schema, evidences contradictions within the same note, and uses subjective or

referential language such as 'unchanged from prior,' 'the same,' 'worsened,' or 'better,' without adequate establishment of normal values." Further, Respondent's "impressions and diagnoses are typically lists of diseases or injuries, many of which are unsupported by the documentation provided." In addition, Respondent's billings "suggest disparate billing for similar services across patients, and the majority of [Respondent's] billing would not be supported by the documentation provided," which was particularly relevant since Respondent was previously disciplined for failures of documentation and billing irregularities.

PEP mentor S.E. reported that Respondent "remains quite opposed to any argument that his billing is inappropriate or that his documentation should be more complete" and continues to "believe that current reimbursement and documentation practices are unfair, and that if he attempted to follow them, he would not be able to operate his business in a profitable fashion." PEP mentor S.E. further reported that Respondent "continues to also believe that his sanctions were part of a 'scam,' and are not reflective of a problem in his style of practice."

26. On or about January 31, 2012, Inspector K.M. informed Respondent that he must immediately implement any and all recommendations made by the PEP faculty mentor (i.e., PEP mentor S.E.).

27. On or about February 23, 2012, PEP mentor S.E. wrote a letter to the administrator of the PACE PEP program formally documenting a telephone conversation with Respondent on February 21, 2012. In that conversation, Respondent told PEP mentor S.E. that he had received "an intimidating and hostile letter" from the prosecutor assigned to his case, and that "she [the female prosecutor] is out to get" Respondent and that they (PEP mentor S.E. and Respondent) could "work out anything [they] needed to between" them, and that PEP mentor S.E. "should not put anything in [his] report that would give her ammunition to hurt him." PEP mentor S.E. reported that Respondent had made similar statements in the past, but had not previously linked them to PEP mentor S.E. modifying his evaluation of Respondent's performance.

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28. On or about March 27, 2012, PEP mentor S.E. generated a report of his review of seven of Respondent's patient charts from December 2011.[3] All of the charts reviewed failed to meet the standard. The same deficiencies were noted as referenced in the previous report, and the report continues by noting that "multiple notes include extensive electrodiagnostic studies of questionable indication." PEP mentor S.E. found that Respondent's billing records appeared elevated for these single patient visits, and noted that one visit generated $9,345 in billing, $7,190 for another, $4,520 for another, $4,156 for another, and $4,150 for another patient.

29. On or about March 29, 2012, PEP mentor S.E. generated another report in which he reviewed six of Respondent's patient charts from January 2012.[4] Out of the six charts reviewed, three failed to meet the standard and the other three contained borderline documentation to meet the standard. In addition to the same deficiencies previously identified, PEP mentor S.E. found that "multiple notes include electrodiagnostic studies of highly questionable indication, and several encounters do not clearly establish an indication for the performed interventional pain procedure." PEP mentor S.E. found that one patient was billed $6,830 for a single visit, another $5,890, another $4,990, and another $3,880.

30. Additionally on or about March 29, 2012, PEP mentor S.E. generated a report reflecting his review of seven of Respondent's patient charts from February 2012. These chart notes, however, did not include billing information. All of the charts reviewed failed to meet the standard and, in addition to the deficiencies previously noted, "several encounters include overtly inaccurate interpretations of electrodiagnostics studies as well as totally inaccurate assessments."

31. On or about June 1, 2012, PEP mentor S.E. generated another report where he reviewed seven more of Respondent's patient chart notes from April 2012. All of the charts reviewed failed to meet the standard. PEP mentor S.E. found that Respondent's "studies often are inappropriately performed, and are either incorrectly recorded or incorrectly interpreted." The accompanying billing records reflect that one patient visit generated $6,120 in billing, another

[3] This review contained a chart for patient S.E. (erroneously identified as ES), who is one of the patients Respondent was interviewed about and is the subject of the concurrent accusation filed against Respondent herein.

[4] This review contained a chart for patient G.S. who is another one of the patients Respondent was interviewed about, and is the subject of the concurrent accusation filed against Respondent in this matter.

$6,055, and another two were billed $3,685 each for their visits. PEP mentor S.E. found that Respondent's billing records, in addition to the other billing records he previously reviewed, reflect a "trend of markedly elevated billing patterns."

32. On or about July 10, 2012, Respondent had his second and third quarter interview with Inspector K.M., who informed Respondent that he needed to make major improvements regarding his charting, and that it was critical to follow the recommendations of PEP mentor S.E. Respondent told Inspector K.M. that he did not agree with the recommendations of PEP mentor S.E. During the interview, Respondent also told Inspector K.M. that he had "lost business due to his inability to treat Medi-Cal and Medicare patients" as a result of his discipline by the Board.

33. On or about July 13, 2012, PEP mentor S.E. generated a report of his review of seven of Respondent's patient chart notes from May 2012. Out of the seven chart notes reviewed, six failed to meet the standard and the other one contained "borderline adequate documentation to meet standards." PEP mentor S.E. found all of the deficiencies previously reported, and noted that "Respondent's trend of markedly elevated billing patterns continue" with one single patient encounter generated $9,850 in billing, another $6,625, another $6,225, another $4,555, another $3,855, and another $3,240.

34. On or about October 22, 2012, and October 23, 2012, PEP mentor S.E. generated additional monthly reports for his review of Respondent's patient chart notes from July and August 2012. All of the charts reviewed failed to meet the standard, and reflected the same deficiencies as found in the earlier reports.

35. On October 30, 2012, PEP mentor S.E. wrote a second letter to the UCSD PEP administrator detailing a telephone conversation with Respondent to discuss his July 2012 and August 2012 chart notes. During the conversation, Respondent became angry and repeatedly shouted obscenities at PEP mentor S.E., while questioning the mentor's honesty and integrity, which had happened previously. Respondent had also inappropriately called the cell phone of PEP mentor S.E. after normal business hours, including on weekends, and oftentimes in an agitated state of mind. PEP mentor S.E. was "unwilling to continue working with" Respondent "unless some sort of formal code of conduct is established."

36. On or about November 15, 2012, Respondent was terminated from the UCSD PEP program due to his "repeated pattern of behavior" as described and documented by PEP mentor S.E. Respondent was further notified that the program would not be offering him with an alternate UCSD PEP faculty mentor.

37. On or about November 29, 2012, Respondent had his fourth quarter interview with Inspector K.M. which began by addressing the PEP program. Respondent immediately became argumentative and began making derogatory statements about PEP mentor S.E. Inspector K.M. informed Respondent that his insults were unacceptable and unprofessional, and that the meeting was to discuss Respondent's compliance with the PEP mentor and his overall probation compliance. Respondent was informed that he needed to locate an equivalent program to the UCSD PACE PEP program on or before December 14, 2012.

38. On or about March 17, 2013, Respondent enrolled in the Center for Professional Education for Physicians Program (CPEP).

39. On or about April 26, 2013, at 10:02:24 p.m., Respondent sent an email to PACE case manager P.R. that he and his patients will sue her, PEP mentor S.E. and "your shady/scam program" for "running a scam and not program without an [sic] proof, experimental subjective nonsense with physician that has xenophobic bias."

40. On or about April 29, 2013, PEP mentor S.E. sent a letter to the UCSD PEP administrator documenting four text messages he received from Respondent. The first two messages were sent on April 26, 2013, at approximately 8:56 p.m., stating "Ashole [sic] piece of shit of will sue you! Xenophobic Ashile [sic]." The second message was "Your mother must be whore." That same night, at approximately 9:49 p.m., PEP mentor S.E. received another message stating, "I know your type very well!!" The next morning, at approximately 8:49 a.m., he received another text stating, "Your wife cute send her over aometimes [sic]."

41. On or about June 18, 2013, Respondent was interviewed for his first and second quarter interview with Inspector K.M. Respondent told Inspector K.M. that his practice is being ruined by certain individuals and that someone has been sending "fake patient" to his office for treatment. Respondent further stated that he felt that Supervising Inspector R.L. was the root

cause of all his current problems with the Board and that he knows PEP mentor S.E. was involved too.

42. On or about July 17, 2013, Inspector K.M. received a letter from Respondent inquiring "why Board continue discriminate and why board did [sic] respond properly to letter" from his attorney "to vacate Board 2011 order since illegally obtained." Respondent also wanted to know why the "Board for decade since 2007 continue to harass" his practice with "fake patients."

43. On or about December 13, 2013, Inspector K.M. received a letter from CPEP Coordinator J.S., along with the initial Quality Review Program Summary (QRPS) report for 30 of Respondent's patient charts from April, May and June 2013. Out of the 30 charts reviewed: 20 failed to contain necessary documentation; 18 reflected issues with Respondent's judgment in his care of the patients; and in 26 of the charts, the CPEP Reviewer was unable to determine the appropriateness of Respondent's care due to documentation deficiencies.

44. On or about May 9, 2014, at approximately 3:17 p.m., CPEP's Coordinator J.S. sent Respondent an email along with a copy of CPEP's second QRPS report covering Respondent's charts from July, August and September 2013. Out of the 20 charts reviewed: 14 failed to contain necessary documentation; 12 reflected issues with Respondent's judgment in his care of the patients; and in 16 of the charts, the CPEP Reviewer was unable to determine the appropriateness of Respondent's care due to documentation deficiencies.

45. On or about May 9, 2014, at approximately 5:16 p.m., Respondent sent a reply email to CPEP Coordinator J.S. stating, verbatim:[5]

> "I barely restrained myself from your reviewer nonsense comments and lies especially abandoning case without talking to me consistent with malice and conspiracy which try to prove UCSD pep program fascist reviewer. I know what community practice and I did also sent copy of 4 other doctors who cover my office but your office refused comments on garbage notes written by these doctors shows ongoing bias and premeditated actions. Because these will prove that not just less what community does but proves him wrong all comments.
> It appears that your office trying to show that somehow I am not cooperating which is truthful at all."

[5] This, and other emails, are included verbatim due to numerous misspellings and improper grammar.

"I have all my rights due above fraudulent reviews that doesn't reflect facts or reviewed by nurse, etc…
I also reminder that recent Medicare[6] payments evidence also shows that I am lowest billed and pain doctor in los angeles another proof of ongoing lies. My expert agreed that your doctor did not but nurse reviewed record which is another evidence of illegal dealings in these review process."
Respondent then asked the CPEP Reviewer: "which patient EMG done to many times" and "which patients getting too much IVIG."

46. On May 10, 2014, at approximately 12:02 a.m., Respondent sent another email to CPEP Coordinator J.S., stating verbatim, in pertinent part, "His critiq on this and many other such as this all not reflect truth but other he trying to justify MBC illegally obtained settlement." Respondent continued to criticize the CPEP reviewers critique stating that "Its clear with all and from his past comments that theses guys in touch with san diego guy and ganged against me in such xenophobic symbiotic relations and thus without doubt. truly believe that your reviewer one way other influenced by other factor and has zero objectivity and lying just to prove San diego guys right suggests criminal intent here. I never seen such disgraceful entity and scam."

47. On May 10, 2014, at approximately 5:11 a.m., Respondent sent another email to CPEP Coordinator J.S. stating, verbatim, in pertinent part:

"Your reviewer leaving also because UCSD reviewer left (due to my personal argument) Most Bizzarre acts I ever seen and incomprehensible and proactive. Its clear by doing this your reviewer leaving no options but put me in automatic guilty seat which is premeditated and openly conspired one way other by UCSD since they Its clearly there must be national meeting or something these PEP people gossip about doctor they review etc... This person consider himself doctors, honest ethical and carry MD degree…. I cant find words to describe."

48. On or about May 14, 2014, the Board received CPEP's second Quarterly Review Program Summary, which covered a review of Respondent's patient charts from October, November, and December 2013. Out of the 20 charts reviewed: 11 failed to contain necessary documentation; 13 reflected issues with Respondent's judgment in his care of the patients; and in 13 of the charts, the CPEP Reviewer was unable to determine the appropriateness of Respondent's care due to documentation deficiencies. The CPEP Reviewer commented that there

[6] On or about July 10, 2012, during Respondent's second and third quarter interview with Inspector K.M., Respondent stated that he "has lost business due to his inability to treat Medi-Cal and Medicare patients."

does not appear to be any "improvement in the quality of the documentation over time" and that the "Objective data is concerning. It is almost always copied from the prior note. Seemingly at random to me, exam findings change, and there is rarely any indication as to why, or what plan is in place to figure that out."

The CPEP Reviewer continued that it "is often difficult to figure out how [Respondent] comes up with a differential diagnosis, and what evidence clearly supports his choice of diagnosis." "There are repeat EMG/NCV performed on frequent intervals without a clear rationale." The CPEP reviewer expressed "concerns that [Respondent] is: 1) not understanding the patient complaint; 2) not actually performing the exams that he documents; 3) makes incorrect diagnoses without considering a full differential diagnosis, but in a pattern that leads to the opportunity to perform many tests/procedures. These procedures that he indicates he performs (but inadequately charts) are suspect." As a result, the CPEP reviewer requested to be removed from the case.

49. On or about June 16, 2014, Respondent was terminated from CPEP program.

50. On or about June 26, 2014, at approximately 3:24 a.m., Respondent sent an email to CPEP Director M.M., stating, verbatim, as follows:

> "You have only sent half of the emails. Its very clear in my emails that I need get answer my questions and why did not your reviewer answer my questions if he so ethical and professional. He is is dishonest in many ways as I put in emails and as others commented that he probably using nurse to review records, etc.. he can just talk nonsense if he can come up explanation what he saying or not answering my questions regarding validity of his criticism.Especially we asked you not to review same charts over over again which nothing but redundant and not helping and useless thing to do which will show no improvement or progress falsely and which conveyed to via email by Gladys.
>
> (You were asking your money for the last two months but I as not able to get to it yet and next thing I get is termination email.)You guys can't be ethical and honest in simple things and I am not sure what to expect from you program anything useful or ethical.
> All can tell you that I am very disappointed from this whole so called some kind of arbitrary program without any scientific background. This program nothing else but useless."

51. On or about July 9, 2014, Inspector K.M. notified Respondent that he was again out of compliance with Condition 5, the PEP program. Respondent was informed that he must

submit a replacement professional enhancement program equivalent to the one offered by UCSD PACE by July 14, 2014.

52. On or about July 14, 2014, at approximately 2:40 p.m., Inspector K.M. received a telephone call from Respondent, who was yelling very loudly and using profanity, calling Supervising Inspector R.L. a "bitch" over and over again. Inspector K.M. asked Respondent not to speak to him that way, but Respondent continued calling Supervising Inspector R.L. a "bitch." Inspector K.M. eventually hung up the telephone as Respondent refused to stop yelling insults.

53. On or about July 14, 2014, Inspector K.M. prepared a "non-compliance report" regarding Respondent's violations of the terms and conditions of his probation.

54. Respondent did not enroll in another equivalent PEP program by July 14, 2014.

SECOND CAUSE TO REVOKE PROBATION

(Dishonesty in Quarterly Declarations)

55. Paragraphs 12 through 21, inclusive, above are incorporated herein by reference as if fully set forth.

56. At all times after the effective date of Respondent's probation, Condition 10 states, in pertinent part:

"QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter."

57. On or about January 9, 2012, a medical malpractice lawsuit was filed in the matter entitled *Alvin Labostrie vs. Beverly Hills Pain Institute and Neurology and Guven Uzun, M.D.*, Los Angeles Superior Court case number BC 476 419.[7]

58. On or about February 3, 2012, Respondent was served with the Summons and Complaint in the *Labostrie* case.

[7] Complainant request administrative notice of the *Labostrie* matter.

59. On or about March 22, July 1, and October 8, 2012, January 1, April 1, September 30,[8] and December 21, 2013, April 23, July 14, and October 10, 2014, Respondent declared, under penalty of perjury in his Quarterly Declarations,[9] that there was "no" civil suit or malpractice action pending against him.

60. On or about July 10, and November 29, 2012, June 18, September 24, and December 17, 2013, and March 20, 2014, Respondent was interviewed by Inspector K.M.. When asked if there were any pending malpractice lawsuits against him, Respondent failed to disclose that the *Labostrie* malpractice lawsuit had been pending against Respondent since January 2012, and that as of February 26, 2014, the trial in that matter was trailing to March 24, 2014.[10]

61. On or about July 15, 2014, Inspector K.M. sent Respondent a letter informing him that he was out of compliance with Condition 10, Quarterly Declarations.

THIRD CAUSE TO REVOKE PROBATION

(Failure to Comply with Practice and Billing Monitoring)

62. Paragraphs 12 through 21, inclusive, above are incorporated herein by reference as if fully set forth.

63. At all times after the effective date of Respondent's probation, Condition 6, states, in pertinent part:

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

[8] The Quarterly Declaration covering April – June 2013, the second quarter of 2013, is unsigned.

[9] Immediately above Respondent's signature, the Declaration states, "I hereby submit this Quarterly Declaration as required by the Medical Board of California and its Order of probation thereof and declare under penalty of perjury under the laws of the State of California that I have read the foregoing declaration and any attachments in their entirely and know their contents and that all statements made are true in every respect and I understand and acknowledge that any misstatements, misrepresentations, or omissions of material fact may be cause for further disciplinary action."

[10] The trial in the *Labostrie* matter commenced on March 27, 2014, and ended on April 2, 2014.

"The monitors shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and billing, and whether respondent is practicing medicine safely, and billing appropriately.

"It shall be the sole responsibility of respondent to ensure that the monitors submit the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

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

"Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation."

64. On or about July 18, 2012, Respondent requested that Dr. R.Y. serve as his practice and billing monitor pursuant to Condition 6 of the probationary order. At that time, Dr. R.Y. signed, under penalty of perjury, an agreement to act as Respondent's practice and billing monitor, stating that she "clearly understand[s] the role of a Monitor and what is expected of" her, and agreed to "regularly submit written reports to the assigned Inspector" as detailed in the Monitoring Plan.

65. On or about August 6, 2012, Dr. R.Y. signed the Board's "Monitoring Plan Practice and/or Billing" form (monitoring plan) which required her to "submit a written report *once each quarter* to the assigned investigator" "on her letterhead" bearing her "original signature." The monitoring plan further required that her reports "are due to the assigned Inspector's office *within*

ten (10) calendar days after the end of the preceding quarter" and lists the due dates as no later than April 10, July 10, October 10, and January 10. The monitoring plan also required that the reports shall, at a minimum, specify the patient name and/or medical record number of the charts reviewed, and for monitoring of billing practices, that the report "will also indicate the medical record number of charts and corresponding billing records review per visit."

66. On or about August 20, 2012, Dr. R.Y. was approved to serve as Respondent's practice and billing monitor.

67. On or about November 6, 2012, P&B monitor R.Y. prepared a Practice and Billing Monitor Report (quarterly monitor report) covering Respondent's practice from June to September 2012. This report, however, was unsigned, did not contain the name, medical record number, nor initials of the patient charts reviewed, and failed to specify the corresponding medical record number and corresponding billing records reviewed as required by the monitoring plan.

68. No quarterly monitor report was received for the time covering October to December 2012.

69. On or about April 30, 2013, the Probation Unit received P&B monitor R.Y.'s quarterly monitor report covering Respondent's practice from January to March 2013, which was due no later than April 10, 2013. Respondent, however, failed to provide his billing records to P&B monitor R.Y. covering this quarter as required by Condition 6.

70. On or about July 17, 2013, the Probation Unit received P&B monitor R.Y.'s quarterly report covering Respondent's practice from April to June 2013, due no later than July 10. This report, however, failed to specify the corresponding medical record number and corresponding billing records reviewed as required by the monitoring plan.

71. No quarterly monitor reports were received for the third and fourth quarters, covering Respondent's practice from July to September 2013, and October to December 2013.

72. On or about March 20, 2014, the Probation Unit received P&B monitor R.Y.'s purported fourth quarterly monitoring report, dated December 28, 2013, allegedly covering Respondent's practice from October to December 2013, which was due no later than January 10,

2014. This report, however, is addressed to Respondent's counsel, A.K., and states that P&B monitor was "specifically asked" by Respondent's counsel , A.K., "to consider medical necessity for any testing or other procedure" performed on two patients, identified in the report as "EIL" and "SCH",[11] whom Respondent treated in 2011 and 2012.

73. As of July 14, 2014, Inspector K.M. still had not received P&B monitor R.Y.'s quarterly monitor reports for the fourth quarter of 2012, due no later than January 10, 2012, the fourth quarter of 2013, due not later than January 10, 2014, the first quarter of 2014, due no later than April 10, 2014, and the second quarter 2014 report with an original signature, due no later than July 10, 2014.

74. On or about July 15, 2014, Inspector K.M. notified Respondent that he was out of compliance with Condition 6, the Practice and Billing Monitor.

75. On or about August 7, 2014, Inspector K.M. met with P&B monitor R.Y. and provided her with a Practice Monitor Report Checklist form, a Sample Practice Monitor Report, an Individual Chart Audit form, and a Multiple Chart Audit form. Inspector K.M. informed her that these forms must accompany her monitoring reports and must be submitted with her report, bearing an original signature, within 10 calendar days after the end of the proceeding quarter. She told Inspector K.M. that she understood and agreed to continue as Respondent's billing and practice monitor.

76. On or about September 4, 2014, Inspector K.M. notified Respondent that Dr. R.Y. had agreed to continue as his practice and billing monitor. The letter reminded Respondent that it was his "sole responsibility to ensure that [the monitor] submits the quarterly written reports with an original signature" within 10 calendar days after the end of the preceding quarter.

77. On or about October 20, 2014, the Probation Unit received P&B monitor R.Y.'s quarterly monitor report, which was due no later than October 10, 2014. The report, however, did not include the necessary documents that were required to accompany the report.

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[11] The patients identified as "EIL" and "SCH" were the subject of a review of Respondent's care and treatment, and the Board was attempting to interview Respondent regarding these patients. These two patients are the subject of the Accusation portion of this pleading and are identified as S.E. (aka EIL and ES) and G.S. (aka SCH).

78. On or about October 22, 2014, Inspector K.M. notified Respondent that P&B monitor R.Y. was disqualified as his practice/billing monitor for her repeated failure to comply with all of the monitoring plan. Inspector K.M. informed Respondent that he needed to submit a nominee as a replacement P&B monitor by close of business on October 28, 2014.

79. On or about November 7, 2014, at approximately 10:19 a.m., Respondent sent Inspector K.M. an email with the name of a new proposed practice and billing monitor.

80. On or about November 26, 2014, at approximately 4:30 a.m., Respondent sent another email to Inspector K.M. disagreeing with the removal of P&B monitor R.Y. stating that Supervising Inspector R.L. did this "to Show that I am not compliant with my terms is premeditated." Respondent continued that "In addition past year Glendale fake investigation created by [Supervising Inspector R.L.] by throwing me to Armenian Investigator Mrs. Shenian so she can take Revenge from Turkish doctor. This was malicious intentional, racist and capricious."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Patient G.S.[12])

81. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of patient G.S. The circumstances are as follows:

82. Paragraphs 22 through 54, and 63 to 80, inclusive, above are incorporated by reference as if fully set forth herein.

83. On or about February 28, 2012, patient G.S., a then 27-year old male, first presented to Respondent with chief complaints of neck, lower back, and headache following a motor vehicle accident (MVA) that occurred approximately three weeks earlier.[13] G.S. denied any loss of consciousness in the accident and gave no history of suffering a head trauma. The patient's neurological examination was normal except for mild reflex asymmetry in the upper and lower

[12] For privacy, the patients in the Accusation will be identified by their first and last initials. Their full names will be disclosed to Respondent upon timely request for discovery pursuant to Government Code section 11507.6.

[13] Respondent produced the certified patient chart on or about August 7, 2013.

extremities and a slow gait. Respondent noted moderate tenderness on palpation of the cervical paraspinal musculature with full range of motion, but no neck stiffness. Respondent listed his diagnoses of G.S. as: post-concussive headache/migraine syndrome; status post MVA and head injury; cervical spasm; lumbar spasm; and Respondent wanted to rule out cervical and lumbar radiculopathy.

On this initial visit, Respondent performed an in-office electroencephalogram (EEG)[14] for the patient's headaches and "head injury," however, the patient never reported suffering a head injury in the accident, or any loss of consciousness or any seizure activity that would justify this study at this time. The EEG was normal. Respondent also performed an in-office electromyography (EMG)[15] and nerve conduction velocity test (NCV)[16] of both bilateral upper and lower extremities; testing 68 muscles which Respondent stated took approximately one hour. During the study, Respondent obtained no response of the bilateral tibial H-Reflexs. Respondent's impression of the NCV was that G.S. suffered from "right sided mild carpal tunnel syndrome"[17] in the "bilateral upper extremities." The test results, however, do not support Respondent's impression as G.S. did not have the electrophysiological features for carpal tunnel syndrome. Respondent's further impression was that the patient had "possible S1 radiculopathy," however, the test results do not establish a diagnosis of S1 radiculopathy.

Respondent also ordered a magnetic resonance imaging (MRI)[18] of the patient's brain,

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[14] An EEG is a record of the tiny electrical impulses produced by the brain's activity. By measuring characteristic wave patterns, the EEG can help diagnose certain conditions of the brain.

[15] Electromyography, also referred to as EMG, is a type of test in which a nerve's function is tested by stimulating a nerve with electricity, and then measuring the speed and strength of the corresponding muscle's response. In this test, needle electrodes are inserted into the patient's muscles.

[16] Nerve conduction velocity test, also referred to as NCV, is a test that measures the time it takes a nerve impulse to travel a specific distance over the nerve after electronic stimulation.

[17] The Carpal tunnel is a passageway in the wrist, created by bones and ligaments of the wrist, through which the median nerve (the nerve which runs through the wrist and into the hand) passes. Carpal tunnel syndrome is a disorder caused by compression at the wrist of the median nerve supplying the hand, causing pain and burning, or numbness and tingling paresthesias in the fingers and hand, sometimes extending to the elbow.

[18] Magnetic resonance imaging, commonly referred to as a MRI, is a noninvasive method using nuclear magnetic resonance to render images of the inside of an object. It is primarily used in medical imaging to demonstrate pathological or other physiological alteration of living tissues.

cervical spine and lumbar spine. Respondent also advised the patient to obtain physical therapy/occupational therapy or chiropractic treatment, however, Respondent failed to write a prescription for physical or occupational therapy and failed to refer G.S. to a facility where he could obtain such treatments.

On this visit, Respondent billed $550 for the office visit, $4,320 for the NCV, $380 for the H-Reflex amp study (for which he obtained no response), $640 for the needle EMG, and $1,125 for the EEG, for a total single visit charge of $7,015.

84. On or about March 6, 2012, G.S. returned for a follow-up visit complaining of increased neck, shoulder and low back pain. Respondent's list of diagnoses remained the same as the previous visit, and appears to be cut and pasted into the new chart note. During this visit, Respondent performed "Cervical and Lumbar trigger points" injections, however, there is no report documenting this procedure in the certified chart and Respondent's billing summary does not reflect a charge for this procedure on this date.

85. On or about April 19, 2012, G.S. underwent an MRI of his brain and lumbar spine at an outside facility, which were interpreted as normal. The cervical MRI, however, revealed a 3 to 4 mm left paramedian disc protrusion at C7 – T1, degenerative changes at C2 to C6, and a 13 mm x 6 mm lesion in the left lobe of the thyroid gland consistent with thyroid adenoma[19] or colloid cyst.[20]

86. On or about April 30, 2012, G.S. returned for a follow-up visit complaining of neck and shoulder pain. Respondent noted moderate tenderness on palpation of the cervical paraspinal musculature at C6 to C7, but the patient's range of movement was within normal limits. Respondent's diagnoses were post-concussive headache syndrome, status post MVA, and cervical and lumbar spasm.

Respondent performed "Cervical Trigger point" injections at six different points, however,

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[19] An adenoma is a growth of cells, usually a benign tumor, that forms a gland or gland-like substance. These tumors can secrete hormones or cause changes in hormone production in nearby glands.

[20] A colloid cyst is a cyst with gelatinous contents.

there is no report documenting this procedure in the certified chart. Respondent also had the patient undergo an in-office carotid artery duplex scan[21] even though the patient had no carotid bruits[22] on examination, had no clinical evidence or history of vascular pathology involving the anterior circulation, nor any evidence or history of transient ischemic attack or other similar medical conditions which would justify the scan. The scan was completely normal. Respondent charted that he asked the patient to go to "intense physical therapy" and told G.S. that his symptoms were mostly due to spasm due to "cervical acute disc herniation." G.S., however, did not have a herniated cervical disc.

Respondent failed to write G.S. a prescription for physical or occupational therapy, and failed to refer him to a physical therapy facility or provide a list of facilities which offered such therapies. Respondent also failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

On this visit, Respondent billed $1,350 for the in-office carotid artery duplex scan, $950 for the trigger point injections with ultrasound guidance (for which there is no procedure report), $415 for interpreting the outside MRI of the spinal canal, and $415 for interpreting the MRI of the brain, which had been reported by the outside facility to be normal.

87. On or about May 2, 2012, G.S. returned for another follow-up visit complaining of pain with spasm in his neck and shoulder area. Respondent charted that G.S. stated the injections from two days earlier, and the new medication helped relieve his pain, it returned last night.[23] Respondent noted neck pain and spasm in the midscapular area with "back pain/sapsm [sic] but less." Respondent, however, does not explain how G.S.'s back pain is less since on the prior visit, two days earlier, the patient had no back complaints. Respondent's list of diagnoses are

[21] A carotid artery duplex study is a procedure that uses ultrasound to look for blood clots, plaque buildup, and other blood flow problems in the carotid arteries which are located in the neck and supply blood to the brain.

[22] Bruits is an abnormal auscultatory sound, e.g., due to arterial narrowing or stenosis, determined via a stethoscope or Doppler.

[23] This means that the patient only received one day of relief from the 6-point cervical trigger injections Respondent allegedly performed on April 30, 2012, for which there is no procedure report.

identical to those listed on G.S.'s initial visit of February 28, 2012, including the status post "head injury" and ruling out "cervical and lumbar Radiculopathy," which appears to be copied and pasted from the February note.

Respondent again advised the patient to "intense PT/OT or chiropractic treatment," but Respondent failed to write a prescription, or refer the patient to a physical or occupational therapy facility, or provide the list of facilities to the patient at this visit. Respondent also failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

88. On or about May 18, 2012, G.S. returned for another follow-up visit complaining of severe neck pain. Respondent noted moderate tenderness in the cervical paraspinal muscles at C4 to C7, and moderate tenderness in the paraspinal muscles at L2 to S1, however, the patient had no back complaints on this visit. Respondent's list of "current" diagnoses are identical to those listed on G.S.'s initial visit of February 28, 2012, including the status post "head injury," "lumbar spasm" and ruling out of "lumbar Radiculopathy," which appears to be cut and pasted from the initial visit in February. In his unsigned cervical injection procedure report, Respondent lists the patient's diagnoses as cervical radiculopathy, cervical spinal stenosis, intractable migraine, postconcussive headache, and cervical muscle spasm, however, there is no evidence in the certified chart that G.S. suffered from all these conditions.

Respondent again failed to write a prescription, or refer the patient to a physical or occupational therapy facility, or provide the list of facilities to the patient at this visit. Respondent further failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

89. On or about May 30, 2012, G.S. returned for a further follow-up visit complaining of neck pain radiating into his left shoulder. Respondent's review of systems (ROS) is identical to that of the previous visit, including the misspelling, and appears to have been copied and pasted from the prior note. Respondent noted back pain and spasms even though the patient had no

back complaints on this visit and no tenderness was found upon examination.

Respondent performed another NCV/EMG of the patient's bilateral upper extremities, however, there had been no significant change in the patient's condition to justify repeating this test. Respondent's impression was that G.S. had bilateral cervical radiculopathy at C5-C7, inter alia, however, the test results do not support Respondent's impression for radiculopathy. Respondent's plan was to order physical therapy for the patient, however, there is no prescription or order found in the certified chart indicating that Respondent ordered or prescribed physical therapy on this visit.

Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

90. On or about June 13, 2012, G.S. returned for another follow-up visit complaining of increased neck pain radiating into his left shoulder. Respondent's review of systems (ROS) is identical to the previous visit, including the misspelling, and notes back pain and spasms even though the patient had no back complaints on this visit. In his unsigned procedure note, Respondent performed a cervical thoracic facet steroid injection, under ultrasound guidance, however, the corresponding ultrasound images list a date of June 14, 2012. The consent for the procedure was not signed by the patient, and there is no explanation in the certified chart indicating why someone else signed the consent for the patient who was alert and talking with Respondent during the visit. On this visit, Respondent wrote a prescription for the patient to receive physical or occupational therapy.

Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

91. On or about June 27, 2012, G.S. returned for another follow-up visit with improved neck pain, but now complaints of back pain and spasm. Respondent's review of systems (ROS) is identical to the previous visit, including the misspelling, and it appears to have been copied and pasted from the prior note. Respondent noted moderate tenderness in the paraspinal musculature

at L2 to S1, but the patient's range of motion was normal. Respondent also recorded ankle jerks upon examination. Respondent performed another NCV/EMG of the patient's bilateral extremities, which Respondent interpreted as showing bilateral radiculopathy at L5 and S1, however, the test results do not support a diagnosis of radiculopathy. Respondent again obtained no responses of the bilateral tibial H-Reflexes, demonstrating improper placement of the electrodes or that these areas were not tested.

Respondent ordered a repeat MRI of the patient's lumbar spine and continued physical therapy, however, there is no documentation in the certified chart that the patient was actually receiving physical therapy at this time. Additionally, Respondent failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI in April, and failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

This appears to be the last time G.S. saw Respondent, however, there is a LabCorp lab request form in the certified chart indicating that labs were collected on June 13, 2014 at 3:48 p.m., however, there is no corresponding chart notes reflecting a patient visit on this date.

92. Respondent committed acts of gross negligence, individually and collectively, in his care and treatment of patient G.S. when Respondent:

A. Failed to accurately analyze and interpret the repeat in-office electromyography/nerve conduction velocity (EMG/NCV) studies performed;

B. Failed to appropriately evaluate the large lesion identified on the cervical MRI in the left lobe of the patient's thyroid gland, and/or refer the patient to an endocrinologist or other appropriate professional for its evaluation and treatment;

C. Failed to fully evaluate and initially treat the patient's neck pain and headaches with conservative care and non-interventional treatment;

D. Failed to fully evaluate and initially treat the patient's back pain with conservative case and non-interventional treatment;

E. Failed to initially order physical therapy for the patient while repeatedly performing invasive treatments; and

F. Failed to overall fully, properly and appropriately evaluate and treat the patient's complaints.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Patient G.S.)

93. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of patient G.S. The circumstances are as follows:

94. Paragraphs 82 through 91, inclusive, above are incorporated by reference as if fully set forth herein.

95. Respondent committed repeated negligent acts in his care and treatment of patient G.S. when Respondent:

A. Failed to accurately analyze and interpret the repeat in-office electromyography/nerve conduction velocity (EMG/NCV) studies performed;

B. Failed to appropriately evaluate the large lesion identified on the cervical MRI in the left lobe of the patient's thyroid gland, and/or refer the patient to an endocrinologist or other appropriate professional for its evaluation and treatment;

C. Failed to fully evaluate and initially treat the patient's neck pain and headaches with conservative care and non-interventional treatment;

D. Failed to fully evaluate and initially treat the patient's back pain with conservative case and non-interventional treatment;

E. Performed an ultrasound guided steroid injections prior to obtaining the MRI study showing the patient's anatomic structures and areas of pathology;

F. Ordered a carotid artery duplex scan when the patient had no carotid bruits on examination, had no clinical evidence or history of vascular pathology involving the anterior circulation, nor any evidence or history of transient ischemic attack or other similar medical conditions which would justify the scan;

G. Ordered an EEG when the patient had no history of loss of consciousness, a head injury or a seizure disorder;

H. Performed a NCV/EMG of too many muscles and nerves on the initial visit;

I. Performed repeat NCV/EMGs when there had been no significant changes in the patient's condition to justify repeating these tests;

J. Failed to initially prescribe or order physical therapy before performing invasive treatments;

K. Performed excessive tests and invasive treatments without appropriate indications;

L. Repeatedly performed invasive treatments prior to employing conservative treatments;

M. Billed for testing the H-Reflexes, which were either not performed or obtained;

N. Charged for interpretation a normal MRI of the brain performed by and interpreted by an outside facility; and

O. Failed to maintain adequate and accurate records.

THIRD CAUSE FOR DISCIPLINE

(Excessive/Unnecessary Diagnostic Studies – Patient G.S.)

96. Respondent is subject to disciplinary action under Business and Professions Code section 725, subdivision (a), in that he engaged in repeated acts of clearly excessive and unnecessary use of diagnostic procedures in his care and treatment of patient G.S. The circumstances are as follows:

97. Paragraphs 82 through 91, inclusive, above are incorporated by reference as if fully set forth herein.

98. Respondent committed acts and omissions in the care and treatment of patient G.S. constituting repeated acts of clearly excessive and unnecessary use of diagnostic procedures:

A. By ordering and administering repeat in-office electromyography/nerve conduction velocity (EMG/NCV) studies without appropriate indications justifying the repeat in-office study;

B. By ordering and administering ultrasound guided facet joint injections prior to obtaining the MRI films showing the patient's anatomical structures, and any evidence of facet joint disease or canal stenosis;

C. By ordering, administering and utilizing an in-office electroencephalogram (EEG) study on the initial visit when the patient had no history of seizures, loss of consciousness or head

injury that would justify the study; and

D. By ordering and administering an in-office carotid artery duplex scan when the patient had no carotid bruits on examination, no clinical evidence or history of vascular pathology involving the anterior circulation or history or evidence of transient ischemic attack or other similar conditions that would justify this scan.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence – Patient S.E.[24])

99. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of patient S.E. The circumstances are as follows:

100. Paragraphs 62 through 80, inclusive, above are incorporated by reference as if fully set forth herein.

101. On or about December 16, 2011, S.E., a then 44 year-old female, first presented to Respondent with a chief complaint of headaches on the left side of her head only, and rated her pain as a 4 out of 10. Respondent noted moderate tenderness in the paraspinal musculature of the cervical spine at C4 to C7 with some limited range of motion, however, Respondent failed to specify how, and in what manner, the patient's range was limited.

Respondent ordered an MRI of the patient's brain and cervical spine, and performed an in-office NCV/EMG of the patient's bilateral upper extremities. Respondent's impression was that S.E. had moderate radiculopathy at C5 and C6 on the left, and mild radiculopathy on the right, and mild carpal tunnel syndrome on the right. The test results, however, do not support Respondent's impressions of radiculopathy or carpal tunnel syndrome. Additionally, S.E. had no clinical examination findings for radiculopathy, making the need for this test, along with its findings questionable. Respondent also misinterpreted the normal findings of the median motor and sensory distal latency and amplitude responses in diagnosing carpal tunnel syndrome.

[24] Patient S.E. is also known as "ES" in the March 27, 2012 PEP mentor report and "EIL" in P&B monitor R.Y.'s December 28, 2013 report to Respondent's counsel A.K.

107. Respondent committed repeated negligent acts in his care and treatment of patient S.E. when Respondent:

A. Failed to accurately analyze and interpret the NCV/EMG;

B. Failed to provide appropriate evaluation and treatment of the patient's headaches;

C. Failed to refer the patient to physical therapy;

D. Billed for a venipuncture not performed or supported by the chart;

E. Billed for an H-Reflex study which was either not obtained or performed; and

F. Billed for interpreting an essentially normal MRI of the patient's brain performed and interpreted by an outside facility as showing no significant abnormalities or evidence of acute disease.

SIXTH CAUSE FOR DISCIPLINE

(Dishonesty)

108. Respondent is subject to disciplinary action under Business and Professions Code section 2234, subdivision (e), in that he committed acts of dishonesty substantially related to the qualifications, functions or duties of a physician and surgeon. The circumstances are as follows:

109. Paragraphs 55 through 61, inclusive, above are incorporated by reference as if fully set forth herein.

110. Between on or about March 22, 2012, and October 10, 2014, Respondent failed to comply with the tenth condition of probation. Complainant incorporates the Second (Dishonesty in Quarterly Declarations) Causes to Revoke Probation herein.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

111. Respondent is subject to disciplinary action under Business and Professions Code section 2266, in that he failed to maintain adequate and accurate records for patients S.E. and G.S. The circumstances are as follows:

112. Paragraphs 83 through 91, and 101 through 103, inclusive, above are incorporated by reference as if fully set forth herein.

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DISCIPLINE CONSIDERATIONS

113. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about April 22, 2011, in a prior disciplinary action entitled *In the Matter of the Accusation Against Guven Uzun, M.D.* before the Medical Board of California, in Case No. 06-2007-181358, Respondent's license was revoked, stayed, and suspended for six (6) months, and Respondent was placed on probation for eight (8) years with numerous terms and conditions, for his admissions to acts of gross negligence, repeated negligent acts, and failure to maintain adequate and accurate records in his care and treatment of three patients. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

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

1. Revoking the probation that was granted by the Medical Board of California in Case No. 06-2007-181358 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate Number A 72928 issued to Guven Uzun, M.D.;

2. Revoking or suspending Physician's and Surgeon's Certificate Number A 72928, issued to Respondent;

3. Revoking, suspending or denying approval of his authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. If placed on probation, ordering him to pay the Medical Board of California the costs of probation monitoring; and

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

DATED: June 5, 2015

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

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

In the Matter of the Accusation And Petition to Revoke Probation Against:	)	
GUVEN UZUN, M.D.	)	**Case No. 800-2014-008477**
Physician's and Surgeon's Certificate No. A 72928	)	
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 19, 2017.

IT IS SO ORDERED: June 19, 2017.

MEDICAL BOARD OF CALIFORNIA

Michelle Anne Bholat MD

Michelle Anne Bholat, M.D., Chair,
Panel B

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

In the Matter of the Accusation and Petition to Revoke Probation Against: Guven Uzun, M.D., Physician's and Surgeon's Certificate Number A 72928, Respondent.	Case No. 800-2014-008477 OAH No. 2015080224

PROPOSED DECISION

Administrative Law Judge Ralph B. Dash heard this matter in Los Angeles, California on February 29, March 1, 2, and 3, September 2, 6, 8, 9,12, 14, and 16, 2016, and March 13, 14 and 15, 2017.

Deputy Attorney General Colleen M. McGurrin represented Kimberly Kirchmeyer (Complainant), the Executive Director of the Medical Board of California (Board).

Attorney at Law Alan I. Kaplan represented Guven Uzun (Respondent).

The record remained open until April 26, 2017, for receipt of closing and reply briefs. Complainant's closing and reply briefs were timely received and were marked for identification as Exhibits 40 and 41, respectively. Respondent's closing and reply briefs were timely received and were marked for identification as Exhibits 551 and 552 respectively. On May 3, 2017, Respondent filed a document entitled Notice of Errata re: Respondent's Reply Brief, which marked for identification as Exhibit 553. The record was closed on May 3, 2017.

Oral and documentary evidence having been received and the matter having been submitted, the Administrative Law Judge makes the following Proposed Decision.

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FACTUAL FINDINGS

Jurisdictional Facts

1. Complainant made the Accusation and Petition to Revoke Probation in her official capacity.

2. On August 24, 2000, the Board issued Physician's and Surgeon's Certificate Number A 72928 to Guven Uzun, M.D. (Respondent). The license was in effect at all times relevant to the charges brought herein, but subject to the prior disciplinary order described below, and is due expire March 31, 2018.

3. In a disciplinary action entitled *In the Matter of Accusation Against Guven Uzun, MD.*, Board case No. 06-2007-181358, the Board issued a decision on March 24, 2011 (effective April 22, 2011), pursuant to stipulation, in which Respondent's Physician's and Surgeon's Certificate was revoked. However the revocation was stayed and the Certificate was suspended for six months and placed on probation for a period of eight years on numerous terms and conditions.[1]

Introductory Facts

4. The Probation Inspector assigned to Respondent is Inspector K.M.[2] The Supervising Probation Inspector is Supervising Inspector R.L. PACE refers to the University of California at San Diego (UCSD) Physician Assessment and Clinical Education Program. The PACE case manager assigned to Respondent is PACE manager P.R. PACE PEP refers to the PACE Professional Enhancement Program. The PACE PEP Faculty Mentor assigned to Respondent is PEP mentor S.E. or Dr. S.E.[3] Respondent's Practice and Billing monitor is

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[1] In the stipulated settlement, Respondent admitted that he committed acts of gross negligence by: (1) prescribing facet joint block injections with no anatomic diagnosis or evidence of facet joint disease or canal stenosis; (2) failing to dispense and administer facet joint block injections utilizing fluoroscopy; and (3) failing to properly interpret and summarize the findings in a electromyography/nerve conduction velocity (EMG/NCV) study. He also admitted to committing 10 acts of simple negligence such as failing to take an adequate initial history and physical examination, and failing to formulate an adequate management plan.

[2] For reasons not made clear from the record, Complainant chose to identify individuals connected with the Board and/connected with PACE/PEP by initials, so that practice is taken forward into this Proposed Decision.

[3] Dr. S.E. is a neurologist and Associate Clinical Professor of Neurosciences at UCSD. He was also one of Respondent's Phase I and II PACE evaluators. The criticisms of

P&B monitor R.Y. or Dr. R.Y. CPEP refers to the Center for Personalized Education for Physicians (CPEP) Program.[4] The Quality Review Coordinator for CPEP is CPEP Coordinator J.S. The Program Services Director for CPEP is CPEP Director M.M.

Failure to Successfully Participate in and Complete Professional Enhancement Program

5. Condition 5 of Respondent's probationary terms states, in pertinent part:

"CLINICAL TRAINING PROGRAM After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program [PEP] equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary. Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation."

6. On January 5, 2012, PEP mentor S.E. reported his review of seven charts from Respondent's practice from November 2011. According to the mentor, six of the charts submitted failed to meet the standard of care, and many of the chart notes had "quite limited descriptions of the patient's clinical presentation and past medical history" and "frequently [Respondent's] documentation of the neurologic examination does not follow his own template's schema, evidences contradictions within the same note, and uses subjective or referential language such as 'unchanged from prior,' 'the same,' 'worsened,' or 'better,' without adequate establishment of normal values." Further, Respondent's "impressions and diagnoses are typically lists of diseases or injuries, many of which are unsupported by the documentation provided." In addition, Respondent's billings "suggest disparate billing for similar services across patients, and the majority of [Respondent's] billing would not be supported by the documentation provided. PEP mentor S.E. reported that Respondent "remains quite opposed to any argument that his billing is inappropriate or that his documentation should be more complete" and continues to "believe that current reimbursement and documentation practices are unfair, and that if he attempted to follow them, he would not be able to operate his business in a profitable fashion." S.E. further

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Respondent, other than as to the two named patients S.E and G.S., come from his reports which are part of Exhibit 4c, and from his testimony.

[4] CPEP is a non-profit organization providing competence assessment and intensive education services to physicians and other healthcare professionals. It is affiliated with the University of Colorado School of Medicine.

reported that Respondent "continues to also believe that his sanctions were part of a 'scam,' and are not reflective of a problem in his style of practice."

7. On January 31, 2012, Inspector K.M. informed Respondent that he must immediately implement any and all recommendations made by PEPmentor S.E.. On February 23, 2012, PEP mentor S.E. wrote a letter to the administrator of the PACE PEP program formally documenting a telephone conversation with Respondent on February 21, 2012. In that conversation, Respondent told PEP mentor S.E. that he had received "an intimidating and hostile letter" from the prosecutor assigned to his case, and that "she [the female prosecutor] is out to get" Respondent, that they (PEP mentor S.E. and Respondent) could "work out anything [they] needed to between" them, and that PEP mentor S.E. "should not put anything in [his] report that would give her ammunition to hurt him." PEP mentor S.E. reported that Respondent had made similar statements in the past, but had not previously linked them to modifying his evaluation of Respondent's performance.

8. On March 27, 2012, PEP mentor S.E. generated a report of his review of seven of Respondent's patient charts from December 2011. None of the charts reviewed met the standard of practice. The same types of deficiencies were noted as referenced in the January 5, 2012 report, and the March 27, 2012 report also noted that "multiple notes include extensive electrodiagnostic studies of questionable indication." PEP mentor S.E. found that Respondent's billing records appeared elevated for single patient visits, and noted that one single visit generated $9,345 in billing, $7,190 for a single visit of another patient, $4,520 for another, $4,156 for another, and $4,150 for another patient.

9. On March 29, 2012, PEP mentor S.E. generated another report in which he reviewed six of Respondent's patient charts from January 2012. Out of the six charts reviewed, three failed to meet the standard of practice, and the other three contained borderline standard documentation. In addition to the same deficiencies previously identified, S.E. found that "multiple notes include electrodiagnostic studies of highly questionable indication, and several encounters do not clearly establish an indication for the performed interventional pain procedure." S.E. found that one patient was billed $6,830 for a single visit, another $5,890 for a single visit, another $4,990 for a single visit, and another $3,880 for a single visit. Additionally on March 29, 2012, S.E. generated a second report reflecting his review of seven of Respondent's patient charts from February 2012. These chart notes, however, did not include billing information. All of the charts reviewed failed to meet the standard of practice and, in addition to the deficiencies previously noted, "several encounters include overtly inaccurate interpretations of electrodiagnostics studies as well as totally inaccurate assessments."

10. On June 1, 2012, PEP mentor S.E. generated another report where he reviewed seven of Respondent's patient charts from April 2012. None of the charts met the standard of practice. PEP mentor S.E. found that Respondent's "studies often are inappropriately performed, and are either incorrectly recorded or incorrectly interpreted." The accompanying billing records reflect that one patient visit generated $6,120 in billing, another $6,055, and another two were billed $3,685 each for their visits. PEP mentor S.E. found that

Respondent's billing records, in addition to the other billing records he previously reviewed, reflect a "trend of markedly elevated billing patterns."

11. On July 10, 2012, Respondent had his second and third quarter interview with Inspector K.M., who informed Respondent that he needed to make major improvements regarding his charting, and that it was critical to follow the recommendations of PEP mentor S.E. Respondent told Inspector K.M. that he did not agree with the recommendations made by Dr. S.E. During the interview, Respondent also told Inspector K.M. that he had "lost business due to his inability to treat Medi-Cal and Medicare patients" as a result of his discipline by the Board.

12. On July 13, 2012, PEP mentor S.E. generated a report of his review of seven of Respondent's patient chart notes from May 2012. Out of the seven chart notes reviewed, six failed to meet the standard of practice and the other one contained "borderline adequate documentation to meet standards." Dr. S.E. found all of the deficiencies previously reported, and noted that "Respondent's trend of markedly elevated billing patterns continue" with one single patient encounter generating $9,850 in billing, another $6,625, another $6,225, another $4,555, another $3,855, and another $3,240.

13. On October 22, 2012, and October 23, 2012, PEP mentor S.E. generated additional monthly reports for his review of Respondent's patient chart notes from July and August 2012. All of the charts reviewed failed to meet the standard and reflected the same deficiencies as found in the earlier reports.

14. On October 30, 2012, Dr. S.E. wrote a second letter to the PACE PEP administrator detailing a telephone conversation with Respondent to discuss his July 2012 and August 2012 chart notes. During the conversation, Respondent became angry and repeatedly shouted obscenities at S.E., while questioning his honesty and integrity. Respondent had also inappropriately called Dr. S.E.'s cell phone after normal business hours, including on weekends, often in an agitated state of mind. S.E. was "unwilling to continue working with" Respondent "unless some sort of formal code of conduct is established."

15. On November 15, 2012, Respondent was terminated from the PACE PEP program due to his "repeated pattern of behavior" as described and documented by PEP mentor S.E. Respondent was further notified that the program would not be offering him an alternate PACE PEP faculty mentor.[5]

16. On November 29, 2012, Respondent had his fourth quarter interview with Inspector K.M. which began by addressing the PEP program. Respondent immediately became argumentative and began making derogatory statements about PEP mentor S.E. Inspector K.M. informed Respondent that his insults were unacceptable and unprofessional, and that the meeting was to discuss Respondent's compliance with the PEP program and his

[5] S.E. was the only neurologist on the PEP staff.

overall probation compliance. Respondent was informed that he needed to locate an equivalent program to the PACE PEP program on or before December 14, 2012.[6]

17. On March 17, 2013, Respondent enrolled in the Colorado CPEP program. On April 26, 2013, Respondent sent an email to PACE case manager P.R. that he and his patients will sue her, PEP mentor S.E., and "your shady/scam program" for "running a scam and not program without an [sic] proof, experimental subjective nonsense with physician that has xenophobic bias."

18. On April 29, 2013, PEP mentor S.E. sent a letter to the UCSD PEP administrator documenting four text messages he received from Respondent. The first two messages were sent on April 26, 2013, at approximately 8:56 p.m., stating "Ashole [*sic*] piece of shit of will sue you! Xenophobic Ashile [*sic*];" the second message was "Your mother must be whore." That same night, at approximately 9:49 p.m., PEP mentor S.E. received another message from Respondent stating, "I know your type very well!!". The next morning, at approximately 8:49 a.m., he received another text from Respondent stating, "Your wife cute send her over sometimes."[7]

19. On June 18, 2013, Respondent underwent his first and second quarter interview with Inspector K.M. Respondent told Inspector K.M. that his practice was being ruined by certain individuals and that someone has been sending "fake patient" to his office for treatment. Respondent further stated that he felt that Supervising Inspector R.L. was the root cause of all his current problems with the Board and that he knew that PEP mentor S.E. was involved too.

20. On July 17, 2013, Inspector K.M. received a letter from Respondent inquiring "why Board continue discriminate [*sic*] and why board did [*sic*] respond properly to letter" from his attorney "to vacate Board 2011 order [presumably referencing the 2011 Board Decision placing Respondent on probation] since illegally obtained." Respondent also wanted to know why the "Board for decade, since 2007 continue to harass" his practice with "fake patients."

21. On December 13, 2013, Inspector K.M. received a letter from CPEP Coordinator J.S., along with the initial Quality Review Program Summary (QRPS) report for 30 of Respondent's patient charts for April, May, and June 2013.[8] Out of the 30 charts

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[6] Since PACE PEP did not have another neurologist on staff who could mentor Respondent, Respondent was required to find a PACE PEP equivalent program to continue the mentoring.

[7] These and other text and email exchanges referenced herein are contained in Exhibits 4f and 5 and are set forth verbatim.

[8] All CPEP reports are contained in Exhibit 4e.

reviewed, 20 failed to contain necessary documentation, 18 reflected issues with Respondent's judgment in his care of the patients; and in 26 of the charts, the CPEP Reviewer, a board-certified actively practicing neurologist, was unable to determine the appropriateness of Respondent's care due to documentation deficiencies.

22. On May 9, 2014, CPEP's Coordinator J.S. sent Respondent an email along with a copy of CPEP's QRPS report covering Respondent's charts from July, August and September 2013. Out of the 20 charts reviewed, 14 failed to contain necessary documentation; 12 reflected issues with Respondent's judgment in his care of the patients; and in 16 of the charts, the CPEP Reviewer was unable to determine the appropriateness of Respondent's care due to documentation deficiencies.

23. On May 9, 2014, Respondent sent a reply email to CPEP Coordinator J.S. stating, verbatim: "I barely restrained myself from your reviewer nonsense comments and lies especially abandoning case without talking to me consistent with malice and conspiracy which try to prove UCSD pep program fascist reviewer. I know what community practice and I did also sent copy of 4 other doctors who cover my office but your office refused comments on garbage notes written by these doctors shows ongoing bias and premeditated actions. Because these will prove that not just less what community does but proves him wrong all comments. It appears that your office trying to show that somehow I am not cooperating which is truthful at all. I have all my rights due above fraudulent reviews that doesn't reflect facts or reviewed by nurse, etc. I also reminder that recent Medicare payments evidence also shows that I am lowest billed and pain doctor in los angeles another proof of ongoing lies. My expert agreed that your doctor did not but nurse reviewed record which is another evidence of illegal dealings in these review process."

24. On May 10, 2014, at approximately 12:02 a.m., Respondent sent another email to CPEP Coordinator J.S., stating verbatim, in pertinent part, "His critiq on this and many other such as this all not reflect truth but other he trying to justify MBC illegally obtained settlement." Respondent continued to criticize the CPEP reviewers critique stating "Its clear with all and from his past comments that theses guys in touch with san diego guy and ganged against me in such xenophobic symbiotic relations and thus without doubt. truly believe that your reviewer one way other influenced by other factor and has zero objectivity and lying just to prove San diego guys right suggests criminal intent here. I never seen such disgraceful entity and scam."

25. On May 10, 2014, at approximately 5:11 a.m., Respondent sent another email to CPEP Coordinator J.S. stating, verbatim, in pertinent part: "Your reviewer leaving also because UCSD reviewer left (due to my personal argument) Most Bizzarre acts I ever seen and incomprehensible and proactive. Its clear by doing this your reviewer leaving no options but put me in automatic guilty seat which is premeditated and openly conspired one way other by UCSD since they Its clearly there must be national meeting or something these PEP people gossip about doctor they review etc... This person consider himself doctors, honest ethical and carry MD degree... I cant find words to describe."

26. On May 14, 2014, the Board received CPEP's QRPS, which covered a review of Respondent's patient charts from October November, and December 2013. Out of the 20 charts reviewed: 11 failed to contain necessary documentation; 13 reflected issues with Respondent's judgment in his care of the patients; and in 13 of the charts, the CPEP Reviewer was unable to determine the appropriateness of Respondent's care due to documentation deficiencies. The CPEP Reviewer commented that there does not appear to be any "improvement in the quality of the documentation over time" and that the "Objective data is concerning. It is almost always copied from the prior note. Seemingly at random to me, exam findings change, and there is rarely any indication as to why, or what practice is in place to figure that out." The CPEP Reviewer continued that it "is often difficult to figure out how [Respondent] comes up with a differential diagnosis, and what evidence clearly supports his choice of diagnosis." There are repeat EMG/NCV performed on frequent intervals without a clear rationale." The CPEP reviewer expressed "concerns that [Respondent] is: 1) not understanding the patient complaint; 2) not actually performing the exams that he documents; 3) makes incorrect diagnoses without considering a full differential diagnosis, but in a pattern that leads to the opportunity to perform many tests/procedures. These procedures that he indicates he performs (but inadequately charts) are suspect." As a result, the CPEP reviewer requested to be removed from the case.

27. On or about June 16, 2014, Respondent was terminated from the CPEP program.

28. On June 26, 2014, at approximately 3:24 a.m., Respondent sent an email to CPEP Director M.M., stating, verbatim, as follows: "You have only sent half of the emails. Its very clear in my emails that I need get answer my questions and why did not your reviewer answer my questions if he so ethical and professional. He is is dishonest in many ways as I put in emails and as others commented that he probably using nurse to review records, etc. he can just talk nonsense if he can come up explanation what he saying or not answering my questions regarding validity of his criticism. Especially we asked you not to review same charts over over again which nothing but redundant and not helping and useless thing to do which will show no improvement or progress falsely and which conveyed to via email by Gladys.[9] (You were asking your money for the last two months but I as not able to get to it yet and next thing I get is termination email.) You guys can't be ethical and honest in simple things and I am not sure what to expect from you program anything useful or ethical. All can tell you that I am very disappointed from this whole so called some kind of arbitrary program without any scientific background. This program nothing else but useless."

29. On July 9, 2014, Inspector K.M. notified Respondent that he was again out of compliance with Condition 5, the PEP program. Respondent was informed that he must submit a replacement professional enhancement program equivalent to the one offered by UCSD PACE by July 14, 2014.

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[9] Gladys Happer, a Certified Registered Nurse Practitioner, is Respondent's wife.

30. On July 14, 2014, at approximately 2:40 p.m., Inspector K.M. received a telephone call from Respondent, who was yelling very loudly and using profanity, calling Supervising Inspector R.L. a "bitch" over and over again. Inspector K.M. asked Respondent not to speak to him that way, but Respondent continued calling Supervising Inspector R.L. a "bitch." Inspector K.M. eventually hung up the telephone as Respondent refused to stop yelling insults.

31. On July 14, 2014, Inspector K.M. prepared a "non-compliance report" regarding Respondent's violations of the terms and conditions of his probation.

32. Respondent did not enroll in another equivalent PEP program by July 14, 2014.

Dishonesty in Quarterly Declarations

33. At all times after the effective date of Respondent's probation, Condition 10 states, in pertinent part:

"QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter."

34. On January 9, 2012, a medical malpractice lawsuit was filed in the matter entitled *Alvin Labostrie vs. Beverly Hills Pain Institute and Neurology and Guven Uzun, MD.*, Los Angeles Superior Court case number BC 476 419. On February 3, 2012, Respondent was served with the Summons and Complaint in the *Labostrie* case. On March 22, July 1, and October 8, 2012, January 1, April 1, September 30, and December 21, 2013, April 23, July 14, and October 10, 2014, Respondent declared, under penalty of perjury in his Quarterly Declarations, that there was no civil suit or malpractice action pending against him. Immediately above Respondent's signature line, the Declaration states, "I hereby submit this Quarterly Declaration as required by the Medical Board of California and its Order of probation thereof and declare under penalty of perjury under the laws of the State of California that I have read the foregoing declaration and any attachments in their entirety and know their contents and that all statements made are true in every respect and I understand and acknowledge that any misstatements, misrepresentations, or omissions of material fact may be cause for further disciplinary action." The Quarterly Declaration covering April-June 2013, (the second quarter of 2013), is unsigned.

35. On July 10 and November 29, 2012, June 18, September 24, and December17, 2013, and March 20, 2014, Respondent was interviewed by Inspector K.M. When asked if there were any pending malpractice lawsuits against him, Respondent failed to disclose that the *Labostrie* malpractice lawsuit had been pending against him since January 2012 and that as of February 26, 2014, the trial in that matter was trailing to March 24, 2014. Trial in that

matter commenced on March 27, 2014, and ended on April 2, 2014, with a verdict in Respondent's favor.

36. On July 15, 2014, Inspector K.M. sent Respondent a letter informing him that he was out of compliance with Condition 10, Quarterly Declarations.

Failure to Comply with Practice and Billing Monitoring

37. At all times after the effective date of Respondent's probation, Condition 6, states, in pertinent part:

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

"The monitors shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and billing, and whether respondent is practicing medicine safely, and billing appropriately.

"It shall be the sole responsibility of respondent to ensure that the monitors submit the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

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

"Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation."

38. On July 18, 2012, Respondent requested that Dr. R.Y. a board certified practicing neurologist and forensic specialist serve as his practice and billing monitor pursuant to Condition 6. At that time, Dr. R.Y. signed, under penalty of perjury, an agreement to act as Respondent's practice and billing monitor, stating that she "clearly

understand[s] the role of a Monitor and what is expected of" her, and agreed to "regularly submit written reports to the assigned Inspector" as detailed in the Monitoring Plan.

39. On August 6, 2012, Dr. R.Y. signed the Board's "Monitoring Plan Practice and/or Billing" form (monitoring plan) which required her to "submit a written report once each quarter to the assigned investigator . . . on her letterhead [bearing her] "original signature." The monitoring plan further required that her reports "are due to the assigned Inspector's office within ten (10) calendar days after the end of the preceding quarter" and lists the due dates as no later than April 10, July 10, October 10, and January 10. The monitoring plan also required that the reports shall, at a minimum, specify the patient name and/or medical record number of the charts reviewed, and for monitoring of billing practices, that the report "will also indicate the medical record number of charts and corresponding billing records reviewed per visit."

40. On August 20, 2012, Dr. R.Y. was approved to serve as Respondent's practice and billing monitor.[10] On November 6, 2012, Dr. R.Y. prepared a Practice and Billing Monitor Report (quarterly monitor report) covering Respondent's practice from June to September 2012. This report, however, was unsigned, did not contain the name, medical record number, or initials of the patient charts reviewed, and failed to specify the corresponding medical record number and corresponding billing records reviewed as required by the monitoring plan.

41. No quarterly monitor report was received for the period covering October to December 2012.

42. April 30, 2013, the Probation Unit received Dr. R.Y.'s quarterly monitor report covering Respondent's practice from January to March 2013, which was due no later than April 10, 2013. Respondent, however, failed to provide Dr. R.Y. his billing records covering this quarter as required by Condition 6.

43. On July 17, 2013, the Probation Unit received Dr. R.Y.'s quarterly report covering Respondent's practice from April to June 2013, which was due no later than July 10. This report failed to specify the corresponding medical record number and corresponding billing records reviewed as required by the monitoring plan.

44. No quarterly monitor reports were received for the third and fourth quarters, covering Respondent's practice from July to September 2013, and October to December 2013.[11]

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[10] Her reports are contained in Exhibit 4g.

[11] Dr. R.Y.'s testimony that the reports she wrote at the request of counsel, discussed below, sufficed in lieu of her actual reports lacks credibility (she knew her reports were for and due to be sent to the Board), and is given no weight.

45. On March 20, 2014, the Probation Unit received what purported to be Dr. R.Y.'s quarterly monitoring report, dated December 28, 2013, covering Respondent's practice from October to December 2013, which was due no later than January 10, 2014. This report, however, is addressed to Respondent's counsel, A.K., and states that the monitor was "specifically asked" by Respondent's counsel, A.K., "to consider medical necessity for any testing or other procedure" performed on two patients, identified in the report as "EIL" and "SCH," whom Respondent treated in 2011 and 2012.

46. As of July 14, 2014, Inspector K.M. still had not received Dr. R.Y.'s quarterly monitor reports for the fourth quarter of 2012, due no later than January 10, 2013, the fourth quarter of 2013, due no later than January 10, 2014, the first quarter of 2014, due no later than April 10, 2014, and the second quarter 2014 report with an original signature, due no later than July 10, 2014.

47. On July 15, 2014, Inspector K.M. notified Respondent that he was out of compliance with Condition 6.

48. On August 7, 2014, Inspector K.M. met with Dr. R.Y. and provided her with a Practice Monitor Report Checklist form, a Sample Practice Monitor Report, an Individual Chart Audit form, and a Multiple Chart Audit form. Inspector K.M. informed her that these forms must accompany her monitoring reports and must be submitted with her report, bearing an original signature, within 10 calendar days after the end of the preceding quarter. Dr. R.Y. told Inspector K.M. that she understood and agreed to continue as Respondent's practice and billing monitor.

49. On September 4, 2014, Inspector K.M. notified Respondent that Dr. R.Y. had agreed to continue as his practice and billing monitor. The letter reminded Respondent that it was his "sole responsibility to ensure that [the monitor] submits the quarterly written reports with an original signature" within 10 calendar days after the end of the preceding quarter.

50. On October 20, 2014, the Probation Unit received Dr. R.Y.'s quarterly monitor report, which was due no later than October 10, 2014. The report, however, did not include all necessary documents that were required to accompany the report.

51. On October 22, 2014, Inspector K.M. notified Respondent that Dr. R.Y. was disqualified as his practice and billing monitor for her repeated failure to comply with all of the monitoring plan requirements. Inspector K.M. informed Respondent that he needed to submit a nominee as a replacement monitor by close of business on October 28, 2014. On November 7, 2014, at approximately 10:19 a.m., Respondent sent Inspector K.M. an email with the name of a new proposed practice and billing monitor. This proposed monitor never agreed to accept the appointment.

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52. On November 26, 2014, at approximately 4:30 a.m., Respondent sent another email to Inspector K.M. disagreeing with the removal of Dr. R.Y. stating that Supervising Inspector R.L. did this "to Show that I am not compliant with my terms is premeditated." Respondent continued that "In addition past year Glendale fake investigation created by [Supervising Inspector R.L.] by throwing me to Armenian Investigator Mrs. Shenian so she can take Revenge from Turkish doctor. This was malicious intentional, racist and capricious."

Patient G.S.[12]

53. On February 28, 2012, patient G.S., a 27-year old male, first presented to Respondent with chief complaints of neck and lower back pain, and headache following a motor vehicle accident that occurred approximately three weeks earlier. G.S. denied any loss of consciousness in the accident and gave no history of suffering a head trauma. The patient's neurological examination was normal except for mild reflex asymmetry in the upper and lower extremities and a slow gait. Respondent noted moderate tenderness on palpation of the cervical paraspinal musculature with full range of motion, but no neck stiffness. Respondent listed his diagnoses of G.S. as: post-concussive headache/migraine syndrome; status post MVA [motor vehicle accident] and head injury; cervical spasm; lumbar spasm; and to rule out cervical and lumbar radiculopathy. Respondent performed an in-office electroencephalogram (EEG) for the patient's headaches and "head injury;" however, the patient never reported suffering a head injury in the accident, nor any loss of consciousness or any seizure activity that would justify this study. The EEG was normal. Respondent also performed an in-office electromyography (EMG) and nerve conduction velocity test (NCV) of bilateral upper and bilateral lower extremities; allegedly testing 68 muscles which Respondent stated took approximately one hour.[13] During the study, Respondent obtained no

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[12] All experts who testified and/or wrote reports, either for Complainant or Respondent, are board-certified in neurology and have relatively equivalent training and experience. The testimony and reports of Complainant's experts were rich in detail, far more so than those of Respondent's experts. Respondent's experts also avoided referencing items that clearly showed Respondent fell below the standard of care, such as Respondent's failure to follow up on this patient's "large lesion" as described in Finding 62 B, a clear extreme departure from the standard of care. Dr. R.Y. did not mention the lesion in her report (part of Exhibit 547) and in her testimony stated only that Respondent should have referred the patient to his "family physician." Respondent's other expert, Dr. N.R., who did not prepare a written report, testified that Respondent told his patient that he "did not deal with thyroid issues" and that there was nothing in the chart to show Respondent attempted to contact the patient for follow-up. Neither doctor testified whether Respondent's conduct with respect to the lesion met the standard of care.

[13] Dr. R.Y. testified convincingly that because Respondent did not set his NCV equipment to record only those muscle groups actually being tested, the "default" reading would show that all 68 groups had been tested. However, only a few of the muscle groups

response of the bilateral tibial H-Reflexes. Respondent's impression of the NCV was that G.S. suffered from "right sided mild carpal tunnel syndrome" in the "bilateral upper extremities." The test results, however, do not support Respondent's impression as G.S. did not have the electrophysiological features for carpal tunnel syndrome. Respondent's further impression was that the patient had "possible S1 radiculopathy;" however, the test results do not support a diagnosis of S1 radiculopathy. Respondent also ordered a magnetic resonance imaging study (MRI) of the patient's brain, cervical spine and lumbar spine. Respondent also advised the patient to obtain physical therapy/occupational therapy or chiropractic treatment, however, Respondent failed to write a prescription for physical or occupational therapy and failed to refer G.S. to a facility where he could obtain such treatments.

54. On March 6, 2012, G.S. returned for a follow-up visit complaining of increased neck, shoulder, and low back pain. Respondent's list of diagnoses remained the same as the previous visit, and appears to be cut and pasted into the new chart note. During this visit Respondent performed "Cervical and Lumbar trigger points" injections; however, there is no report documenting this procedure in the certified chart, and Respondent's billing summary does not reflect a charge for this procedure on this date.

55. On April 19, 2012, G.S. underwent an MRI of his brain and lumbar spine at an outside facility, which were interpreted as normal. The cervical MRI, however, revealed a 3 to 4 mm left paramedian disc protrusion at C7-T1, degenerative changes at C2 to C6, and a 13 mm x 6 mm lesion in the left lobe of the thyroid gland consistent with thyroid adenoma or colloid cyst.

56. On April 30, 2012, G.S. returned for a follow-up visit complaining of neck and shoulder pain. Respondent noted moderate tenderness on palpation of the cervical paraspinal musculature at C6 to C7, but the patient's range of movement was within normal limits. Respondent's diagnoses were post-concussive headache syndrome, status post MVA, and cervical and lumbar spasm. Respondent performed "Cervical Trigger point" injections at six different points, however, there is no report documenting this procedure in the certified chart. Respondent also had the patient undergo an in-office carotid artery duplex scan even though the patient had no carotid bruits on examination, had no clinical evidence or history of vascular pathology involving the anterior circulation, and had no evidence or history of transient ischemic attack or other similar medical conditions which would justify the scan. The scan was completely normal. Respondent charted that he asked the patient to go to "intense physical therapy" and told G.S. that his symptoms were mostly due to spasm due to "cervical acute disc herniation." Respondent failed to write G.S. a prescription for physical or occupational therapy. He also failed to refer him to a physical therapy facility or provide a list of facilities which offered such therapies. Respondent also failed to order additional tests or studies concerning the unexpected thyroid lesion identified on the cervical MRI, and he

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on the NCV readout showed actual values instead of all zeroes. Dr. R.Y. taught Respondent to properly set his testing equipment so that only the muscles actually tested would show up on the printout.

failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment. On this visit, Respondent billed $415 for interpreting the MRI of the brain, which had been reported by the outside facility to be normal.[14]

57. On May 2, 2012, G.S. returned for another follow-up visit complaining of pain with spasm in his neck and shoulder area. Respondent charted that G.S. stated the injections from two days earlier, and the new medication helped relieve his pain, but "[the pain] returned last night." Respondent noted neck pain and spasm in the midscapular area with "back pain/sapsm [*sic*] but less." Respondent, however, did not explain how G.S.'s back pain was less since on the prior visit, two days earlier, the patient had no back complaints. Respondent's list of diagnoses are identical to those listed on G.S.'s initial visit of February 28, 2012, including the status post "head injury" and rule out "cervical and lumbar Radiculopathy," which appear to be copied and pasted from the February note. Respondent again advised the patient to obtain "intense PT/OT or chiropractic treatment," but Respondent failed to write a prescription, or refer the patient to a physical or occupational therapy facility, or to provide a list of facilities to the patient. Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and he again failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion

58. On May 18, 2012, G.S. returned for another follow-up visit complaining of severe neck pain. Respondent noted moderate tenderness in the cervical paraspinal muscles at C4 to C7, and moderate tenderness in the paraspinal muscles at L2 to SI; however, the patient had no back complaints on this visit. Respondent's "current" diagnoses are identical to those listed on G.S.'s initial visit of February 28, 2012, including the status post "head injury," "lumbar spasm" and ruling out of "lumbar Radiculopathy," which appears to be cut and pasted from the initial visit in February. In his unsigned cervical injection procedure report, Respondent listed the patient's diagnoses as cervical radiculopathy, cervical spinal stenosis, intractable migraine, postconcussive headache, and cervical muscle spasm; however, there is no evidence in the certified chart that G.S. suffered from all these conditions. Respondent again failed to write a prescription for, or refer the patient to, a physical or occupational therapy facility or provide a list of facilities to the patient at this visit. Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI and again failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

59. On May 30, 2012, G.S. returned for a further follow-up visit complaining of neck pain radiating into his left shoulder. Respondent's review of systems (ROS) is identical to that of the previous visit, including the misspellings, and appears to have been copied and

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[14] No adverse inference is drawn from Respondent's billing for his own reading of each of the two MRI's. While a radiologist's report accompanied the imaging study, it is highly common for a neurologist to do his or her own reading of the images.

pasted from the prior note. Respondent noted back pain and spasms even though the patient had no back complaints on this visit and no tenderness was found upon examination. Respondent performed another NCV/EMG of the patient's bilateral upper extremities; however, there had been no significant change in the patient's condition to justify repeating this test. Respondent's impression was that G.S. had bilateral cervical radiculopathy at C5-C7, however, the test results do not support Respondent's impression of radiculopathy. Respondent's plan was to order physical therapy for the patient; however, there was no prescription or order found in the certified chart indicating that Respondent ordered or prescribed physical therapy on this visit. Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and he again failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

60. On June 13, 2012, G.S. returned for another follow-up visit complaining of increased neck pain radiating into his left shoulder. Respondent's ROS is identical to the previous visit, including the misspellings, and notes back pain and spasms even though the patient had no back complaints on this visit. In his unsigned procedure note, Respondent performed a cervical-thoracic facet steroid injection, under ultrasound guidance; however, the corresponding ultrasound images list a date of June 14, 2012. The consent for the procedure was not signed by the patient, and there is no explanation in the certified chart indicating why someone else signed the consent for the patient who was alert and talking with Respondent during the visit. Respondent finally wrote a prescription for the patient to receive physical or occupational therapy. Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI, and he again failed to refer the patient to an endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion.

61. On June 27, 2012, G.S. returned for another follow-up visit with improved neck pain, but new complaints of back pain and spasm. Respondent's ROS is identical to the previous visit, including the misspellings, and it appears to have been copied and pasted from the prior note. Respondent noted moderate tenderness in the paraspinal musculature at L2 to S1, but the patient's range of motion was normal. Respondent also recorded ankle jerks upon examination. Respondent performed another NCV/EMG of the patient's bilateral extremities, which Respondent interpreted as showing bilateral radiculopathy at LS and S1; however, the test results do not support a diagnosis of radiculopathy. Respondent again obtained no responses of the bilateral tibial H-Reflexes,[15] demonstrating improper placement of the electrodes or that these areas were not tested. Respondent ordered a repeat MRI of the patient's lumbar spine and continued physical therapy; however, there is no documentation in the certified chart that the patient was actually receiving physical therapy at this time. Respondent again failed to order additional tests or studies concerning the thyroid lesion identified on the cervical MRI in April, and again failed to refer the patient to an

[15] This patient had positive Achilles tendon reflexes (ankle jerks) so, Respondent should have been able to elicit bilateral tibial H-Reflexes.

endocrinologist or other appropriate specialist for further evaluation and treatment of the thyroid lesion. This appears to be the last time G.S. saw Respondent.

GROSS NEGLIGENCE AS TO G.S.

62. Respondent committed acts of gross negligence (extreme departures from the standard of care), individually and collectively, in his care and treatment of patient G.S. when he:

A. Failed to accurately analyze and interpret the repeat in-office EMG/NCV studies performed;

B. Failed to appropriately evaluate the large lesion identified on the cervical MRI in the left lobe of the patient's thyroid gland, and/or refer the patient to an endocrinologist or other appropriate professional for evaluation and treatment;

C. Failed to fully evaluate and initially treat the patient's neck pain and headaches with conservative care and interventional treatment;

D. Failed to fully evaluate and initially treat the patient's back pain with conservative care and non-interventional treatment; and

E. Failed to initially order physical therapy for the patient while repeatedly performing invasive treatments.

REPEATED NEGLIGENT ACTS AS TO PATIENT G.S.

63. Respondent committed repeated negligent acts (simple departures from the standard of care) in his care and treatment of patient G.S.

64. The circumstances are as follows:

65. Respondent:

A. Performed an ultrasound guided steroid injections prior to obtaining the MRI study showing the patient's anatomic structures and areas of pathology;

B. Ordered a carotid artery duplex scan when the patient had no carotid bruits on examination, had no clinical evidence or history of vascular pathology involving the anterior circulation, nor any evidence or history of transient ischemic attack or other similar medical conditions which would justify the scan;

C. Ordered an EEG when the patient had no history of loss of consciousness, a head injury, or a seizure disorder;

D. Performed repeat NCV/EMGs when there had been no significant changes in the patient's condition to justify repeating these tests;

E. Performed excessive tests and invasive treatments without appropriate indications;

F. Billed for testing the H-Reflexes, which were either not performed or performed so poorly that results could not be obtained;

H. Failed to maintain adequate and accurate records.

EXCESSIVE/UNNECESSARY DIAGNOSTIC STUDIES AS TO PATIENT G.S.

66. Respondent engaged in repeated acts of clearly excessive and unnecessary use of diagnostic procedures in his care and treatment of patient G.S.

67. The circumstances are as follow:

A. Ordering and administering repeat in-office EMG/NCV studies without appropriate indications justifying the repeat in-office study;

B. Ordering and administering ultrasound guided facet joint injections prior to obtaining the MRI films showing the patient's anatomical structures, and any evidence of facet joint disease or canal stenosis;

C. Ordering, administering and utilizing an in-office EEG study on the initial visit when the patient had no history of seizures, loss of consciousness or head injury that would justify the study; and

D. Ordering and administering an in-office carotid artery duplex scan when the patient had no carotid bruits on examination, no clinical evidence or history of vascular pathology involving the anterior circulation and no history or evidence of transient ischemic attack or other similar conditions that would justify this scan.

Patient S.E.

68. On December 16, 2011, S.E., a then 44 year-old female, first presented to Respondent with a chief complaint of headaches on the left side of her head only, and she rated her pain as a 4 out of 10. Respondent noted moderate tenderness in the paraspinal musculature of the cervical spine at C4 to C7 with some limited range of motion; however, Respondent failed to specify how, and in what manner, the patient's range was limited. Respondent ordered an MRI of the patient's brain and cervical spine, and performed an in-office NCV/EMG of the patient's bilateral upper extremities. Respondent's impression was that S.E. had moderate radiculopathy at C5 and C6 on the left, and mild radiculopathy on the right. He also diagnosed mild carpal tunnel syndrome on the right. The test results,

however, do not support Respondent's impressions of radiculopathy or carpal tunnel syndrome. Additionally, S.E. had no clinical examination findings for radiculopathy, making the need for this test, along with its findings, questionable. Respondent misinterpreted the normal findings of the median motor and sensory distal latency and amplitude responses in diagnosing carpal tunnel syndrome. Respondent billed $350 for the office visit, $2,160 for the NCV, $380 for the H-Reflex amp study, and $50 for venipuncture, a charge which is not supported by the certified records, for a total charge for this single visit of $2,940.[16]

69. On January 11, 2012, S.E. had an MRI of her brain performed and interpreted by an outside facility. The MRI showed no significant abnormalities or evidence of acute disease.

70. On January 16, 2012, S.E. returned for a follow-up visit and complained of continued headaches, now, a 7 out of 10, and stated they were worse at night, and that she was unable to lie on her left side. Respondent noted moderate tenderness of the cervical paraspinal musculature at C4 to C7, with limited range of motion bilaterally. Respondent performed an occipital block and cervical trigger point injection under ultrasound guidance; however, there was no report documenting this procedure in the patient's certified chart. Respondent never referred this patient for physical therapy and never evaluated the effectiveness of the occipital block for the headache. This appears to be the patient's last visit with Respondent.

71. Respondent committed gross negligence in his care and treatment of patient S.E. when he failed to accurately analyze and interpret the NCV/EMG and determined that the patient had carpal tunnel syndrome.

REPEATED NEGLIGENT ACTS AS TO PATIENT S.E

72. Respondent committed repeated negligent acts in his care and treatment of patient S.E. The circumstances are as follows:

73. Respondent:

A. Failed to provide appropriate evaluation and treatment of the patient's headaches;

B. Failed to refer the patient to physical therapy;

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[16] The dollar figures Respondent billed are for illustrative purposes only. The uncontradicted evidence was that no matter how much Respondent billed, the insurance companies and Medicare only paid a fixed amount based on the billing codes, and Respondent did not ask the patient to make up the difference between his bill and his reimbursement.

C. Billed for a venipuncture either not performed or not supported by the chart; a

D. Billed for an H-Reflex study which was either not obtained or not performed; and

E. Failed to offer appropriate treatment for carpal tunnel syndrome.

DISHONESTY

74. Respondent committed acts of dishonesty that were substantially related to the qualifications, functions or duties of a physician and surgeon. The circumstances are as follows:

75. Between on or about March 22, 2012, and October 10, 2014, Respondent failed to comply with the tenth condition of probation when he failed to disclose the *Labostrie* malpractice action in his quarterly reports.

Failure to Maintain Adequate and Accurate Records

76. Respondent is subject to disciplinary action under Business and Professions Code section 2266, in that he failed to maintain adequate and accurate records for patients S.E. and G.S. as set forth in Findings 53 through 61, 68 and 70.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standards of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; it is sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

3. Complainant also bears the burden of proof to establish that cause exists to revoke probation in this administrative proceeding. The standard of proof in a proceeding to revoke probation is preponderance of the evidence. (*Sandarg v. Dental Board of California* (2010) 184 Cal.App.4th 1434, 1441-1442.) The phrase "preponderance of evidence" is usually defined in terms of probability of truth, e.g., "such evidence as, when weighed with that opposed to it, has more convincing force and the greater probability of truth." (BAJI (8th ed.), No. 2.60; 1 Witkin, Evidence, Burden of Proof and Presumptions § 35 (4th ed. 2000).)

Applicable Statutes Regarding Causes to Impose Discipline

4. Business and Professions Code section 2227, subdivision (a), states:

A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

5. Business and Professions Code section 2234 provides in part:

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

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a

separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(d) Incompetence.

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

6. Business and Professions Code section 2266 provides: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Business and Professions Code section 725, subdivision (a) provides, in part:

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

Decisional Authority Regarding Standards of Care

7. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal. App. 4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal. App. 4th 234, 280.)

8. The courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal. App. 3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Incompetence has been defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Id.* at 1054)

9. Respondent violated the terms of his probation in Board case number 06-2007-181358 by his failure to complete the PACE PEP program, as set forth in Findings 5 through 32; by his dishonesty in filing his quarterly reports, as set forth in Findings 33 through 36; and by his failure to have a Board-approved monitor as set forth in Findings 36 through 50. These violations, separately and collectively, constitute grounds to vacate the stay order and impose the stayed discipline, revocation of his certificate to practice medicine.

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10. Respondent committed acts of gross negligence in his care and treatment of patients G.S. and S.E. as set forth in Findings 53 through 62 and 68 through 71, thereby subjecting his certificate practice medicine to discipline under the provisions of Business and Professions code section 2234, subdivision (b)

11. Respondent committed repeated negligent acts in his care and treatment of patients G.S. and S.E. as set forth in Findings 63 through 65 and 72 and 73, thereby subjecting his certificate practice medicine to discipline under the provisions of Business and Professions code section 2234, subdivision (c)

12 Respondent conducted clearly excessive and unnecessary use of diagnostic procedures in his care and treatment of patient G.S. thereby subjecting his certificate to practice medicine to discipline under the provisions of Business and Professions Code section 725, subdivision (a) by reason of Findings 66 and 67.

13. Respondent committed acts of dishonesty in the filing of his quarterly reports as set forth in Findings 74 and 75, thereby subjecting his certificate to practice medicine to discipline under the provisions of Business and Professions Code section 2234, subdivision (e).

14. Respondent failed to keep adequate and accurate records as set forth in Finding 76, thereby subjecting his certificate to practice medicine to discipline under the provisions of Business and Profession Code section 2266.

ORDER

Physician's and Surgeon's Certificate number A 72928 issued to Guven Uzun, together with all licensing rights appurtenant thereto, is revoked.

Date: May 16, 2017

DocuSigned by:
Ralph Dash
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RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings