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

In the Matter of the Accusation Against: **Michael Theodore Lardon, M.D.** **3750 Convoy Street, Suite 318** **San Diego, CA 92111** **Physician's and Surgeon's Certificate No. A 48664,** Respondent.	Case No. 800-2017-035372 **A C C U S A T I O N**

PARTIES

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

2. On or about September 17, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. A 48664 to Michael Theodore Lardon, 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 May 31, 2022, unless renewed.

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JURISDICTION

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

4. Section 2227, subdivision (a) of the Code 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:
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> (1) Have his or her license revoked upon order of the board.
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> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
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> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
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> (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.
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> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

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

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

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6. Section 2242, subdivision (a) of the Code states:

Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

7. Section 725, subdivision (a) of the Code states:

Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

8. 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent Michael Theodore Lardon, M.D. has subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code in that he committed gross negligence in his care and treatment of one or more patients. The circumstances are as follows:

10. At all times pertinent to the patient care and treatment described herein, Respondent operated a private psychiatry practice in or around San Diego, California.

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Patient A

11. On or about April 23, 2015, "Patient A"[1] presented to Respondent for the first time. In his progress note for this clinical encounter, Respondent documented a medical history including, but not limited to, multiple gastrointestinal ailments, high blood pressure, hyperlipidemia, migraines, muscle spasms and pain in her upper and lower extremities. Respondent documented diagnoses including, but not limited to, major depressive disorder and chronic pain disorder, as well as a history of severe ulcer, gastrointestinal disease, chronic pain syndrome secondary to atypical fibromyalgia, migraine headaches, and C. difficile infection.

12. In his progress note for the clinical encounter with Patient A on or about April 23, 2015, Respondent further documented that Patient A was receiving pain medications from a neurologist. Respondent documented that Patient A's medications at the time included, but were not limited to, eight Percocet 10/325 mg tablets,[2] six tizanidine 4 mg pills,[3] and 1 mg to 3 mg of Klonopin[4] per day.

13. In or about June 2015, Patient A's then neurologist advised Patient A or Respondent that he was going to no longer practice neurology. At or shortly after this time, Respondent took over the prescribing of opioid or opiate medications to Patient A.

14. Respondent failed to adequately assess Patient A's chronic pain, fibromyalgia, muscle spasms or other pain-related symptoms or ailment—including, but not limited to, failing to adequately obtain or document vital signs, a physical examination, diagnostic workup, or review

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[1] Patient true names are not used in the accusation to maintain patient confidentiality. The identity of any patient referenced herein is known to Respondent or will be disclosed to Respondent following Complainant's receipt of a duly-issued request for discovery pursuant to Government Code section 11507.6.

[2] Percocet is a brand name for the drug combination of oxycodone (2.5 mg, 5 mg, 7.5 mg, or 10 mg) and acetaminophen (325 mg). The "10/325" notation refers to the prescribed strength of each tablet consisting of 10 mg of oxycodone and 325 mg of acetaminophen. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

[3] Zanaflex is a brand name for tizanidine. It is a muscle relaxant and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Klonopin is a brand name for clonazepam. It is a benzodiazepine, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

of records from prior treatment providers, or any combination thereof—prior to initiating his chronic prescribing of high-dose opioids or opiates to Patient A.

15. Respondent failed to enter into a pain management agreement with or otherwise obtain and document adequate informed consent from Patient A at or near the outset of his prescribing of controlled substances to Patient A for chronic pain.

16. In or about July 2015 to December 8, 2015, Respondent issued to Patient A multiple prescriptions for purported monthly supplies of opioid or opiate medications including, but not limited to, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
7/16/2015	Fentanyl[5]	25 mcg	10
7/16/2015	Percocet	10/325 mg	240
8/10/2015	Percocet	10/325 mg	240
8/10/2015	OxyContin[6]	20 mg	30
9/3/2015	Percocet	10/325 mg	240
9/3/2015	OxyContin	10 mg	30
9/28/2015	Oxycodone[7]	10 mg	240
10/19/2015	Oxycodone	10 mg	240
11/12/2015	Oxycodone	10 mg	240
12/7/2015	Oxycodone	10 mg	240

17. During this period, the California Controlled Substance Utilization Review and Evaluation System (CURES) lists prescriptions for purported 30-day supplies of 90 Klonopin 1 mg tablets issued by healthcare providers other than Respondent and filled or refilled to Patient A on or about August 17, September 18, November 12, and December 8, 2015.

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[5] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[6] OxyContin is a brand name for extended-release oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Commencing on or about December 7, 2015, if not earlier, Respondent took over the prescribing of Zanaflex to Patient A, on this occasion issuing her a prescription for a purported one-month supply of approximately 180 Zanaflex 4 mg pills.

19. Respondent failed to adequately document an assessment of Patient A or the rationale for his prescribing of Zanaflex, or the dosage prescribed, to Patient A.

20. On or about December 28, 2015, Respondent issued a Klonopin prescription to Patient A.

21. Respondent failed to adequately document a clinical assessment or rationale for his prescribing of Klonopin, or the dosage prescribed, to Patient A.

22. Respondent failed to adequately discuss or document discussing with Patient A the risks associated with concomitant use of opioids or opiates and benzodiazepines, or the possibility of prescribing Narcan[8] to Patient A.

23. In or about December 28, 2015 to July 2016, Respondent issued to Patient A multiple prescriptions for purported monthly supplies of oxycodone, Klonopin or Zanaflex including, but not limited to, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
12/28/2015	Oxycodone	10 mg	240
12/28/2015	Klonopin	1 mg	90
1/21/2016	Oxycodone	10 mg	240
1/21/2016	Klonopin	1 mg	90
2/11/2016	Oxycodone	10 mg	240
2/11/2016	Klonopin	1 mg	90
2/11/2016	Zanaflex	4 mg	180
3/3/2016	Oxycodone	10 mg	240
3/31/2016	Oxycodone	10 mg	240
4/21/2016	Oxycodone	10 mg	240

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[8] Narcan is a brand name for naloxone and is commonly used to reverse the effects of opioid or opiate overdose.

24. During this period, the CURES database lists prescriptions for purported 30-day supplies of 90 Klonopin 1 mg tablets issued by a healthcare provider other than Respondent and filled or refilled to Patient A on or about March 9, April 4, April 28 and May 21, 2016.

25. In a progress note for a clinical encounter with Patient A on or about May 12, 2016, Respondent documented that he was "going to take over writing the Klonopin [prescriptions]."

26. On or about April 28, 2016, Respondent received a "Retrospective Drug Utilization Review Program" notice from an insurance carrier advising, among other things, that Patient A had filled prescriptions issued by Respondent for purported 30-day supplies of 240 oxycodone 10 mg tablets on January 23, February 16, and March 10, 2016. The notice further stated that "[c]hronic early refills may be associated with an increased risk of medication abuse/misuse [and] [e]arly refills may also indicate that pain is not well controlled for a patient."

27. In or about May 2016 to September 2016, Respondent continued to issue to Patient A multiple prescriptions for purported monthly supplies of oxycodone, Klonopin or Zanaflex including, but not limited to, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
5/12/2016	Oxycodone	10 mg	240
5/12/2016	Klonopin	1 mg	90
5/12/2016	Zanaflex	4 mg	180 (3 refills)
6/9/2016	Oxycodone	10 mg	240
6/9/2016	Klonopin	1 mg	90
6/9/2016	Zanaflex	4 mg	180 (3 refills)
6/30/2016	Oxycodone	10 mg	240
6/30/2016	Klonopin	1 mg	90
7/25/2016	Oxycodone	10 mg	240
7/25/2016	Klonopin	1 mg	90
8/11/2016	Oxycodone	10 mg	240
8/11/2016	Klonopin	1 mg	90
9/8/2016	Oxycodone	10 mg	240
9/8/2016	Klonopin	1 mg	90
9/8/2016	Zanaflex	4 mg	180 (3 refills)

Date	Drug Name	Strength	Quantity
9/29/2016	Oxycodone	10 mg	240
9/29/2016	Klonopin	1 mg	90

28. During this period, on or about July 23, 2016, Respondent received another "Retrospective Drug Utilization Review Program" notice from an insurance carrier advising, among other things, that Patient A had filled prescriptions issued by Respondent for purported 30-day supplies of 240 oxycodone 10 mg tablets on April 2, April 25, May 18, and June 10, 2016. The notice further stated that "[c]hronic early refills may be associated with an increased risk of medication abuse/misuse [and] [e]arly refills may also indicate that pain is not well controlled for a patient."

29. During this period, in a progress note for a clinical encounter with Patient A on or about August 11, 2016, Respondent documented that Patient A had woken up the previous weekend delirious and with a blood pressure of 60/40 mmHg. Respondent documented that paramedics were called and Patient A was taken to the hospital. Respondent documented that eventually Patient A "did leave the hospital [against medical advice] because they didn't give her any of her pain medicine or sleep medicine."

30. In his progress note for a clinical encounter with Patient A on or about October 24, 2016, Respondent documented that Patient A and her spouse stated that another healthcare provider had advised that Patient A would be in more pain due to a recent bout of sepsis. Respondent further documented that he was going to increase the quantities of Patient A's prescriptions because Patient A was running out of medication at the end of the month. Respondent also documented that he was decreasing Patient A's Klonopin prescription to 2.5 mg per day.

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31. In or about October and November 2016, Respondent increased his prescribing of the purported monthly supplies of oxycodone and Zanaflex, and decreased his prescribing of Klonopin, to Patient A. Such prescriptions during this period included, without limitation, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
10/24/2016	Oxycodone	10 mg	279
10/24/2016	Klonopin	1 mg	75
10/24/2016	Zanaflex	4 mg	279
11/17/2016	Oxycodone	10 mg	279
11/17/2016	Klonopin	1 mg	60
11/17/2016	Zanaflex	4 mg	279

32. On or about November 30, 2016, Respondent received another "Retrospective Drug Utilization Review Program" notice from an insurance carrier advising, among other things, that Patient A had filled prescriptions issued by Respondent for purported 30-day supplies of 240 oxycodone 10 mg tablets on July 3, July 26, August 18 and September 10, 2016. The notice further stated that "[c]hronic early refills may be associated with an increased risk of medication abuse/misuse [and] [e]arly refills may also indicate that pain is not well controlled for a patient." On one of the pages of the notice, Respondent documented that Patient A had stated that she had a stockpile of pills and that Respondent wanted Patient A or her spouse to bring the stockpile in.

33. In a progress note for a clinical encounter with Patient A on or about December 1, 2016, Respondent documented:

> [Respondent] did get a Drug Utilization Review that stated over the last 4 months [Patient A] was filling her oxycodone essentially 1 week early. [Respondent was] unclear about this...[¶]...[Respondent was] going to have [Patient A's spouse] come in [and] bring in any extra meds...."

34. In a progress note for a clinical encounter with Patient A on or about December 12, 2016, Respondent documented:

> [Patient A] came in with her husband today. Essentially, had to address the issue of the oxycodone. We very carefully went through the early refills and essentially prior to increasing the number per month from #240 to #270 [Patient A] was running a deficit and getting them filled early. With that being said, none of that has happened since. We went through this very carefully with her husband here.

35. In or about the following year, Respondent continued to prescribe the increased purported monthly supplies of oxycodone and Zanaflex to Patient A, but ceased to prescribe Klonopin to Patient A for a period of multiple months before resuming in or about October 2017. Respondent's prescriptions of oxycodone, Zanaflex, and Klonopin to Patient A in or about December 2016 to December 2017 included, without limitation, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
12/1/2016	Oxycodone	10 mg	279
12/1/2016	Zanaflex	4 mg	279
12/12/2016	Oxycodone	10 mg	279
12/12/2016	Zanaflex	4 mg	279
12/29/2016	Oxycodone	10 mg	279
12/29/2016	Zanaflex	4 mg	279
1/19/2017	Oxycodone	10 mg	279
1/19/2017	Zanaflex	4 mg	279
2/13/2017	Oxycodone	10 mg	279
2/13/2017	Zanaflex	4 mg	279
3/13/2017	Oxycodone	10 mg	279
3/13/2017	Zanaflex	4 mg	279
4/3/2017	Oxycodone	10 mg	279
4/3/2017	Zanaflex	4 mg	279
5/1/2017	Oxycodone	10 mg	279
5/1/2017	Zanaflex	4 mg	279
5/25/2017	Oxycodone	10 mg	279
5/25/2017	Zanaflex	4 mg	279
6/15/2017	Oxycodone	10 mg	279
6/15/2017	Zanaflex	4 mg	279
7/5/2017	Oxycodone	10 mg	279
7/5/2017	Zanaflex	4 mg	279
7/24/2017	Oxycodone	10 mg	279
7/24/2017	Zanaflex	4 mg	279
8/15/2017	Oxycodone	10 mg	279
8/15/2017	Zanaflex	4 mg	279
9/11/2017	Oxycodone	10 mg	279

Date	Drug Name	Strength	Quantity
9/11/2017	Zanaflex	4 mg	279
10/2/2017	Oxycodone	10 mg	279
10/2/2017	Klonopin	1 mg	90
10/2/2017	Zanaflex	4 mg	279
10/25/2017	Oxycodone	10 mg	279
11/15/2017	Oxycodone	10 mg	279
11/15/2017	Klonopin	1 mg	90
11/15/2017	Zanaflex	4 mg	279
12/6/2017	Oxycodone	10 mg	279
12/6/2017	Klonopin	1 mg	90
12/6/2017	Zanaflex	4 mg	279

36. In a progress note for a clinical encounter with Patient A on or about December 6, 2017, Respondent documented asking Patient A's spouse to "cut back the oxycodone by 25% during this time to see how [Patient A] does." However, Respondent did not reduce the purported monthly supply of oxycodone he prescribed to Patient A on or about December 6, 2017.

37. Commencing on or about December 27, 2017, Respondent did begin to modify the purported monthly supplies of oxycodone, Klonopin, and Zanaflex he was prescribing to Patient A. Respondent's prescribing of such medications in or around December 27, 2017 to December 5, 2018 included, without limitation, prescriptions issued approximately on and for the following dates and dosages:

Date	Drug Name	Strength	Quantity
12/27/2017	Oxycodone	10 mg	249
12/27/2017	Klonopin	1 mg	60
12/27/2017	Zanaflex	4 mg	279
1/24/2018	Oxycodone	10 mg	249
1/24/2018	Klonopin	1 mg	45
1/24/2018	Zanaflex	4 mg	249
2/14/2018	Oxycodone	10 mg	234
2/14/2018	Klonopin	1 mg	45
2/14/2018	Zanaflex	4 mg	249
3/7/2018	Oxycodone	10 mg	234

Date	Drug Name	Strength	Quantity
3/7/2018	Klonopin	1 mg	45
3/7/2018	Zanaflex	4 mg	219
3/28/2018	Oxycodone	10 mg	234
3/28/2018	Klonopin	1 mg	30
3/28/2018	Zanaflex	4 mg	219
4/18/2018	Oxycodone	10 mg	234
4/18/2018	Klonopin	1 mg	30
4/18/2018	Zanaflex	4 mg	219
5/9/2018	Oxycodone	10 mg	210
5/9/2018	Klonopin	1 mg	30
5/9/2018	Zanaflex	4 mg	219
5/30/2018	Oxycodone	10 mg	210
5/30/2018	Klonopin	1 mg	30
5/30/2018	Zanaflex	4 mg	200
6/20/2018	Oxycodone	10 mg	200
6/20/2018	Klonopin	1 mg	30
6/20/2018	Zanaflex	4 mg	200
7/11/2018	Oxycodone	10 mg	200
7/11/2018	Klonopin	1 mg	30
7/11/2018	Zanaflex	4 mg	190

38. During this period, in his progress note for a clinical encounter with Patient A on or about April 18, 2018, Respondent documented that "[he] had planned to cut back the oxy[codone]. [Patient A's spouse] has asked [Respondent] to just cut back the Klonopin, which [Respondent] will do...." In fact, Respondent failed to reduce the amount of either the oxycodone or Klonopin prescribed to Patient A on or about April 18, 2018.

39. During this period, in a progress note for an encounter on or about May 9, 2018, Respondent documented that Patient A's spouse, without Patient A present, presented to Respondent. On or about May 9, 2018, Respondent provided prescriptions for Patient A for oxycodone, Klonopin and Zanaflex.

40. On or about July 25, 2018, Respondent received a call from Patient A and her spouse in which they represented that Patient A's medication had been stolen. In response, Respondent

issued to Patient A prescriptions for purported one-week supplies of approximately 50 oxycodone 10 mg tablets and 50 Zanaflex 4 mg pills.

41. On or about August 1, 2018, Respondent issued to Patient A prescriptions for purported one-month supplies of approximately 190 oxycodone 10 mg tablets, 30 Klonopin 1 mg tablets, and 190 Zanaflex 4 mg pills.

42. In a progress note for an encounter on or about August 20, 2018, Respondent documented that Patient A's spouse again presented to Respondent, without Patient A present. Respondent documented that he explained to Patient A's spouse that Respondent has to see Patient A in person, but nonetheless provided temporary prescriptions, for approximately 30 oxycodone 10 mg tablets, 30 Klonopin 1 mg tablets, and 30 Zanaflex 4 mg pills, that would be deducted from Patient A's purported total monthly prescriptions.

43. In a progress note for a clinical encounter on or about August 22, 2018, Respondent documented that Patient A presented to his office with her spouse, and that Respondent issued to Patient A prescriptions for approximately 160 oxycodone 10 mg tablets and 160 Zanaflex 4 mg pills.

44. In a progress note for an encounter on or about September 6, 2018, Respondent documented that Patient A's spouse again presented to Respondent, without Patient A present. Respondent documented that Patient A's spouse represented that Patient A was at another facility's emergency room for a flare up of colitis. Respondent further documented that Patient A's spouse wanted to obtain an extra week's worth of medication in anticipation of Patient A's discharge from the emergency room because Patient A had increased her usage of the oxycodone tablets to approximately 10 tablets per day and had run out of oxycodone early. Respondent documented that he did not provide the requested prescription during this encounter.

45. On or about September 14, 2018, Respondent issued for Patient A prescriptions for approximately 42 oxycodone 10 mg tablets and 30 Zanaflex 4 mg pills.

46. In a progress note for a clinical encounter on or about September 19, 2018, Respondent documented that Patient A presented to him, with her spouse present. Respondent further documented that Patient A had been discharged after a four-day hospitalization for severe

colitis, and that Respondent had given Patient A's spouse a short-term prescription the previous week because Patient A had run out early. Respondent documented that he advised Patient A that he was prescribing her 180 oxycodone tablets per month, which was six per day. Respondent documented that Patient A's spouse told Respondent that Patient A is taking eight oxycodone tablets per day.

47. In fact, on or about September 19, 2018, Respondent issued to Patient A a prescription for approximately 190 oxycodone 10 mg tablets, as well as for additional medications including, but not limited to, 30 Klonopin 1 mg tablets and 180 Zanaflex 4 mg pills.

48. On or about September 24, 2018, Respondent received a notification from an insurance carrier stating, among other things, that Patient A filled prescriptions from Respondent in the month of August 2018 totaling approximately 380 oxycodone 10 mg tablets, and filled a prescription issued by a health care provider other than Respondent for approximately 50 oxycodone 10 mg tablets on or about September 10, 2018.

49. On or about October 10, 2018, Respondent issued to Patient A prescriptions for medications including, but not limited to, approximately 190 oxycodone 10 mg tablets, 30 Klonopin 1 mg tablets, and 180 Zanaflex 4 mg pills.

50. In his progress note for a clinical encounter with Patient A on or about November 1, 2018, Respondent documented that he had helped to set up an appointment with a "pain doctor." Respondent documented that the pain doctor had requested some of Patient A's medical records from Respondent but that Patient A was not willing to provide such records, or authorization for their release, until she met the pain doctor.

51. On or about November 1, 2018, Respondent issued to Patient A prescriptions for purported monthly supplies of medications including, but not limited to, approximately 190 oxycodone 10 mg tablets, 30 Klonopin 1 mg tablets, and 180 Zanaflex 4 mg pills.

52. On or about December 5, 2018, Patient A presented to Respondent. In his progress note for this clinical encounter, Respondent documented that he had reviewed the CURES database, which contained entries indicating that Patient A had received Klonopin, oxycodone,

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and fentanyl patches from another healthcare provider on November 11, 2018. Respondent documented that he explained to Patient A that this clinical encounter would be their final one.

53. On or about December 5, 2018, Respondent issued to Patient A prescriptions for medications including, but not limited to, approximately 210 oxycodone 10 mg tablets, 30 Klonopin 1 mg tablets, and 180 Zanaflex 4 mg pills.

54. At or near the outset of his prescribing of controlled substances or muscle relaxants to Patient A, Respondent failed to adequately perform or document patient evaluation, assessment and risk stratification for Patient A.

55. On multiple occasions during the course of his prescribing of controlled substances to Patient A, Respondent failed to adequately document details regarding the controlled substances being prescribed or the rationale for prescribing such medications, or the prescribed dosages.

56. During the course of his prescribing of controlled substances to Patient A, Respondent failed to adequately establish or document treatment goals and outcomes for Patient A.

57. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately obtain or maintain records from other healthcare providers that had previously provided pain management treatment to Patient A, or were treating Patient A contemporaneously with Respondent.

58. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately document discussions with other healthcare providers to Patient A.

59. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately review or document review of the CURES database for controlled substance prescriptions filled to Patient A.

60. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately review or document review of toxicology drug testing for Patient A.

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61. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately conduct physical examinations of Patient A.

62. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately conduct or document reassessment for the continuation, revision or termination of the controlled substances prescribed to Patient A.

63. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately obtain or document vital signs for Patient A.

64. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately discuss or document discussing with Patient A the risks associated with the use of opioids in combination with benzodiazepines.

65. During the course of Respondent's prescribing of controlled substances to Patient A, Respondent failed to adequately consider or document consideration of prescribing Narcan to Patient A.

66. During the course of Respondent's care and treatment of Patient A, Respondent failed to adequately assess or document assessment of the effects of his chronic prescribing of opioids, benzodiazepines, or muscle relaxants, or any combination thereof, to Patient A.

67. During the course of Respondent's care and treatment of Patient A, Respondent failed to adequately assess or document assessment of Patient A for aberrant medication use or substance use disorder.

68. During the course of Respondent's care and treatment of Patient A, Respondent prescribed chronic high-doses of oxycodone, Klonopin, and Zanaflex without adequate medical indication.

69. Respondent's inappropriate prescribing of chronic high doses of opioids and benzodiazepines to Patient A resulted in harm to Patient A including, but not limited to, worsening drowsiness, deterioration of cognition, cycles of vomiting and diarrhea, flares of colitis, constipation, hypotension with syncope, opioid-induced hyperanalgesia, or any combination thereof.

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70. On multiple occasions during the course of Respondent's care and treatment of Patient A, Respondent failed to adequately document the performance of a mental status examination (MSE) or the working diagnosis or diagnoses for Patient A.

71. On multiple occasions during the course of Respondent's care and treatment of Patient A, Respondent prescribed high doses of oxycodone or Klonopin during a period in which Patient A was exhibiting a decreased or low glomerular filtration rate (GFR).

72. Respondent committed gross negligence in the course of his care and treatment of Patient A including, but not limited to:

(a) Failure to maintain adequate records for Patient A.

(b) Failure to adequately perform evaluation, assessment and risk stratification of Patient A while prescribing her multiple controlled substances.

(c) Issuing one or more prescriptions without adequate medical indication or outside Respondent's scope of practice, or both.

(d) Inappropriate prescribing of opioid or opiate medications in combination with benzodiazepines to Patient A.

Patient B

73. On multiple occasions beginning in or around April 2006,[9] Respondent rendered medical care and treatment to Patient B, whose medical history includes, but is not limited to, depression, dissociative identity disorder, bipolar mood disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

74. In his progress note for a clinical encounter with Patient B on or about January 15, 2015, Respondent documented that Patient B's "[c]urrent [m]edications" included, but were not limited to, approximately 4 mg per day of Klonopin and 75 mg per day of Adderall XR.[10]

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[9] Any acts or omissions by Respondent alleged herein to have occurred more than seven years prior to the filing of the accusation are pleaded for informational purposes only, and not as grounds for disciplinary action.

[10] Adderall XR is a brand name for an extended-release formulation of dextroamphetamine and amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an amphetamine salts commonly used for attention-deficit/hyperactivity disorder and narcolepsy.

Respondent further documented that he increased Patient B's prescribed monthly supply of Klonopin 2 mg tablets from approximately 60 tablets to 90 tablets (i.e., from approximately 4 mg to 6 mg per day).

75. In or about January 2015 to March 2015, Respondent issued multiple prescriptions to Patient B including, but not limited to, prescriptions corresponding to approximately 75 mg per day of Adderall XR and 4 to 6 mg per day of Klonopin.

76. In his progress note for a clinical encounter with Patient B on or about March 12, 2015, Respondent documented that Patient B was scheduled for gastric bypass surgery in April 2015.

77. The CURES database lists two controlled substance prescriptions, for tramadol[11] and Lortab,[12] issued by healthcare providers other than Respondent and filled to Patient B in or about March or April 2015.

78. The CURES database lists multiple controlled substance prescriptions issued by Respondent and filled to Patient B in or about April 9, 2015 to June 15, 2015:

Date Filled	Drug Name	Strength	Quantity	Days Supply
4/9/2015	Clonazepam	2 mg	90	30
5/18/2015	Clonazepam	2 mg	90	30
5/20/2015	Adderall XR	15 mg	30	30
5/21/2015	Adderall XR	30 mg	60	30
6/15/2015	Clonazepam	2 mg	90	30

79. Respondent's medical records for Patient B contain no record of any clinical encounters with Patient B between March 13, 2015 and June 15, 2015, inclusive, or any prescriptions issued during such period.

80. On or about June 29, 2015, Patient B presented to Respondent. In his progress note for this clinical encounter, Respondent documented that it was "the first time the patient [had]

[11] Tramadol is a Schedule IV controlled substance pursuant to 21 C.F.R., § 1308.14 and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Lortab is a brand name for the drug combination of hydrocodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

seen [him] in quite some time." Respondent further documented that she had been in the hospital, gotten septic, and had had a bowel obstruction.

81. In or about June 29, 2015 to January 2016, Respondent issued multiple prescriptions to Patient B including, but not limited to, prescriptions corresponding to approximately 75 mg per day of Adderall XR and 4 to 6 mg per day of Klonopin.

82. In or about October or November 2015, Respondent issued to Patient B a prescription for a purported one-month supply of approximately 30 Belsomra 20 mg tablets.[13] Patient B filled or refilled the Belsomra prescription on or about November 5, 2015, December 8, 2015, and January 23, 2016.

83. In his progress note for a clinical encounter with Patient B on or about February 4, 2016, Respondent documented that Patient B was "having a heck of a time sleeping" and that she had taken Klonopin, Belsomra, and Zyprexa[14] "and not slept."

84. In or about February 2016 to December 2016, Respondent continued to issue prescriptions to Patient B including, but not limited to, prescriptions corresponding to approximately 75 mg per day of Adderall XR and 4 to 6 mg per day of Klonopin.

85. During this period, in a progress note for a clinical encounter with Patient B on or about October 20, 2016, Respondent documented that "[t]he patient [was] dealing with a lot of problems with gallstones.... She's not taking pain meds, which [Respondent was] happy about."

86. In fact, the CURES database lists prescriptions issued by healthcare providers other than Respondent and filled to Patient B for oxycodone HCL/acetaminophen 10/325 mg or oxycodone HCL 5 mg on or about October 15, October 28, and November 15, 2016.

87. In a telephone note dated January 12, 2017, Respondent documented that "[Patient B was] very agitated. She's having suicidal thoughts. She doesn't feel safe. She is willing to contract for safety." Respondent documented that he prescribed approximately 20 Zyprexa 15 mg

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[13] Belsomra is a brand name for suvorexant, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is commonly used to treat insomnia.

[14] Zyprexa is a brand name for olanzapine, a psychotropic agent and dangerous drug pursuant to Business and Professions Code section 4022.

pills and asked Patient B to start with taking half a pill and check in with Respondent. Respondent documented that Patient B would see her psychologist in the morning.

88. On or about January 12, 2017, Respondent failed to adequately perform or document an MSE or a suicide risk assessment of Patient B.

89. On or after January 12, 2017, Respondent failed to adequately consult or document consultation with any other healthcare provider to Patient B, or schedule a follow-up appointment with Patient B within a time frame consistent with her acute presentation on or about January 12, 2017.

90. In or about January 2017 to December 2017, Respondent continued to issue prescriptions to Patient B including, but not limited to, prescriptions corresponding to approximately 75 mg per day of Adderall XR and 4 to 6 mg per day of Klonopin.

91. The CURES database lists a prescription issued by a healthcare provider other than Respondent, and filled to Patient B on or about December 15, 2017, for approximately six tramadol 50 mg tablets.

92. In or about January 2018 to July 2018, Respondent continued to issue prescriptions to Patient B including, but not limited to, prescriptions corresponding to approximately 75 mg per day of Adderall XR and 4 to 6 mg per day of Klonopin.

93. During the course of Respondent's prescribing of Klonopin to Patient B in or around January 2015 to July 2018, Respondent failed to adequately discuss or document discussing with Patient B the risks of benzodiazepine use in combination with opioids or opiates, or the possibility of prescribing Narcan to Patient B.

94. On multiple occasions during the course of Respondent's care and treatment of Patient B in or around January 2015 to July 2018, Respondent failed to adequately obtain or document obtaining vital signs including, but not limited to, blood pressure or heart rate from Patient B.

95. During the course of Respondent's prescribing of controlled substances to Patient B in or around January 2015 to July 2018, Respondent failed to adequately review or document review of the CURES database for controlled substance prescriptions filled to Patient B.

96. During the course of Respondent's prescribing of controlled substances to Patient B in or around January 2015 to July 2018, Respondent failed to adequately review or document review of toxicology drug testing for Patient B.

97. On multiple occasions during the course of Respondent's care and treatment of Patient B in or about January 2015 to July 2018, Respondent failed to adequately document a clinical encounter with Patient B including, but not limited to, failing to adequately document subjective impressions or assessments of the patient's psychiatric status, the basis for continuation or modification of treatment, a psychiatric diagnosis or diagnoses, Respondent's treatment plan, or any combination thereof.

98. On multiple occasions during the course of Respondent's care and treatment of Patient B in or about January 2015 to July 2018, Respondent failed to adequately perform or document an MSE during a clinical encounter with Patient B.

99. During the course of Respondent's care and treatment of Patient B in or around January 2015 to July 2018, Respondent failed to adequately discuss or document discussion with Patient B's psychologist regarding Patient B's mental health treatment.

100. During the course of Respondent's care and treatment of Patient B in or about January 2015 to July 2018, Respondent failed to adequately assess or document assessment of his ongoing chronic prescribing of Klonopin to Patient B.

101. On multiple occasions during the course of Respondent's care and treatment of Patient B in or around January 2015 to July 2018, Respondent increased the dosage or quantity of Klonopin prescribed to Patient B in response to an increase in one or more of the patient's PTSD symptoms. Benzodiazepines, such as Klonopin, are contraindicated for PTSD.

102. During the course of Respondent's prescribing of Adderall to Patient B in or around January 2015 to July 2018, Respondent failed to adequately assess or document assessment of whether his chronic, high-dose prescribing of Adderall was contributing to Patient B's complaints of insomnia.

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103. Respondent committed gross negligence in the course of his care and treatment of Patient B including, but not limited to, failing to adequately:

(a) Maintain medical records for Patient B.

(b) Perform evaluation, assessment and risk stratification of Patient B while prescribing her multiple controlled substances.

(c) Complete and document a suicide risk assessment for Patient B in or around January 2017.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

104. Respondent Michael Theodore Lardon, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code in that he committed repeated negligent acts in his care and treatment of one or more patients as more particularly alleged in paragraphs 9 to 103, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Prescribing, Dispensing, or Furnishing of a Dangerous Drug without an Appropriate Prior Examination and a Medical Indication)

105. Respondent Michael Theodore Lardon, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code in that he prescribed, dispensed, or furnished a dangerous drug on one or more occasions without an appropriate prior examination and medical indication as more particularly alleged in paragraphs 9 to 104, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

106. Respondent Michael Theodore Lardon, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code in that he committed repeated acts of clearly excessive

prescribing, furnishing, dispensing or administering of a drug or treatment as more particularly alleged in paragraphs 9 to 104, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

107. Respondent Michael Theodore Lardon, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code in that he failed to maintain adequate and accurate records relating to his provision of services to one or more patients as more particularly alleged in paragraphs 9 to 104, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

108. Respondent Michael Theodore Lardon, M.D. has further subjected his Physician's and Surgeon's Certificate No. A 48664 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code in that he violated or attempted to violate, directly or indirectly, any provision of the Medical Practice Act as more particularly alleged in paragraphs 9 to 107, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 48664, issued to Respondent Michael Theodore Lardon, M.D.;

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

3. Ordering Respondent Michael Theodore Lardon, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUL 30 2020

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