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

In the Matter of the Accusation Against: **MARC HOUSTON REINER, M.D.** **2240 Shelter Island Drive, No. 205** **San Diego, CA 92106** **Physician's and Surgeon's Certificate No. G 49887,** Respondent.	Case No. 800-2020-064246 **A C C U S A T I O N**

Complainant alleges:

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 May 9, 1983, the Board issued Physician's and Surgeon's Certificate No. G 49887 to Marc Houston Reiner, 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, 2023, unless renewed.

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 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
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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.
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> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code states, 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.
>
> (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.

(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 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.

COST RECOVERY

7. Section 125.3 of the Code states:

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

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

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

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

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

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

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

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

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

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

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

FACTUAL ALLEGATIONS

2014[1]

8. On or about June 30, 2014, Patient A,[2] a then 26-year-old female, presented for treatment with Respondent to address Patient A's complaint of poor concentration. In or around 2014, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately three (3) occasions, including, but not limited to, June 30, July 28, and September 16.

9. On or about June 30, 2014, according to records, Respondent evaluated Patient A and diagnosed Patient A with attention deficit hyperactivity disorder (ADHD) and issued a

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[1] Conduct occurring over more than seven (7) years from the filing date of the instant Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[2] For patient privacy purposes, the patient's name is not used in the instant Accusation to maintain patient confidentiality. The patient's identity is known to Respondent or will be disclosed to Respondent upon receipt of a duly issued request for discovery and in accordance with Government code section 11507.6.

prescription for Adderall[3] (20 mg, 60 tablets, two per day). According to records, Respondent regularly prescribed Adderall to Patient A through the remainder of her treatment, from in or around 2014, through in or around 2019. However, according to records, in his evaluation of Patient A, Respondent did not indicate that Patient A displayed six (6) or more symptoms of inattention or hyperactivity, Respondent did not indicate that Patient A expressed having symptoms prior to age twelve (12), and Respondent did not indicate that Patient A experienced symptoms in two (2) different settings.

10. On or about June 30, 2014, in Respondent's initial intake evaluation of Patient A, Respondent confirmed Patient A consumed alcohol, but in his evaluation, Respondent did not determine, or inquire into, Patient A's past substance use, the amount of substance used, any past treatment for substance use disorder, or family history of substance use disorder.

11. On or about July 28, 2014, Patient A presented for a visit with Respondent. According to records, Patient A reported taking 30 mg of Adderall in the morning and 10 mg of Adderall in the evenings. According to Patient A's medical records, Respondent continued Patient A's prescription for Adderall (20 mg, 60 tablets, two per day).

12. On or about September 16, 2014, according to the Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES),[4] Respondent issued a

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[3] Adderall, brand name for dextroamphetamine and amphetamine salt combination, is 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. When indicated, it is commonly used in the treatment of attention deficit hyperactivity disorder and narcolepsy. When issued to treat ADHD, the maximum recommended dose is 40 mg per day.

[4] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

prescription to Patient A for clonazepam[5] (0.5 mg, 15 tablets). However, according to Patient A's medical records, Respondent's issuance and basis for prescribing clonazepam to Patient A was not documented in Patient A's medical records. Patient A's records show no diagnosis to justify this prescription, nor is there any documentation of an assessment performed by Respondent to support this prescription.

13. According to Patient A's medical records, Patient A did not present for any clinical visits with Respondent after September 16, 2014, until January 6, 2015.

14. On or about November 5, 2014, according to CURES, Respondent issued a prescription to Patient A for Adderall (30 mg, 60 tablets, two per day). This increase in dosage, Respondent's rationale for this change in prescription, and Respondent's basis for prescribing above the maximum recommended dose of Adderall for ADHD, was not documented in Patient A's medical records.

15. According to CURES, in or around 2014, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
6/30/14	Adderall	20 mg	60
7/31/14	Adderall	20 mg	60
8/25/14	Adderall	20 mg	60
9/16/14	Clonazepam	0.5 mg	15
9/16/14	Adderall	20 mg	60
10/11/14	Adderall	20 mg	60
11/5/14	Adderall	30 mg	60
12/4/14	Adderall	30 mg	60

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[5] Clonazepam, brand name Klonopin or Clonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

2015

16. In or around 2015, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately six (6) occasions, including, but not limited to, January 6, March 10, May 26, July 21, October 21, and December 22.

17. On or about January 6, 2015, Patient A presented for a visit with Respondent. According to records, Patient A reported taking 30 mg of Adderall in the morning and 15 mg of Adderall in the evenings. According to Patient A's medical records, at this visit, Respondent increased Patient A's prescription for Adderall from 20 mg (two per day) to 30 mg (two per day). This increase in dosage, Respondent's rationale for this change in prescription, and Respondent's basis for prescribing above the maximum recommended dose of Adderall for ADHD, was not documented in Patient A's medical records.

18. On or about March 10, 2015, Patient A presented for a visit with Respondent. According to CURES, Respondent changed Patient A's prescription for Adderall from 30 mg (two per day) to 20 mg (three per day). This change in prescription and Respondent's rationale for this change in prescription was not documented in Patient A's medical records. According to Patient A's medical records, Respondent maintained Patient A's prescription for Adderall at 30 mg (two per day).

19. According to CURES, on or about April 13, 2015, Respondent issued a prescription to Patient A for Adderall (20 mg, 90 tablets, three per day). According to CURES, on or about April 20, 2015, Respondent again issued a prescription to Patient A for Adderall (20 mg, 90 tablets, three per day). Respondent's rationale and issuance of these two prescriptions within one week was not documented in Patient A's medical record.

20. On or about May 26, 2015, Patient A presented for a visit with Respondent. According to CURES, Respondent issued a prescription to Patient A for alprazolam[6] (0.5 mg, 30 tablets, one per day). However, according to Patient A's medical records, Respondent's issuance

[6] Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

and basis for prescribing alprazolam to Patient A was not documented in Patient A's medical records. Patient A's records show no diagnosis to justify this prescription, nor is there any documentation of an assessment performed by Respondent to support this prescription. According to records, Respondent regularly prescribed alprazolam to Patient A through the remainder of her treatment, from in or around 2015, through in or around 2019. However, according to records, Respondent did not document Patient A's prescriptions for alprazolam until on or about May 16, 2017.

21. On or about July 21, 2015, Patient A presented for a visit with Respondent. According to CURES, Respondent changed Patient A's prescription for Adderall from 20 mg (three per day) to 30 mg (two per day). This change in prescription and Respondent's rationale for this change in prescription was not documented in Patient A's medical records.

22. In or around 2015, according to CURES, Respondent regularly issued prescriptions to Patient A for Adderall and alprazolam, however, Patient A's records do not document the issuance of the prescriptions for alprazolam, any assessment or diagnosis to support the prescriptions for alprazolam, any review of Patient A's vital signs by Respondent, or any discussion with Patient A regarding the risks associated with taking Adderall and alprazolam.

23. According to CURES, in or around 2015, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
1/7/15	Adderall	30 mg	60
2/2/15	Adderall	30 mg	60
3/10/15	Adderall	20 mg	90
4/13/15	Adderall	20 mg	90
4/20/15	Adderall	20 mg	90
5/26/15	Alprazolam	0.5 mg	30
7/17/15	Alprazolam	0.5 mg	30
7/23/15	Adderall	30 mg	60

DATE	DRUG	STRENGTH	QUANTITY
8/27/15	Adderall	30 mg	60
9/1/15	Alprazolam	0.5 mg	30
10/23/15	Adderall	30 mg	60
10/23/15	Alprazolam	0.5 mg	30
11/18/15	Alprazolam	0.5 mg	30
12/30/15	Alprazolam	0.5 mg	30

2016

24. In or around 2016, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately four (4) occasions, including, but not limited to, March 28, May 24, August 2, and October 18.

25. On or about March 28, 2016, Patient A presented for a visit with Respondent. According to records, Patient A reported her Adderall prescription for 30 mg (two per day) was too much and elected to decrease her Adderall prescription to 20 mg (two per day). According to CURES, Respondent issued a prescription to Patient A for Adderall (20 mg, 60 tablets, two per day).

26. On or about May 24, 2016, Patient A presented for a visit with Respondent. According to records, Patient A indicated she preferred the 30 mg tablets to cut in half for a 15 mg dose. According to CURES, Respondent resumed issuing prescriptions to Patient A for Adderall (30 mg, 60 tablets, two per day).

27. According to Patient A's medical records, Patient A did not present for any clinical visits with Respondent after October 18, 2016, until March 14, 2017.

28. In or around 2016, according to CURES, Respondent regularly issued prescriptions to Patient A for Adderall and alprazolam, however, Patient A's records do not document the issuance of the prescriptions for alprazolam, any assessment or diagnosis to support the prescriptions for alprazolam, any review of Patient A's vital signs by Respondent, or any discussion with Patient A regarding the risks associated with taking Adderall and alprazolam.

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29. According to CURES, in or around 2016, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
1/4/16	Adderall	30 mg	60
2/5/16	Adderall	30 mg	60
3/29/16	Alprazolam	0.5 mg	30
3/30/16	Adderall	20 mg	60
4/29/16	Adderall	20 mg	60
6/25/16	Adderall	30 mg	60
8/3/16	Alprazolam	0.5 mg	30
8/3/16	Adderall	30 mg	60
9/19/16	Adderall	30 mg	60
10/22/16	Alprazolam	0.5 mg	30
11/29/16	Alprazolam	0.5 mg	30
11/29/16	Adderall	30 mg	60

2017

30. In or around 2017, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately five (5) occasions, including, but not limited to, March 14, May 16, July 25, September 26, and November 27.

31. On or about March 14, 2017, Patient A presented for a visit with Respondent. According to CURES, Respondent issued a prescription to Patient A for Ambien[7] (10 mg, 30 tablets, one per day). However, according to Patient A's medical records, Respondent's issuance and basis for prescribing Ambien to Patient A was not documented in Patient A's medical records. Patient A's records do not document a diagnosis or assessment performed by

[7] Ambien is a brand name for zolpidem, 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. Ambien is a benzodiazepine analog. When properly prescribed and indicated, it is commonly used to treat short term insomnia.

Respondent to support this prescription for Ambien. Patient A's records do not document a discussion between Respondent and Patient A regarding the risks associated with Patient A being prescribed Adderall, alprazolam, and Ambien. Patient A's records do not document any consideration by Respondent to consider the lesser recommended dose of 5 mg for Ambien.

32. According to records, Respondent regularly prescribed Ambien to Patient A through the remainder of her treatment, from in or around 2017, through in or around 2019. However, Patient A's records do not document Patient A's prescriptions for Ambien until on or about September 26, 2017. Patient A's records also do not document Respondent's rationale for prescribing Ambien to Patient A for long-term use.

33. On or about May 16, 2017, Patient A presented for a visit with Respondent. According to Patient A's medical records, on this date, Respondent first documents his prescription to Patient A for alprazolam and indicates anxiety as the basis for this prescription. However, according to Patient A's medical records, Respondent did not document an assessment or explanation for this prescription other than a notation of anxiety.

34. On or about September 26, 2017, Patient A presented for a visit with Respondent. According to Patient A's medical records, on this date, Respondent first documents his prescription to Patient A for Ambien. However, according to Patient A's medical records, Respondent did not document a diagnosis, assessment, or explanation for this prescription other than direction to take as needed for sleep.

35. According to Patient A's medical records, Patient A did not present for any clinical visits with Respondent after November 27, 2017, until February 7, 2018.

36. In or around 2017, according to CURES, Respondent regularly issued prescriptions to Patient A for Adderall, alprazolam, and Ambien, however, Patient A's records do not document any assessment or diagnosis to support the prescriptions for alprazolam and Ambien, any review of Patient A's vital signs by Respondent, or any discussion with Patient A regarding the risks associated with taking Adderall, alprazolam, and Ambien.

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37. According to CURES, in or around 2017, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
2/2/17	Adderall	30 mg	60
2/21/17	Alprazolam	0.5 mg	30
3/16/17	Adderall	30 mg	60
3/16/17	Ambien	10 mg	30
3/23/17	Alprazolam	0.5 mg	30
4/20/17	Adderall	30 mg	60
5/20/17	Adderall	30 mg	60
5/20/17	Alprazolam	0.5 mg	30
6/19/17	Adderall	30 mg	60
7/17/17	Alprazolam	0.5 mg	30
7/25/17	Adderall	30 mg	60
8/18/17	Ambien	10 mg	30
8/22/17	Alprazolam	0.5 mg	30
8/25/17	Adderall	30 mg	60
9/26/17	Adderall	30 mg	60
9/26/17	Ambien	10 mg	30
10/29/17	Alprazolam	0.5 mg	30
10/29/17	Adderall	30 mg	60
12/3/17	Adderall	30 mg	60
12/3/17	Alprazolam	0.5 mg	30
12/4/17	Ambien	10 mg	30

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2018

38. In or around 2018, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately five (5) occasions, including, but not limited to, February 7, May 16, July 16, September 19, and November 27.

39. In or around 2018, Patient A attempted to commit suicide. Patient A's records do not reflect any documentation of this suicide attempt or any careful examination by Respondent or performance of Patient A's suicide risk assessment on an ongoing basis.

40. On or about September 19, 2018, Patient A presented for a visit with Respondent. According to Patient A's medical records, she requested a prescription for Inderal.[8] According to Patient A's records, Respondent added a prescription for Inderal while documenting the continued prescriptions for Adderall, alprazolam, and Ambien.

41. In or around 2018, according to CURES, Respondent regularly issued prescriptions to Patient A for Adderall, alprazolam, and Ambien, however, Patient A's records do not document any assessment or diagnosis to support the prescriptions for alprazolam and Ambien, any review of Patient A's vital signs by Respondent, or any discussion with Patient A regarding the risks associated with taking Adderall, alprazolam, and Ambien.

42. According to CURES, in or around 2018, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
1/3/18	Adderall	30 mg	60
2/7/18	Adderall	30 mg	60
2/7/18	Alprazolam	0.5 mg	30
3/1/18	Ambien	10 mg	30
3/21/18	Adderall	30 mg	60
4/17/18	Alprazolam	0.5 mg	30

[8] Inderal, brand name for propranolol, is a beta blocker commonly used to treat high blood pressure, chest pain and irregular heart rhythm. Off label, Inderal is commonly prescribed for performance anxiety. It is a dangerous drug pursuant to Business and Professions Code section 4022.

DATE	DRUG	STRENGTH	QUANTITY
5/16/18	Adderall	30 mg	60
6/18/18	Ambien	10 mg	30
6/18/18	Alprazolam	0.5 mg	30
6/18/18	Adderall	30 mg	60
7/16/18	Adderall	30 mg	60
7/31/18	Ambien	10 mg	30
8/19/18	Adderall	30 mg	60
9/19/18	Adderall	30 mg	60
10/11/18	Ambien	10 mg	30
10/11/18	Alprazolam	0.5 mg	30
10/20/18	Adderall	30 mg	60
11/20/18	Alprazolam	0.5 mg	30
11/20/18	Ambien	10 mg	30
11/27/18	Adderall	30 mg	60
12/22/18	Ambien	10 mg	30
12/26/18	Alprazolam	0.5 mg	30
12/28/18	Adderall	30 mg	60

2019

43. In or around 2019, according to Patient A's medical records, Patient A attended office visits with Respondent on approximately three (3) occasions, including, but not limited to, January 28, April 1, and June 3.

44. On or about April 1, 2019, Patient A presented for a visit with Respondent. According to CURES, Respondent changed Patient A's prescription for Adderall from 30 mg (two per day), to 20 mg (three per day). This change in prescription and Respondent's rationale for this change in prescription was not documented in Patient A's medical records. According to

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Patient A's medical records, Respondent maintained Patient A's prescription for Adderall at 30 mg (two per day) for the remainder of her treatment.

45. In or around 2019, according to CURES, Respondent regularly issued prescriptions to Patient A for Adderall, alprazolam, and Ambien, however, Patient A's records do not document any assessment or diagnosis to support the prescriptions for alprazolam and Ambien, any review of Patient A's vital signs by Respondent, or any discussion with Patient A regarding the risks associated with taking Adderall, alprazolam, and Ambien.

46. According to CURES, in or around 2019, Respondent issued the following prescriptions to Patient A:

DATE	DRUG	STRENGTH	QUANTITY
1/28/19	Ambien	10 mg	30
1/29/19	Adderall	30 mg	60
3/1/19	Adderall	30 mg	60
3/1/19	Alprazolam	0.5 mg	30
3/1/19	Ambien	10 mg	30
4/1/19	Adderall	20 mg	90
4/3/19	Alprazolam	0.5 mg	30
4/3/19	Ambien	10 mg	30
5/1/19	Adderall	20 mg	90
5/8/19	Alprazolam	0.5 mg	30
5/8/19	Ambien	10 mg	30
6/3/19	Adderall	20 mg	90
6/12/19	Alprazolam	0.5 mg	30
6/12/19	Ambien	10 mg	30
7/4/19	Adderall	20 mg	90

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47. According to Patient A's medical records, from in or around 2014, through in or around 2019, Respondent did not perform a thorough history and physical examination of Patient A.

48. According to Patient A's medical records, from in or around 2014, through in or around 2019, Respondent did not thoroughly assess or evaluate Patient A's risk of substance use disorder.

49. According to Patient A's medical records, from in or around 2014, through in or around 2019, Respondent did not discuss the risks associated with long-term use of Adderall, alprazolam, and Ambien with Patient A.

50. According to Patient A's medical records and CURES, from in or around 2014, through in or around 2019, Respondent did not review Patient A's patient activity report in CURES to monitor for compliance or to review for possible indications of substance use disorder.

51. According to Patient A's CURES report, from in or around 2014, through in or around 2019, based upon prescriptions and refills issued or authorized by Respondent, Patient A filled a total number of fifty (50) prescriptions for Adderall, twenty-seven (27) prescriptions for alprazolam, and fifteen (15) prescriptions for Ambien.

52. According to Patient A's CURES report, from in or around 2014, through in or around 2019, Patient A filled her prescriptions authorized by Respondent, at approximately eight (8) different pharmacies.

53. According to Patient A's CURES report, from in or around 2014, through in or around 2019, Patient A filled six (6) prescriptions for controlled substances issued by three (3) other healthcare providers.

54. On or about July 23, 2019, Patient A passed away as a result of suicide.

55. According to medical records, Patient A's toxicology results tested positive for cocaine, tetrahydrocannabinol (THC),[9] benzodiazepines, and amphetamines.

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[9] Tetrahydrocannabinol (THC) is the principal psychoactive component found in cannabis, marijuana.

56. On or about March 29, 2021, Respondent attended an interview with investigators with the Department of Consumer Affairs (DCA), Health Quality Investigation Unit (HQIU). During this interview, Respondent indicated, throughout his care and treatment of Patient A, she only reported a family history of ADHD and never disclosed her family history of alcohol or drug abuse. Respondent stated he was aware Patient A consumed alcohol, but never observed any indications of abuse during his office visits with Patient A. Respondent also indicated he had no knowledge of Patient A's suicide attempt in 2018 until Patient A's parents disclosed this information to Respondent after her death. During this interview, Respondent affirmed, throughout his care and treatment of Patient A, he did not assess her vital signs, request any of Patient A's records from other providers, review Patient A's patient activity report in CURES, or determine Patient A to have any suicidal ideation.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

57. Respondent has subjected his Physician's and Surgeon's Certificate No. G 49887 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 a Patient A, which included, but was not limited to:

A. Paragraphs 8 through 56, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to document his issuance of repeated prescriptions to Patient A for alprazolam from on or about May 26, 2015, through on or about May 16, 2017;

C. Respondent failed to perform, and/or document the performance of, an evaluation, assessment, diagnosis, or rationale for initiating and maintaining prescriptions to Patient A for alprazolam on or about May 26, 2015, or thereafter;

D. Respondent failed to document his issuance of repeated prescriptions to Patient A for Ambien from on or about March 14, 2017, through on or about

September 26, 2017, and Respondent failed to perform, and/or document the performance of, an evaluation, assessment, diagnosis, or rationale for initiating and maintaining prescriptions to Patient A for Ambien on or about March 16, 2017, or thereafter; and

E. Respondent failed to review Patient A's patient activity in CURES to monitor for compliance or review for indications of substance use disorder.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

58. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 49887 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 a Patient A, which included, but was not limited to:

A. Paragraphs 8 through 57, above, are hereby incorporated by reference and realleged as if fully set forth herein;

B. Respondent failed to perform, and/or document the performance of, a thorough evaluation of Patient A throughout his care and treatment of Patient A to support his diagnosis of ADHD;

C. Respondent failed to perform, and/or document the performance of, a thorough evaluation of Patient A throughout his care and treatment of Patient A to assess for substance use disorder;

D. Respondent failed to document his rationale for increasing Patient A's Adderall prescription on or about January 6, 2015, from 40 mg per day to 60 mg per day;

E. Respondent failed to document his rationale for prescribing above the maximum recommended dose of Adderall (40 mg per day) when he prescribed Adderall (60 mg per day) to Patient A beginning on or about January 6, 2015, and thereafter;

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F. Respondent failed to document his issuance of two (2) prescriptions for Adderall (20 mg, 90 tablets) to Patient A on or about April 13, 2015, and again, on or about April 20, 2015;

G. Respondent failed to recognize the issuance of two (2) prescriptions for Adderall to Patient A within one (1) week, on or about April 13, 2015, and April 20, 20215, as a warning sign of possible substance use disorder and/or take appropriate steps to monitor for other signs of possible substance use disorder;

H. Respondent failed to discuss, and/or document a discussion, with Patient A the risks associated with maintaining regular prescriptions for three (3) controlled substances, Adderall, alprazolam, and Ambien;

I. Respondent failed to consider, and/or document consideration of, issuing the lower recommended dose of Ambien for women (5 mg) before initiating and issuing regular prescriptions to Patient A for Ambien (10 mg);

J. Respondent failed to document his rationale for prescribing Ambien to Patient A on a long-term basis;

K. Respondent failed to review Patient A's vital signs throughout his care and treatment of Patient A while issuing regular prescriptions to Patient A for Adderall, alprazolam, and Ambien, over several years;

L. Respondent failed to perform, and/or document the performance of, an ongoing suicide risk assessment of Patient A throughout his care and treatment of Patient A, including, but not limited to, an inquiry into Patient A's past suicide attempt, past suicide ideation, or past self-harm;

M. Respondent failed to maintain more frequent clinic visits with Patient A between on or about September 16, 2014, and on or about January 6, 2015, while issuing regular prescriptions to Patient A for Adderall;

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N. Respondent failed to maintain more frequent clinic visits with Patient A between on or about October 18, 2016, and March 14, 2017, while issuing regular prescriptions to Patient A for Adderall and alprazolam; and

O. Respondent failed to document a diagnosis to support the issuance of regular prescriptions to Patient A for alprazolam and Ambien.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and/or Accurate Records)

59. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 49887 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and/or accurate records regarding his care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 58, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Violation and/or Violations of a Provision and/or Provisions of the Medical Practice Act)

60. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 49887 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that he committed a violation and/or violations of a provision and/or provisions of the Medical Practice Act in his care and treatment of Patient A, as more particularly alleged in paragraphs 8 through 59, above, which are hereby incorporated by reference and realleged 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 or suspending Physician's and Surgeon's Certificate No. G 49887, issued to Respondent Marc Houston Reiner, M.D.;

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

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3. Ordering Respondent Marc Houston Reiner, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: DEC 21 2021

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

Reji Varghese
Deputy Director

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