ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
KALEV KASEORU
Deputy Attorney General
State Bar No. 331645
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7508
Facsimile: (916) 327-2247
E-mail: Kalev.Kaseoru@doj.ca.gov
Attorneys for Complainant

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: **ARUDRA BODEPUDI, M.D.** **5250 Claremont Ave., Ste. 103** **Stockton, CA 95207-5700** **Physician's and Surgeon's Certificate No. A 73676** Respondent.	Case No. 800-2022-087548 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

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

2. On or about December 28, 2000, the Medical Board of California issued Physician's and Surgeon's Certificate Number A 73676 to Arudra Bodepudi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in effect at all times relevant to the charges brought herein and will expire on June 30, 2024, unless renewed.

3. In a disciplinary action titled "In the Matter of Accusation and Petition to Revoke Probation Against Arudra Bodepudi, M.D.," Case No. 800-2015-012722, the Medical Board of California, issued a decision, effective August 25, 2016, in which Respondent's Physician's and Surgeon's Certificate was revoked.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 placed on probation for a period of 35 months with certain terms and conditions. A copy of that decision is attached as Exhibit A and is incorporated by reference.

JURISDICTION

4. This Accusation and Petition to Revoke Probation 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.

5. 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:

(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 discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(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.

6. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

7. Section 822 of the Code states:

If a licensing agency determines that its licentiate's ability to practice his or her profession safely is impaired because the licentiate is mentally ill, or physically ill

affecting competency, the licensing agency may take action by any one of the following methods:

(a) Revoking the licentiate's certificate or license.

(b) Suspending the licentiate's right to practice.

(c) Placing the licentiate on probation.

(d) Taking such other action in relation to the licentiate as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

CAUSE TO REVOKE PROBATION

(Failure to Comply with Probation Conditions)

8. At all times after the effective date of Respondent's probation, Condition 10 stated:

"Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that

meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice 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 probations: Obey All Laws; and General Probation Requirements."

9. At all times after the effective date of Respondent's probation, Condition 12 stated:

"Failure to comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, 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 or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final."

10. Respondent's probation is subject to revocation because she failed to comply with Probation Condition 10 and 12, referenced above. The facts and circumstances regarding this violation are as follows:

A. On or about November 19, 2019, Respondent went into non-practice status when a Cease Practice Order was issued following her suspension from the UCSD Physician Enhancement Program (PEP), due to failure to provide PEP with billing records.

B. On or about May 2021, Respondent's period of non-practice exceeded 18 calendar months and she was required to successfully complete a clinical competence assessment program prior to returning to the practice of medicine.

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C. On or about November 19, 2021, Respondent exceeded two years of non-practice. On this same day, Respondent provided proof of enrollment in the UCSD Physician Assessment and Clinical Education Program (PACE) clinical competence assessment program.

D. On or about April 13, 2022, the Board received the report from PACE indicating that they found Respondent unfit for duty.

CAUSE FOR RESTRICTION AND/OR REVOCATION

(Mental or Physical Illness Affecting Competency to Practice Medicine)

11. Respondent's Physician's and Surgeon's Certificate No. A 73676 is subject to action under section 822 of the Code in that her ability to safely practice medicine is impaired due to a mental or physical illness affecting competency, as more particularly alleged in paragraphs 8 to 10 above, which are hereby incorporated herein 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 the probation that was granted by the Medical Board of California in Case No. 800-2015-012722 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate No. A 73676 issued to Arudra Bodepudi, M.D.;

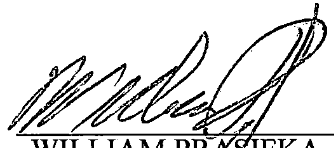
2. Revoking or suspending Physician's and Surgeon's Certificate No. A 73676, issued to Arudra Bodepudi, M.D.;

3. Revoking, suspending or denying approval of Arudra Bodepudi, M.D.'s authority to supervise physician's assistants and advanced practice nurses;

4. Ordering Arudra Bodepudi, M.D. to pay the Medical Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

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

1 DATED: AUG 3 0 2022



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

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Exhibit A

Decision and Order

Medical Board of California Case No. 800-2022-087548

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

In the Matter of the Accusation Against:	
Arudra Bodepudi, M.D.	Case No. 02-2009-200813
Physician's and Surgeon's Certificate No. A 73676	
Respondent	

DECISION

The attached Proposed Stipulated Settlement 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 February 16, 2012.

IT IS SO ORDERED: January 17, 2012.

MEDICAL BOARD OF CALIFORNIA

Shelton Duruisseau

Shelton Duruisseau, Ph.D, Chair
Panel A

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.
Signature
for Custodian of Records
Title
4-14-2022
Date

KAMALA D. HARRIS
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-3496
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 02-2009-200813
ARUDRA BODEPUDI, M.D. **3883 Canyonlands Road** **Stockton, CA 95209** **Physician and Surgeon's No. A 73676** Respondent.	OAH No. 2010080468 **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. 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 Jannsen Tan, Deputy Attorney General.

2. Respondent Arudra Bodepudi, M.D. (Respondent) is represented in this proceeding by attorney Albert J. Garcia Esq., whose address is: Watergate Office Towers III, 2000 Powell Street, Suite 1290, Emeryville, CA 94608-1860

3. On or about December 28, 2000, the Medical Board of California issued Physician and Surgeon's No. A 73676 to Audra Bodepudi, M.D. (Respondent). The certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 02-2009-200813

and will expire on June 20, 2012, unless renewed.

JURISDICTION

4. Accusation No. 02-2009-200813 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 July 13, 2010. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 02-2009-200813 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. 02-2009-200813. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of her 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 her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her 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, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 02-2009-200813.

9. Respondent agrees that her Physician and Surgeon's is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

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RESERVATION

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

11. 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 Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

12. 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.

13. 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:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician and Surgeon's No. A 73676 issued to Respondent Audra Bodepudi, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. **CLINICAL TRAINING PROGRAM**

Within 60 calendar days of the effective date of this Decision, Respondent shall

enroll in a clinical training or educational program equivalent to 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 date obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board 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 Board 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 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 Board 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.

If Respondent fails to complete the clinical training program within the designated time period, Respondent shall cease the practice of medicine within 72 hours after being notified by the Board or its designee that Respondent failed to complete the clinical training program.

///

2. **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 Board or its designee. Failure to successfully complete the course during the first six (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 Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board 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 Board 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. **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 Board or its designee. Failure to successfully complete the course during the first six (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 Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board 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 Board 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.

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4. **NOTIFICATION**

Prior to engaging in the practice of medicine, the Respondent shall provide a true copy of the Decision and Accusation 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 Board or its designee within 15 calendar days.

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

5. **SUPERVISION OF PHYSICIAN ASSISTANTS**

During probation, Respondent is prohibited from supervising physician assistants.

6. **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.

7. **QUARTERLY DECLARATIONS**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, 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.

8. **PROBATION UNIT COMPLIANCE**

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board 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).

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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 Board, 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.

9. **INTERVIEW WITH THE BOARD, 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 Board or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

10. **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 Board 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 Board 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; and Probation Unit Compliance.

Respondent's license shall be automatically canceled if Respondent's periods of temporary or permanent residence or practice outside California total two years. However, Respondent's license shall not be canceled 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.

11. **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 Board 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 Board 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 canceled 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.

12. **COMPLETION OF PROBATION**

Respondent shall comply with all financial obligations (e.g., probation monitoring 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.

13. **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 Board, 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 Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. **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 Board 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 Board 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.

15. **PROBATION MONITORING COSTS**

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which are currently set at $3,173.00, but may be adjusted on an annual basis. Such costs shall be payable to the "Medical Board of California," and delivered to the Board 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.

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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Albert J. Garcia Esq.. I understand the stipulation and the effect it
4 will have on my Physician and Surgeon's. I enter into this Stipulated Settlement and Disciplinary
5 Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order
6 of the Medical Board of California.
7
8 DATED: 11/21/11 [signature]
9 AUDRA BODEPUDI, M.D.
Respondent

10 I have read and fully discussed with Respondent Audra Bodepudi, M.D. the terms and
11 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
12 I approve its form and content.
13 DATED: 11/21/11 [signature]
14 Albert J. Garcia Esq.
Attorney for Respondent

15 ENDORSEMENT

16 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
17 submitted for consideration by the Medical Board of California of the Department of Consumer
18 Affairs.
19 Dated: 11/28/11 Respectfully submitted,
20 KAMALA D. HARRIS
21 Attorney General of California
GAIL M. HEPPELL
22 Supervising Deputy Attorney General
23 [signature]
24 JANNSEN TAN
25 Deputy Attorney General
Attorneys for Complainant
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Exhibit A

Accusation No. 02-2009-200813

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 13 2010
BY [signature] ANALYST

EDMUND G. BROWN JR.
Attorney General of California
GAIL M. HEPPELL
Supervising Deputy Attorney General
W. DAVID CORRICK
Deputy Attorney General
State Bar No. 171827
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-3496
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 02-2009-200813
ARUDRA BODEPUDI, M.D.	
3883 Canyonlands Road Stockton, CA 95209	**ACCUSATION**
Physician's and Surgeon's Certificate Number A 73676	
Respondent.	

Complainant alleges:

PARTIES

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

2. On or about December 28, 2000, the Board issued physician's and surgeon's certificate number G 73676 ("license") to Arudra Bodepudi, M.D., ("Respondent"). The license was in full force and effect at all times relevant to the charges brought hereon, and will expire on June 30, 2012, unless renewed.

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JURISDICTION

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

4. The Medical Practice Act ("MPA") is codified at sections 2000-2521 of the Business and Professions Code.

5. Pursuant to section 2001.1, the Board's highest priority is public protection.

6. Section 2227(a) of the Code provides as follows:

> 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 [B]oard[1], may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.
>
> (2) Have his or her 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) Be publicly reprimanded by the division.
>
> (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.

7. Section 2234 reads, in relevant part, as follows:

> The Division of Medical Quality 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

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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 "[B]oard" as used in the Medical Practice Act refers to the Medical Board of California. References to the "Division of Medical Quality" and "Division of Licensing" set forth in the Medical Practice Act are also referable to the Medical Board of California.

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.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)
[B&P Code Section 2234(b)]

8. Respondent is a physician and surgeon, and is certified by the American Board of Psychiatry and Neurology. Her subspecialty is in geriatric psychiatry. At the time the events giving rise to the instant Accusation occurred, Respondent was providing medical services through the Permanente Medical Group (Kaiser), in Stockton, California.

9. Respondent committed gross acts of negligence relative to her care and treatment of two separate patients. The facts constituting gross negligence are set forth, *infra*.

Patient PCC218

10. Patient PCC218 ("PCC") was a 71 year-old female patient who presented to Respondent on or about **March 6, 2008**, for "medication management". At that time, PCC reported she was taking Tagamet (histamine antagonist), lisinopril (blood pressure control), Trimpex (antibiotic), Pamelor (antidepressant), prednisone (corticosteroid), Zymar (eye drops), and Klonopin (antianxiety), and that she was medication compliant. She also reported that she had been recently convicted of driving under the influence of alcohol, and that she was scheduled to undergo cataract surgery. PCC stated she was "going to school." The type of school is not specified in the progress note. She expressed displeasure over having to depend upon others for her transportation. PCC claimed she had been "sober" since June of 2007. Respondent did not document an assessment of current symptoms, except to indicate PCC was stable on her medication regimen, that she had been sober for approximately 8 months, and that her global assessment of functioning ("GAF") was relatively good. Respondent documented she discussed

tapering and eventually discontinuing Klonopin with PCC. Respondent's documented plan was to have PCC return in June of 2008, to evaluate her medications.

11. PCC was next seen by Respondent on or about **June 19, 2008**. Her presenting diagnoses were noted as chronic depression and anxiety disorder, not otherwise specified. Respondent reported she was attending "DUI class". She had undergone cataract surgery since the prior visit, but was still having some vision difficulties. Respondent noted PCC was in good spirits, making jokes, and that she stated her sleep pattern and appetite were satisfactory. Her current medications were listed as Vytorin (cholesterol control), lisinopril, Flexeril (muscle relaxant), Pamelor, Klonopin, Relafen (NSAID), Tagamet, and several hormonal agents. Respondent performed a mental status examination on PCC and found she was doing very well. Her thought process was logical, and the content was appropriate. Her affect was normal, and she appeared well-groomed. Her GAF was higher than it had been the previous visit. Recent lab work had all been returned as normal, except that blood was found in PCC's stool. Consequently, she had been scheduled to undergo a sigmoidoscopy and colonoscopy. Respondent made no medication changes, and advised PCC to return in September of 2008, for medication evaluation.

12. PCC next presented to Respondent on or about **September 19, 2008**. At that time, PCC reported that her medical problems were having a negative impact on her psychological well-being. She stated that her lungs "were bad", she had two bulging disks, and she was having difficulty sleeping. She also complained that she was having intermittent panic attacks. Since PCC's last visit with Respondent, Vicodin (narcotic analgesic) had been added to her list of medications. Respondent performed a mental status examination on PCC, which was within normal limits, aside from a dysphoric mood that Respondent attributed to the patient's health concerns. Respondent's treatment plan was to add Prozac to PCC's medication regimen, and to have her return three months later for further evaluation.

13. PCC returned to Respondent's office on or about **January 27, 2009**. She had turned 72 years of age since her prior appointment. PCC reported she was doing well at that time. She denied any problems with sleep, appetite, energy, mood, depression, or anxiety. New medications she was taking since her last visit with Respondent included OxyContin (narcotic

1 analgesic) and Neurontin. Based on her assessment of PCC, Respondent felt she was doing quite
2 well; significantly better since her last appointment. Respondent made no medication changes,
3 and her plan was to have PCC return in three months for continuing psychiatric evaluation.

4 14. On or about the morning of **February 25, 2009**, PCC presented to the Kaiser
5 Psychiatry Department on an emergent basis. She complained of racing thoughts, an inability to
6 concentrate, and reported feeling at possible risk for hurting herself and/or others. She was
7 initially evaluated by Jan Moore, R.N., and was then seen by Respondent. PCC told Respondent
8 she was having difficulty getting along with her sister, had been irritable, and that her mind would
9 not "shut-up". A mental status examination performed by Respondent indicated PCC was
10 hyperkinetic, paranoid, delusional, and was experiencing both visual and auditory hallucinations.
11 Respondent did not feel PCC was a danger to herself or others. According to the medication list,
12 PCC was no longer taking OxyContin at that time. Respondent diagnosed PCC as having bipolar
13 disorder. Her plan was to continue PCC on Klonopin and Pamelor, and to start her on Seroquel
14 (antipsychotic). Respondent also referred PCC to attend a bipolar class, a depression class, and to
15 see an individual psychotherapist. PCC was instructed to return to Respondent's office the next
16 week for follow-up.

17 15. PCC did not return to Respondent's office until **March 18, 2009**. PCC reported
18 that since her last contact with Respondent she had moved into an assisted living facility called
19 Casa de Sol. She was accompanied to her appointment with Respondent by an attendant from the
20 facility. Respondent noted that PCC's speech was rambling in nature, but that she "makes sense."
21 PCC stated she was having problems with sleep, appetite, energy, and irritability. PCC had been
22 hospitalized since her last office visit with Respondent for reasons not specified in Respondent's
23 progress note. Respondent performed a mental status examination on PCC and noted she was
24 hyperverbal, hypomanic, and demonstrated tangential and paranoid ideation. Nonetheless, PCC
25 was appropriately groomed, and was pleasant and cooperative. Respondent's treatment plan
26 included increasing PCC's Seroquel dosage, and continuing her on Pamelor and Klonopin.
27 Respondent also changed the form of the Depakote (anti-manic) PCC had been prescribed since
28

her last visit. Respondent did not order any lab work at that time, but requested PCC to return for follow-up in two weeks.

16. PCC returned for follow-up with Respondent on or about **April 1, 2009**, and was accompanied by an attendant from Casa del Sol. PCC told Respondent she was not feeling "together" that day. The attendant reported that PCC had been "slurry" and leaning to one side at some point, and had been advised to follow-up with her primary care physician. The attendant also stated PCC had been hallucinating intermittently. A mental status examination conducted by Respondent revealed PCC was experiencing paranoia, delusions, and hallucinations. Respondent felt that, overall, PCC was doing better than she had been at the previous appointment. Her diagnosis for PCC was bipolar disorder with psychotic features. Respondent decreased PCC's Seroquel dosage, and kept her on Pamelor, Klonopin, and Depakote. She ordered a Depakote blood level, and requested PCC to return two weeks later.

17. Respondent last saw PCC as a patient on or about **April 21, 2009**. At that time, PCC reported she did not feel she was doing very well, and was having trouble sleeping. Hallucinations were still present. On examination, Respondent felt PCC's affect was improved, but she noted PCC was still suffering from paranoid ideation, delusions, and hallucinations. But, PCC was pleasant, oriented x3, and was less manic than before. Respondent's increased PCC's Seroquel and Depakote dosages, and kept her on Pamelor and Klonopin. Respondent ordered a Depakote level to be taken two weeks later, but did not document the results of the prior Depakote level. She requested PCC to return in one month for continuing assessment.

18. PCC's psychiatric care was thereafter transferred to Mindy Rothbard, M.D., ("Dr. Rothbard"), who first saw PCC as a patient on or about **June 11, 2009**. PCC was accompanied by her younger sister who held power of attorney for PCC's medical decisions. At the time Dr. Rothbard first saw PCC, she was delusional, and unable to communicate a coherent history. Consequently, her sister provided a patient history. Dr. Rothbard documented a thorough patient history and evaluation. Dr. Rothbard immediately made significant changes to PCC's medication regimen, ordered laboratory studies, and initiated steps to coordinate care with PCC's primary care physician.

1 19. Respondent's care and treatment of PCC was grossly negligent in the following
2 two respects: 1) Respondent failed to assess the etiology of PCC's new-onset psychosis; and,
3 2) Respondent failed to properly manage PCC's medications and failed to appropriately consider
4 drug interactions.
5 20. PCC presented to Respondent on or about February 25, 2009, exhibiting psychotic
6 signs and symptoms for the first time while under Respondent's care. PCC had been
7 Respondent's patient for almost a full year by that point, and had only sought treatment for
8 depression and anxiety. When the new-onset psychosis emerged, the standard of care required
9 that Respondent initiate an investigation as to the etiology of the psychosis. There is no
10 indication from the progress notes that Respondent made any efforts to determine why a patient
11 who had a history of depression and anxiety, had a sudden onset of psychosis at age 72.
12 Respondent did not document any consideration of the anticholinergic effects of the numerous
13 medications PCC was taking, or make any effort to coordinate care with PCC's primary care
14 physician. Respondent's treatment plan consisted of an effort to treat the psychosis in a vacuum,
15 without any regard to the totality of factors at play. Respondent's failure to adequately assess
16 PCC's psychosis represents an extreme departure from the ordinary standard of conduct required
17 of a physician in caring for a patient.
18 21. Throughout the time Respondent cared for PCC, she was on a variety of
19 medications; some prescribed by Respondent, some prescribed by other physicians. It is critical
20 that physicians assess potential drug interactions in their patients, especially among the elderly,
21 and that physicians coordinate care to ensure patient safety. Respondent failed to assess the
22 potential interactions of the myriad drugs PCC was taking while she was under Respondent's
23 care. Even when PCC developed new-onset psychoses, Respondent failed to adequately consider
24 the role drug interactions may have been playing in PCC's mental status. For example, Pamelor
25 is a substrate of cytochrome P450 2D6, and if P450 2D6 is not properly metabolized, its
26 anticholinergic side-effects can be toxic, particularly in elderly persons. On or about September
27 19, 2008, Respondent added Prozac to PCC's medication regimen. Prozac is a potent inhibitor
28 cytochrome P450 2D6 metabolism, and its presence can cause up to a six-fold increase in

1 Pamelor blood levels. Vicodin and OxyContin are substrates of cytochrome P450 2D6, and the
2 presence of other substrates and metabolic inhibitors can adversely impact the biochemical
3 processing of those medications. At the time Respondent saw PCC as a patient on or about
4 January 27, 2009, Prozac, Vicodin, and OxyContin had been added to her pre-existing
5 medications, which included Pamelor. Less than one month later, PCC suffered a psychotic
6 break. Yet, on or about February 25, 2009, when PCC first presented to Respondent with
7 psychotic signs and symptoms, Respondent did not consider drug interactions, or any other
8 factors, in PCC's development of psychotic ideation. She simply attempted to treat the psychosis
9 by prescribing Seroquel. Another example of Respondent's failure to properly manage PCC's
10 medication regimen is the fact that she never communicated with PCC's primary care physician
11 to coordinate car, and to ensure that PCC did not experience negative drug interactions.
12 Respondent's failure to appropriately manage PCC's medications represents an extreme departure
13 from the ordinary standard of conduct required of a physician in caring for a patient.

14 **Patient CAM559**

15 22. Patient CAM559 ("CAM") was an 88 year-old female patient who first presented to
16 Respondent on or about **March 30, 2009**, on referral by her primary care physician secondary to
17 problems with sleep. At the time of her initial presentation, CAM was under urological care for
18 incontinence, and under a cardiologist's care for congestive heart failure. CAM was accompanied
19 to the appointment by her niece. By history, CAM had been living in an assisted living retirement
20 community in Stockton. When she could no longer afford to live there, though, she moved in
21 with her niece. At some point, CAM was taken to Dameron Hospital with a chief complaint of
22 chest pains. After she was released from the hospital, she went to stay at Meadowood Health and
23 Rehabilitation Center in Stockton. While there, she made a suicidal attempt/gesture by wrapping
24 a cord around her neck. Consequently, she was sent to the psychiatric ward at Dameron Hospital
25 for evaluation, and was later released. Her in-patient hospitalization occurred earlier that month.
26 CAM told Respondent she was depressed, and that she was worried about her living situation and
27 limited financial resources. However, she denied that she would ever really commit suicide
28

because of her religious beliefs. Aside from noting some recent history information as described above, Respondent did not conduct anything approaching a thorough patient history on CAM.

23. Respondent noted that during her initial patient visit with CAM, she complained about anxiety, depression, sleep problems, psychomotor retardation, hallucinations, delusions, paranoia, and recurrent thoughts of death. CAM was on a number of medications at the time she presented to Respondent, including antibiotics, Vicodin, blood pressure medication, thyroid medication, and imipramine. (Imipramine treats depression and enuresis.) Respondent performed a mental status examination on CAM, which she documented as being well within normal limits. Respondent determined that CAM was not a suicide risk at that time, and she contracted with CAM to not hurt herself. After her evaluation, Respondent added Remeron (antidepressant) to CAM's medication regimen, recommended psychotherapy, and asked CAM to return in two weeks for further assessment. She did not order any laboratory work.

24. Respondent was grossly negligent in her care and treatment of CAM on or about March 30, 2009, because she failed to adequately assess the patient's psychosis in relation to her overall medical status. When CAM first presented to Respondent, Respondent learned that CAM had a history of psychosis, and that she had recently made an attempt at suicide. (Whether the attempt may properly be called a "gesture" is of no moment.) She also learned that CAM was on imipramine, which is an anticholinergic. Thus, imipramine is prescribed with caution to the elderly, and with extreme caution to elderly persons who are psychotic. Despite the foregoing, Respondent did not take a thorough patient history, failed to consider the etiology of CAM's psychosis, and failed to assess the potential drugs and/or drug interactions which may have been affecting both CAM's physical and psychological well-being. Respondent then prescribed Remeron, which is an antihistaminic medication, without any apparent regard to CAM's underlying psychosis, and without any plan for a neurological and/or metabolic analysis. Respondent ignored CAM's psychosis and gave her a highly antihistaminic agent in addition to imipramine, which is also a highly antihistaminic and an anticholinergic, which together can adversely affect mental status in an 88 year-old psychotic patient. Respondent's failure to

adequately assess CAM's psychosis in relation to her overall medical status represents an extreme departure from the ordinary standard of conduct required of a physician in caring for a patient.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)
[B&P Code Section 2234(c)]

25. Respondent's license is subject to disciplinary action under section 2234(c) in that she is guilty of repeated negligent acts relative to her care and treatment of four separate patients. The facts constituting the negligence are set forth, *infra*.

Patient PCC218

26. Complainant hereby incorporates paragraphs 11-18 of the instant Accusation as though fully set forth herein.

27. When she first presented to Respondent on or about **March 6, 2008**, PCC reported that she had been recently convicted of driving under the influence of alcohol, but that she had been sober since June of 2007. Despite that knowledge, Respondent never assessed PCC for alcoholism at any time while PCC was under her care. When PCC developed a sudden-onset psychosis, Respondent never considered the potential role of alcohol; either secondary to acute use, or the interaction of alcohol with the many drugs she was taking which could adversely affect her mental status. Respondent also failed to assess PCC's issues with alcohol despite keeping her on Klonopin, and when she became aware that PCC had been prescribed Vicodin and OxyContin in addition to her Klonopin, she did not consider the combination of medications and how they would affect mental status as well as the possibility of the effect of adding alcohol to the interaction. Respondent appears to have simply accepted PCC's representation that she had quit drinking at the visit of **June 19, 2008**, and never reassessed whether it was still the case that she was not drinking when she presented with psychosis in February of 2009. When she was "slurry" and leaning to one side, Respondent's failure to assess the use of substances of abuse including alcohol, her pain medications and Klonopin led her to reduce her antipsychotic medication, rather than to address the other sedative agents PCC was taking. Respondent's failure to adequately assess and manage PCC for substance abuse issues constitutes a departure from the applicable standard of care relative to Respondent's care and treatment of patient PCC.

1 **Patient CAM559**

2 28. Complainant hereby incorporates paragraphs 23-24 of the instant Accusation as
3 though fully set forth herein.

4 29. As noted, *supra*, CAM presented to Respondent on or about **March 30, 2009**, with
5 a history of psychosis, congestive heart failure, and enuresis. CAM was taking a host of
6 prescribed medications at the time with a variety of indications. Nonetheless, Respondent failed
7 to obtain an adequate medical history; not even documenting CAM's congestive heart failure.
8 Respondent charted no effort to determine the drug interactions which may have been
9 contributing to CAM's psychosis, or whether adding another antihistaminic medication
10 (Remeron) was appropriate for the patient. Respondent simply addressed CAM's sleep disorder
11 in complete isolation, and without regard to the totality of her clinical picture. Respondent's
12 failure to take an adequate patient history, particularly in an 88 year-old patient with serious
13 known co-morbidities, constitutes a departure from the applicable standard of care relative to
14 Respondent's care and treatment of patient CAM.

15 **Patient TEB457**

16 30. Patient TEB457 ("TEB") was a 47 year-old female patient with a complex medical
17 history, which included post-traumatic stress disorder ("PTSD"), atrial fibrillation,
18 hypothyroidism, hypertension, alcohol abuse, and anticoagulation monitoring when she was first
19 seen by Dr. Bodepudi on or about **January 28, 2009**. TEB's PTSD stemmed from being robbed
20 at gun point in June of 2007, while working as a bank teller. TEB's psychiatric history was
21 positive for having attempted suicide three times, and for several psychiatric hospitalizations.
22 During her initial visit with Respondent, TEB complained of anxiety, depression, insomnia, and
23 recurrent thoughts of death. Her current medication list included anti-psychotic, anti-depressant,
24 and pain medication. TEB reported she was on disability from work due to a wrist injury, and
25 that she was seeing Respondent for medications. Respondent did not document a psychosocial
26 history, and did not document TEB's history with respect to alcohol abuse. She simply noted that
27 TEB denied any current substance abuse problems. Respondent continued TEB's antipsychotic
28

and antidepressant medications. (It is unclear from the record as to when TEB was to return for follow-up.)

31. Respondent next saw TEB as a patient on or about **March 30, 2009**. TEB reported that, since her last office visit, she had moved and had temporarily lived alone. She did not like living by herself, and had twice called the police because she thought she had seen shadows. There is no indication Respondent followed-up on TEB's reports regarding "seeing shadows", and there is no indication that the issue of substance abuse was addressed during this visit. In addition to having called the police on two occasions, Respondent also indicated that she felt "antsy" and uncomfortable in crowds. Nonetheless, Respondent determined that TEB was stable and doing well. She continued her medications, and instructed her to return in three months.

32. On or about **April 27, 2009**, TEB's daughter called Kaiser and spoke with a nurse in the Mental Health Department. She reported that her mother had been "drinking all the time", and that she refused to come out of her house. She stated her mother was convinced there was a man outside her house and had called the police. The police responded, but did not see anybody. The nurse discussed emergency protocol with TEB's daughter, and advised her to call back if her mother's condition worsened.

33. TEB saw a different Kaiser psychiatrist, Alice Park, M.D., ("Dr. Park"), on or about **August 24, 2009**. Dr. Park documented the problems TEB was having with alcohol abuse, and TEB acknowledged she should not be drinking while on psychiatric medications. It does not appear from the records that Respondent saw TEB as a patient again after she was seen by Dr. Park.

34. TEB was a medically complex patient, with a history of alcohol abuse, and a significant psychiatric history, including three suicide attempts. Yet, Respondent failed to take an adequate medical history during either office visit she had with TEB. Respondent also failed to address TEB's substance abuse issues in any manner, even after TEB reported she had been seeing "shadows", and talked about being "antsy" and uncomfortable in crowds. As demonstrated by the call to Kaiser placed by TEB's daughter on or about April 27, 2009, substance abuse was an on-going problem for TEB. Despite numerous warning signs,

Respondent took no steps to assess or manage the issue. Respondent's failure to ever obtain an adequate medical history, and her failure to ever assess or manage TEB's substance abuse issues constitutes a departure from the applicable standard of care relative to Respondent's care and treatment of patient TEB.

Patient DLJ170

35. Patient DLJ170 ("DLJ") was a 30 year-old male patient who was concerned that he may have been suffering from undiagnosed bipolar disorder when he initially presented to Respondent for evaluation on or about **October 23, 2008.** During his initial appointment with Respondent, he revealed that he had been having "issues" all his life, and that his previous doctor thought he might be bipolar. DLJ expressed problems with excessive worry, hypervigilence, depression, finances, insomnia, and alcohol abuse. He reported past manic episodes consisting of elevated mood, grandiose feelings, and increased energy, but stated he was in a depressive cycle at that time. He indicated that he consumed "1-2 beers", and used marijuana on a daily basis. DLJ's prescription medications included an antihistamine/narcotic cough suppressant, ibuprofen (600 mg.), Flexeril, and Celexa (antidepressant). Respondent did not document a medical history. She performed a mental status examination, and noted DLJ was "overweight and slender." Aside from depressed mood, DLJ's mental status examination was documented as being within normal limits. Respondent decided to initiate treatment with lithium, which is frequently prescribed to treat bipolar disorder. She ordered pre-lithium lab work, and an electrocardiogram, and she indicated DLJ should return in four weeks for assessment. Respondent did not document discussing with the patient any possible consequences of using lithium in conjunction with ibuprofen, alcohol, and/or marijuana.

36. DLJ failed to show for his November 20, 2008, appointment. He did not see Respondent again until **January 20, 2009.** At that visit, DLJ reported that he was doing much better, and that his family had noticed a "wonderful change" in him. By the time DLJ saw Respondent the second time, naproxen had been added to his medication regimen. Like ibuprofen, naproxen is a non-steroidal anti-inflammatory drug (NSAID). Respondent again failed to obtain a medical history from DLJ, and she did not document the results of any prior

lithium levels. Her progress notes from that day make no mention at all with respect to DLJ's alcohol consumption or cannabis use. And again, there is no documented discussion between Respondent and DLJ regarding the use of lithium with NSAIDs, alcohol, and/or marijuana. Respondent made no medication changes, ordered a lithium level, and advised DLJ to return in three months.

37. Respondent saw DLJ as a patient for the third and final time on or about **March 23, 2009**. At that time, DLJ reported he was not doing as well as at the time of his prior visit. He reported problems with anxiety and acute sadness, with some associated crying spells. He stated that he felt "down" most of the time. His medications had not changed since his last office visit with Respondent. DLJ requested Respondent to fill-out Family Medical Leave Act ("FMLA") forms on his behalf, as he was apparently having difficulty maintaining his employment. Once again, Respondent did not obtain a medical history, did not document the results of any lithium levels, and did not document any discussions with DLJ regarding his alcohol and marijuana use. Respondent's plan was to obtain a lithium level, and increase DLJ's lithium dosage in accordance with the laboratory values. She also added Wellbutrin (antidepressant) to DLJ's medications, and recommended follow-up one month later.

38. Roger Siouffey, M.D., ("Dr. Siouffey") assumed DLJ's psychiatric care and treatment from Respondent, and first saw DLJ as a patient on or about August 6, 2009. At that time DLJ reported that the lithium had not helped him, and that he had not taken the medication "for months."

39. When DLJ first presented to Respondent on or about **October 23, 2008**, he was already on psychotropic medication. Despite that fact, Respondent did not document any history involving DLJ's current or prior use of psychotropic medications, or any other relevant medical history. Respondent's failure to document DLJ's past medical history, particular as it related to the use of psychotropic medications constitutes a departure from the applicable standard of care relative to Respondent's care and treatment of patient DLJ.

40. When DLJ first presented to Respondent on or about **October 23, 2008**, he reported daily cannabis and alcohol use. The use of cannabis has an effect on the course of bipolar

disorder, and yet Respondent did not document any discussion with DLJ regarding the impact of cannabis use on bipolar disorder, and she did not document substance abuse. Further, the use of alcohol, particularly beer, can have a deleterious impact on the effectiveness of lithium in a bipolar patient. Respondent documented no discussions with DLJ relative to the negative impact his daily consumption of beer could have on the effectiveness of taking lithium for his bipolar disorder. Respondent's failure to counsel DLJ regarding his cannabis use, basically ignoring the issue, and her failure to discuss the negative consequences of combining alcohol and lithium with DLJ constitute a departure from the applicable standard of care relative to Respondent's care and treatment of patient DLJ.

41. When Respondent first presented to Respondent on or about **October 23, 2008**, his medication list included ibuprofen, which is an NSAID. During the course of DLJ's treatment with Respondent, a second NSAID, naproxen, was added to DLJ's medication regimen. NSAIDs can raise lithium levels. The therapeutic range for lithium is very narrow, and lithium can be toxic if blood levels exceed the therapeutic range. There is no indication from the patient record that Respondent ever talked to DLJ about his use of NSAIDs. She did not determine the frequency or the dosage of his NSAID use. Had he been taking NSAID medications frequently and in high dosages, the standard of care would require Respondent to begin lithium at a lower than usual starting dose, and to check DLJ's blood levels after 5-7 days. Even if Respondent determined DLJ was not using NSAIDs at high level, he clearly had a history of significant NSAID use, and needed to be advised that if his use of NSAIDs were to increase, it would be imperative for him to request a lithium level. Similar to DLJ's cannabis use, Respondent ignored DLJ's NSAID use relative to her treatment plan. Respondent's failure to obtain a history regarding DLJ's current and past NSAID use, her failure to consider his NSAID use in establishing his starting dose of lithium, her failure to assess DLJ's lithium level in a standard timeframe, and her failure to warn DLJ about the potential impact of NSAIDs on lithium levels constitute a departure from the applicable standard of care relative to Respondent's care and treatment of patient DLJ.

///

42. When Respondent saw DLJ as a patient for the third and final time on or about March 23, 2009, he reported an increase in his depressed mood, and that he was feeling "down" most of the time. Without assessing the dose of the antidepressant DLJ was already taking, and without assessing whether his lithium level was maximized, Respondent started DLJ on a second antidepressant medication (Wellbutrin). At that time, Respondent was on a very low dose of Celexa (10 mg.), and there is no indication that Respondent considered raising the dose of the Celexa, which DLJ was already tolerating, rather than adding a second antidepressant. She did not investigate whether DLJ had been on a higher dosage of Celexa in the past, and if so, if it had been beneficial. She also failed to ensure that DLJ had reached an optimum therapeutic level before initiating treatment with the Wellbutrin. Respondent's addition of a second antidepressant to DLJ's medication regimen without first exploring the efficacy of raising his Celexa dosage, and without first assessing his lithium level, constitutes a departure from the applicable standard of care relative to Respondent's care and treatment of patient DLJ.

43. In sum, Respondent's actions as described, *supra*, constitute repeated negligent acts within the meaning of section 2234(c) relative to her care and treatment of patients PCC, CAM, TEB, and DLJ, respectively, as follows:

a. Respondent failed to adequately assess and manage patient PCC for substance abuse issues.

b. Respondent failed to obtain an adequate patient history from patient CAM when patient CAM initially presented to Respondent on or about March 30, 2009, particularly in view of CAM's advanced age (88), and significant health issues.

c. Respondent failed to obtain an adequate medical history from patient TEB, who was a medically complex patient, and failed to assess and/or manage TEB's substance abuse issues.

d. Respondent failed to obtain an adequate medical history from DLJ when he first presented to her for care and treatment on or about October 23, 2008, particularly as he was seeking treatment for suspected bipolar disorder, and was already on a low dose of the psychotropic medication Celexa.

e. When Respondent prescribed lithium to patient DLJ to treat presumed bipolar disorder, she failed to counsel him regarding his cannabis use, basically ignoring the issue, and she failed to advise DLJ regarding the negative consequences

of combining alcohol and lithium.

f. Respondent failed to consider DLJ's NSAID use in establishing his starting dose of lithium, she failed to assess DLJ's lithium level in a standard timeframe given his NSAID use, and failed to warn DLJ about the potential impact of NSAIDS on lithium levels.

g. Respondent added a second antidepressant to DLJ's medication regimen without first exploring the efficacy of raising his Celexa dosage, and without first assessing his lithium level.

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:

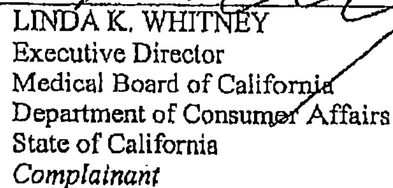
1. Revoking or suspending physician's and surgeon's certificate number A 73676, issued to Arudra Bodepudi, M.D.,

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

3. Ordering Arudra Bodepudi, M.D., to pay the costs of probation monitoring, if placed on probation; and,

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

DATED: July 13, 2010



LINDA K. WHITNEY
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/Petition to Revoke Probation Against: Arudra Bodepudi, M.D. Physician's and Surgeon's Certificate No. A 73676 Respondent	Case No. 800-2015-012722

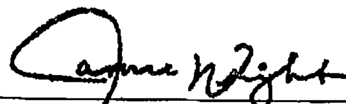
DECISION

The attached Stipulated Settlement and Disciplinary Order 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 August 25, 2016.

IT IS SO ORDERED: July 26, 2016.

MEDICAL BOARD OF CALIFORNIA



Jamie Wright, J.D., Chair
Panel A

MEDICAL BOARD OF CALIFORNIA
I do hereby certify that this document is a true and correct copy of the original on file in this office.
M.Y.
Signature
For Custodian of Records
Title
4-14-2022
Date

KAMALA D. HARRIS
Attorney General of California
VLADIMIR SHALKEVICH
Acting Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-3496
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **ARUDRA BODEPUDI, M.D.** 3883 Canyonlands Road Stockton, CA 95209 **Physician's and Surgeon's Certificate No. A 73676** Respondent.	Case No. 800-2015-012722 OAH No. 2015120180 **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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California. 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 Jannsen Tan, Deputy Attorney General.

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1 2. Respondent Arudra Bodepudi, M.D. ("Respondent") is represented in this proceeding
2 by Jonathan C. Turner Esq., whose address is: 1007 7th Street, Suite 304,Sacramento, CA 95814.
3 3. On or about December 27, 2000, the Medical Board of California issued Physician's
4 and Surgeon's Certificate No. A 73676 to Arudra Bodepudi, M.D. (Respondent). The Physician's
5 and Surgeon's Certificate was placed on four year's probation on June 22, 2012, and will expire
6 on June 30, 2016, unless renewed.

7 JURISDICTION

8 4. Accusation/Petition to Revoke Probation No. 800-2015-012722 was filed before the
9 Medical Board of California (Board), Department of Consumer Affairs, and is currently pending
10 against Respondent. The Accusation/Petition to Revoke Probation and all other statutorily
11 required documents were properly served on Respondent on June 22, 2015. Respondent timely
12 filed her Notice of Defense contesting the Accusation/Petition to Revoke Probation.
13 5. A copy of Accusation/Petition to Revoke Probation No. 800-2015-012722 is attached
14 as exhibit A and incorporated herein by reference.

15 ADVISEMENT AND WAIVERS

16 6. Respondent has carefully read, fully discussed with counsel, and understands the
17 charges and allegations in Accusation/Petition to Revoke Probation No. 800-2015-012722.
18 Respondent has also carefully read, fully discussed with counsel, and understands the effects of
19 this Stipulated Settlement and Disciplinary Order.
20 7. Respondent is fully aware of her legal rights in this matter, including the right to a
21 hearing on the charges and allegations in the Accusation/Petition to Revoke Probation; the right
22 to confront and cross-examine the witnesses against her; the right to present evidence and to
23 testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of
24 witnesses and the production of documents; the right to reconsideration and court review of an
25 adverse decision; and all other rights accorded by the California Administrative Procedure Act
26 and other applicable laws.
27 8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and
28 every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation/Petition to Revoke Probation No. 800-2015-012722, if proven at a hearing, constitute cause for imposing discipline upon her Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation/Petition to Revoke Probation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation/Petition to Revoke Probation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent agrees that if she ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against her, before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2015-012722 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

RESERVATION

13. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

14. 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 Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her 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.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. 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:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 73676 issued to Respondent Arudra Bodepudi, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for 35 months on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. PROFESSIONALISM PROGRAM (ETHICS COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall

provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program 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 Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

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

3. MONITORING - BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a billing monitor(s), the name and qualifications of a billing service who will monitor Respondent's billing or one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS). A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, 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 monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor 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 monitor shall submit a signed statement that the monitor has 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 monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of billing, and whether Respondent is billing appropriately. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

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

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the

1 University of California, San Diego School of Medicine, that includes, at minimum, quarterly
2 chart review, semi-annual practice assessment, and semi-annual review of professional growth
3 and education. Respondent shall participate in the professional enhancement program at
4 Respondent's expense during the term of probation.

5 4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
6 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
7 Chief Executive Officer at every hospital where privileges or membership are extended to
8 Respondent, at any other facility where Respondent engages in the practice of medicine,
9 including all physician and locum tenens registries or other similar agencies, and to the Chief
10 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
11 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
12 calendar days.

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

14 5. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is
15 prohibited from supervising physician assistants.

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

19 7. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
20 under penalty of perjury on forms provided by the Board, stating whether there has been
21 compliance with all the conditions of probation.

22 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
23 of the preceding quarter.

24 8. GENERAL PROBATION REQUIREMENTS.

25 Compliance with Probation Unit

26 Respondent shall comply with the Board's probation unit and all terms and conditions of
27 this Decision.

28 Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board 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).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

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

Travel or Residence Outside California

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

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All

time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice 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; and General Probation Requirements.

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., 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.

12. 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 Board, 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, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license.

The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining 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 Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jonathan C. Turner. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6-1-2016

ARUDRA BODEPUDI, M.D.
Respondent

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

DATED: 6-1-2016

JONATHAN C. TURNER
Attorney for Respondent

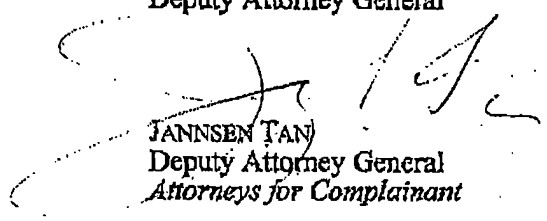
ENDORSEMENT

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

Dated: June 2, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
VLADIMIR SHALKEVICH
Deputy Attorney General



JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation/Petition to Revoke Probation No. 800-2015-012722

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 22 20 15
BY D. Richards ANALYST

KAMALA D. HARRIS
Attorney General of California
CONNIE A. BROUSSARD
Supervising Deputy Attorney General
JANNSEN TAN
Deputy Attorney General
State Bar No. 237826
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-3496
Facsimile: (916) 327-2247
Attorneys for Complainant

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

In the Matter of the Accusation/Petition to Revoke Probation Against: **ARUDRA BODEPUDI, M.D.** 5250 Claremont Avenue, Suite 103, Stockton, CA 95207 Physician's and Surgeon's Certificate No. A 73676, Respondent.	Case No. 800-2015-012722 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

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

2. On or about December 28, 2000, the Medical Board issued Physician's and Surgeon's Certificate Number A 73676 to Arudra Bodepudi, M.D. (Respondent). The Physician's and Surgeon's Certificate will expire on June 30, 2016.

JURISDICTION

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

4. Section 2227 of the Code 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:

"(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 discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(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:

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

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

1 "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
2 violation of, or conspiring to violate any provision of this chapter.
3 "(b) Gross negligence.
4 "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
5 omissions. An initial negligent act or omission followed by a separate and distinct departure from
6 the applicable standard of care shall constitute repeated negligent acts.
7 "(1) An initial negligent diagnosis followed by an act or omission medically appropriate
8 for that negligent diagnosis of the patient shall constitute a single negligent act.
9 "(2) When the standard of care requires a change in the diagnosis, act, or omission that
10 constitutes the negligent act described in paragraph (1), including, but not limited to, a
11 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the
12 applicable standard of care, each departure constitutes a separate and distinct breach of the
13 standard of care.
14 "(d) Incompetence.
15 "(e) The commission of any act involving dishonesty or corruption which is substantially
16 related to the qualifications, functions, or duties of a physician and surgeon.
17 "(f) Any action or conduct which would have warranted the denial of a certificate.
18 "(g) The practice of medicine from this state into another state or country without meeting
19 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
20 apply to this subdivision. This subdivision shall become operative upon the implementation of the
21 proposed registration program described in Section 2052.5.
22 "(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and
23 participate in an interview by the board. This subdivision shall only apply to a certificate holder
24 who is the subject of an investigation by the board."
25 6. Section 2263 of the Code states: "The willful, unauthorized violation of professional
26 confidence constitutes unprofessional conduct."
27 ///
28 ///

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 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997 (42 USC 1396a(n)(3)(B)) provides:

"...

"(n)(1) In the case of medical assistance furnished under this title for Medicare cost-sharing respecting the furnishing of a service or item to a qualified Medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified Medicare beneficiaries.

" (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost--sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a Medicare beneficiary.

" (3) In the case in which a State's payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2).

(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

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(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any Medicare cost–sharing by a Medicare supplemental policy or an employer retiree health plan on behalf of an individual.

DISCIPLINARY CONSIDERATIONS

9. To determine the degree of discipline, if any, to be imposed on Respondent Arudra Bodepudi, M.D., Complainant alleges that on or about February 16, 2012, in a prior disciplinary action entitled In the Matter of the Accusation Against Arudra Bodepudi, M.D. before the Medical Board of California, in Case Number 02-2009-200813, Respondent's license was revoked, revocation stayed, and was placed on probation for four years, with other terms and conditions including but not limited to Clinical Training Program (PACE), Medical Record Keeping Program, Prescribing Practices Course, and other standard terms and conditions for gross negligence and repeated negligent acts in the care and treatment of two patients. Respondent failed to adequately manage and assess symptoms and medication. That decision is now final and is incorporated by reference as if fully set forth herein.

FIRST CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

10. Respondent is subject to discipline under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that she committed repeated negligent acts in her care and treatment of Patients LR, SV, and AAJ[2] as more particularly alleged hereinafter:

Patient LR

11. Patient LR was a 67-year-old female who saw Respondent in her Stockton office for an initial psychiatric evaluation on or about March 29, 2013. Patient LR reported persistent depressive symptoms, excessive sleep, anxiety, poor energy and fatigue, and some panic attacks. She was taking Paxil 40 mg per day, prescribed by her primary care physician ("PCP").

[2] Patient and provider names are abbreviated to protect patient confidentiality. Full patient names will be provided upon receipt of a Request for Discovery.

Diagnoses given were recurrent major depression, panic disorder with agoraphobia, and personality disorder, unspecified. Respondent's plan was to have psychotherapy with Respondent and to continue Paxil and Ambien. Respondent offered Xanax but Patient LR refused. Respondent documented that relaxation exercises were taught, with recommendation to return in one week. Respondent documented that the visit was for 1 hour. No medication changes were made or recommended. Patient LR was noted to have agreed to the treatment plan. Patient LR alleged that Respondent did not charge her for this visit but told her to pay for multiple sessions to establish a standard assessment and to complete the required documentation. Patient LR was covered by Medicare. Respondent failed to provide Patient LR with her billing practices and clinic policies regarding insurance and payments, as well as the number of sessions required to do an assessment.

12. On or about April 4, 2013, Respondent saw Patient LR for a follow up visit. Respondent documented that Patient LR had persistent depressive symptoms, anxiety, and hypersomnia. Patient LR was noted to be reluctant to make medication changes. Patient LR expressed gratitude to Respondent for therapy sessions and stated that they were benefitting her. Respondent engaged in "balance billing"[3] when she billed Medicare and also received payment from Patient LR in the amount of $300.00 cash.

13. On or about April 18, 2013 Respondent saw Patient LR for a follow up visit. Patient LR reported improved sleep and energy. Her medication allergies were listed. Generalized anxiety disorder was added to her diagnoses. Respondent noted she informed Patient LR of the medication options. Respondent engaged in "balance billing" when she billed Medicare and also received payment from Patient LR in the amount of $300.00 cash.

14. On or about April 25, 2013, Respondent saw Patient LR for a follow up visit. Patient LR reported feeling better. A detailed description of therapy given is recorded. Patient LR reported improved mood and sleep. Narcissistic and borderline personality traits were noted in

[3] Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing beneficiaries for Medicare cost-sharing.

1 19. Respondent wrote an undated letter to Patient LR. Respondent wrote that the letter
2 was in response to her conversation with Patient LR that occurred on August 18, 2013. In her
3 letter, Respondent enclosed money orders for a refund of $1,200.00 to Patient LR for the "first
4 four visits you paid me." Respondent wrote "I am returning this as Medicare was charged." She
5 stated she saw Patient LR 13 times between March 29 and July 2, 2013. Respondent stated that
6 session notes were "not completed" because Patient LR was "crying so much" during the first 4
7 sessions. A "summary of treatment" was provided. Respondent stated her diagnoses were major
8 depression, recurrent, generalized anxiety disorder, panic disorder with agoraphobia, and "some
9 personality issues". Respondent stated she provided psychotherapy which was effective in
10 reducing Patient LR's symptoms.

11 20. In an interview with a Board investigator on or about May 12, 2014, Respondent
12 stated that Patient LR cried throughout the first sessions and exhibited a high level of emotional
13 intensity. Respondent stated that Patient LR appeared fragile and overwhelmed initially and
14 appeared to require close monitoring. She noted that Patient LR was resistant to medication
15 changes. She stated she saw Patient LR on a frequent basis due to the severity of her symptoms.
16 Respondent stated that after several sessions she felt that she could not provide the therapy
17 required for Patient LR within the time allotted by Medicare. Respondent stated that Patient LR
18 agreed to be seen as a private pay patient and not Medicare, because she liked her approach to her
19 treatment. Respondent noted that Medicare patients pay a $50.00 co-pay. She stated that LR
20 agreed to pay the co-pay as well as $300.00 cash for a 45-60 minute visit and that she would be
21 refunded whatever her secondary insurance, AARP, reimbursed. Respondent stated that Patient
22 LR improved with the therapy. Respondent stated that she refunded payments for the first 4
23 sessions to Patient LR after she realized that Medicare had reimbursed for these sessions.
24 Respondent stated she did not send the records to Patient LR as requested, because she felt that
25 Patient LR would not be able to handle it well and it might be detrimental to her, so she provided
26 her a summary of the visits instead. She stated that she did not send Patient LR's record to
27 Patient LR's doctor due to confidentiality concern. She stated she then felt that LR was
28 "harassing" her for the records and for a receipt of money paid to her and she became fearful of

1 Patient LR. She stated she finally refunded all payment because of "the commotion ...I was so
2 disheartened (by her behavior) ....I'm repulsed by this charging business."
3 21. Respondent's care and treatment of Patient LR fell below the standard of care in that:
4 A. She pressured Patient LR to pay for multiple sessions to establish a standard
5 assessment, and to complete the required documentation;
6 B. Her payment practices and clinic policies regarding insurance and payments, as
7 well as the number of sessions required to do an assessment, should be written and provided to
8 the patient in advance. Her policies in these areas appear inconsistent and unclear;
9 C. She failed to provide receipts of cash payment taken from the patient at the time of
10 the evaluations;
11 D. She engaged in "balance billing;"
12 E. She failed to release records to the referring physician, despite a signed release of
13 information for release of Patient LR's records to her primary care physician.
14 Patient SV
15 22. On or about November 13, 2013, the Board received a complaint from Patient SV.
16 She stated that Respondent made her feel "uncomfortable" during her Social Security Disability
17 psychiatric evaluation, asking intrusive and unnecessary questions, such as about her ex-husband.
18 Patient SV alleged that Respondent included inaccurate information in her medical record,
19 including about her occupation and current medications. She stated that she has post-traumatic
20 stress disorder ("PTSD"), anxiety and panic attacks. Patient SV stated that she filed the complaint
21 with the MBC after she reviewed her disability file because she felt that the questions asked by
22 Respondent about domestic violence and her divorce during the psychiatric evaluation were
23 "inappropriate," and notes that she felt that Respondent made "condescending" remarks about her
24 appearance. Patient SV stated the Social Security Disability ("SSD") report inaccurately noted
25 that she had quit her job, did not need medications, was supposed to be taking Ativan and Zoloft,
26 contained inaccurate information regarding her employment, socializing and taking public
27 transportation. SV stated that Respondent noted that SV lacked anxiety, did not have mood
28 swings and had good appetite, energy, and sleep, though Patient SV stated these points were not

discussed. Patient SV stated that Respondent's notes regarding her pain history were also inaccurate.

23. The Board investigator requested Patient SV's records from Respondent. On or about March 24, 2014 and subsequently on April 14, 2014, Respondent informed the Board investigator that Patient SV did not match any of her patient's names and that Patient SV was not her patient.

24. On or about May 7, 2014, Pacific Health Clinic confirmed that Respondent saw Patient SV for a psychiatric examination at their clinic.

25. Respondent, in an interview with the Board, stated that she performed SSD evaluations before, and that she may have seen Patient SV, but Respondent failed to keep any records of her examination of SV.

Patient AAJ

26. Patient AAJ was a 39 year old female who was seen by Respondent for an initial psychiatric evaluation on July 12, 2013. Patient AAJ reported witnessing a violent event in which her colleague's car was hit by a jealous boyfriend. Police were called. AAJ reported having been threatened by the boyfriend after she made statements to police. Patient AAJ reported persistent PTSD symptoms, including nightmares and flashbacks and anhedonia. Patient AAJ stated that Respondent initially told her that the evaluation would require two sessions. Patient AAJ alleged that Respondent told her that she had not finished the evaluation in two sessions, and needed a third session to complete it. Patient AAJ stated that Respondent told her at first that she would not be charged for the third session as it was required to complete the assessment but then charged her for it.

27. Patient AAJ requested her receipts for the July 12 and 15, 2013 office visits. Patient AAJ stated she paid $350.00 cash for each of these visits. Respondent failed to give Patient AAJ her receipts.

28. Respondent failed to adequately document the visit on July 15, 2013. In an undated letter to Patient AAJ, Respondent stated that she was unable to contact Patient AAJ, and as her evaluation was incomplete after the first 2 sessions, she is refunding her $700.00 paid.

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29. Respondent's care and treatment of Patient AAJ fell below the standard of care in that:

A. Respondent stated that she had not completed a basic evaluation in 2 sessions and apparently pressured Patient AAJ to come in for a third session in order to complete a relatively uncomplicated evaluation;

B. Respondent failed to keep legible and adequate notes of Patient AAJ's visits;

C Respondent failed to provide receipts to the patient for the required cash payments;

D. Respondent failed to clearly inform Patient AAJ of her policies involving insurance, billing, payments, appointments and receipts;

E. Respondent communicated with Patient AAJ's attorney despite Patient AAJ's prohibition to do so;

30. Respondent's conduct as described above constitutes unprofessional conduct in violation of sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, and thereby provides cause for discipline of Respondent's physician and surgeon's license for repeated negligent acts in the care and treatment of Patients LR, SV, and AAJ, collectively and individually.

SECOND CAUSE FOR DISCIPLINE
(General Unprofessional Conduct)

31. Respondent is further subject to discipline under sections 2227 and 2234, as defined by section 2234 of the Code, in that she has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter: Paragraphs 10 to 30, above, are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE
(Inaccurate Medical Records)

32. Respondent is subject to disciplinary action under section 2266 of the Code in that she failed to maintain adequate and accurate medical records for patient SV and AAJ.

Specifically, Respondent failed to adequately record history, physicals, and treatment notes for patient SV and failed to keep legible and adequate notes for patient AAJ.

33. Paragraphs 22 through 30 are repeated here as more fully set forth above.

34. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of her patients in violation of section 2266 of the Code, and provides cause for discipline against his physician's and surgeon's certificate.

CAUSE TO REVOKE PROBATION
(Obey All Laws)

35. At all times after the effective date of Respondent's probation, Condition 6 of the January 17, 2012, Order of the Medical Board of California in the action entitled *In the Matter of the Accusation Against Arudra Bodepudi, M.D.*, Case Number 02-2009-200813, stated:

> "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."

36. Respondent's probation is subject to revocation because she failed to comply with Probation Condition 6, referenced above. The facts and circumstances regarding this violation are as follows:

A. The facts and circumstances alleged in paragraph 10 through 34 above are incorporated here as if fully set forth.

B. Respondent's probation is subject to revocation due to her violations of the laws and regulations governing the practice of medicine as alleged above.

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:

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1. Revoking or suspending Physician's and Surgeon's Certificate Number A 73676, issued to Arudra Bodepudi, M.D.;

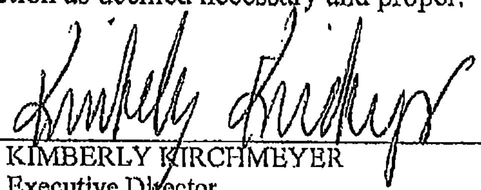
2. Revoking the probation that was granted by the Medical Board of California in Case No. 02-2009-200813 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate Number A 73676, issued to Arudra Bodepudi, M.D.;

3. Revoking, suspending or denying approval of Arudra Bodepudi, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

4. Ordering Arudra Bodepudi, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: June 22, 2015



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

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