

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

In the Matter of the Accusation Against:)

PAUL JOSEPH CIMOCH, M.D.)

File No. 04-2006-173926

Physician's and Surgeon's)
Certificate No. A 46088)

Respondent.)

_____)

DECISION

The attached Stipulation for 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 January 25, 2010.

IT IS SO ORDERED December 23, 2009.

MEDICAL BOARD OF CALIFORNIA

By: Shelton Duruisseau
Shelton Duruisseau, Ph.D., Chair
Panel A

1 EDMUND G. BROWN JR.
Attorney General of California
2 STEVEN V. ADLER
Supervising Deputy Attorney General
3 BETH FABER JACOBS
Deputy Attorney General
4 State Bar No. 89145
110 West "A" Street, Suite 1100
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Attorneys for Complainant

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 04-2006-173926

13 PAUL JOSEPH CIMOCH, M.D.

OAH No. L2009010687

14
15 Respondent.

STIPULATION FOR SETTLEMENT

16
17 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the
18 above-entitled proceedings that the following matters are true:

19 **PARTIES**

20 1. Barbara Johnston ("Complainant") is the Executive Director of the Medical
21 Board of California and is represented herein by Edmund G. Brown Jr., Attorney General of the
22 State of California, by Beth Faber Jacobs, Deputy Attorney General.

23 2. Respondent Paul J. Cimoch, M.D. ("respondent") is represented herein by
24 Henry Lewin, of Lewin & Levin, 11377 West Olympic Boulevard, Los Angeles, CA 90064-1683,
25 telephone: (310) 312-3737.

26 **JURISDICTION**

27 3. On May 15, 1989, the Medical Board of California ("Board") issued
28 Physician's and Surgeon's Certificate No. A 46088 to respondent. The Certificate was in full

1 force and effect at all times relevant to the charges brought in Accusation No. 04-2006-173926
2 and will expire on July 31, 2010, unless renewed.

3 4. On December 1, 2008, Complainant Barbara Johnston, in her official capacity
4 as the Executive Director of the Board, filed Accusation No. 04-2006-173926 against respondent,
5 a true and correct copy of which is attached as Attachment "A" and is incorporated herein by
6 reference.

7 5. On or about December 1, 2008, respondent was served with a true and correct
8 copy of Accusation No. 04-2006-173926, together with true and correct copies of all other
9 statutorily required documents, at his address of record then on file with the Board: 11190
10 Warner Avenue, Suite 411, Fountain Valley, CA 92708. Respondent filed a timely Notice of
11 Defense.

12 ADVISEMENT AND WAIVERS

13 6. Respondent has carefully read and fully understands the charges and allegations
14 contained in Accusation No. 04-2006-173926, and has fully reviewed and discussed same with
15 his attorney, Henry Lewin, Esq.

16 7. Respondent has carefully read and fully understands the contents, force, and
17 effect of this Stipulated Settlement and Disciplinary Order, and has fully reviewed and discussed
18 same with his attorney, Henry Lewin, Esq.

19 8. Respondent is fully aware of his legal rights in this matter, including his right to
20 a hearing on the charges and allegations contained in Accusation No. 04-2006-173926, his right
21 to present witnesses and evidence and to testify on his own behalf, his right to confront and cross-
22 examine all witnesses testifying against him, his right to the issuance of subpoenas to compel the
23 attendance of witnesses and the production of documents, his right to reconsideration and court
24 review of an adverse decision, and all other rights accorded him pursuant to the California
25 Administrative Procedure Act, the California Code of Civil Procedure, and all other applicable
26 laws, having been fully advised of same by his attorney of record, Henry Lewin, Esq.
27 Respondent, having the benefit of counsel, hereby knowingly, intelligently, and voluntarily
28 waives all the rights set forth above.

1 CULPABILITY

2 9. Respondent admits the allegations in Accusation No. 04-2006-173926 that he
3 violated Business and Professions Code sections 2266 (failed to maintain adequate and accurate
4 medical records) and 2234, subdivision (c) (engaged in repeated negligent acts), as follows:
5 Respondent admits that between December, 2001 and June, 2004, when he owned and was
6 President of the Center for Special Immunology (CSI), and had other physicians affiliated with
7 CSI who provided care and treatment for patient D.H., he failed to ensure that his registered nurse
8 who performed intravenous infusions on patient D.H. was being adequately supervised and
9 thereby allowed the nurse to create and maintain inadequate medical records related to the
10 patient's infusions; and that he failed to adequately monitor the overall care and treatment of
11 patient D.H. in accordance with the standard of practice in the medical community.

12 Respondent admits he has thereby subjected his Physician's and Surgeon's Certificate No.
13 A 46088 to disciplinary action and agrees to be bound by the Board's imposition of discipline as
14 set forth in the Disciplinary Order below.

15 CONTINGENCY

16 10. The parties agree that this Stipulated Settlement and Disciplinary Order shall be
17 submitted to the Board for its consideration in the above-entitled matter and, further, that the
18 Board shall have a reasonable period of time in which to consider and act on this Stipulated
19 Settlement and Disciplinary Order after receiving it.

20 11. The parties agree that this Stipulated Settlement and Disciplinary Order shall be
21 null and void and not binding upon the parties unless approved and adopted by the Board, except
22 for this paragraph, which shall remain in full force and effect. Respondent fully understands and
23 agrees that in deciding whether to approve and adopt this Stipulated Settlement and Disciplinary
24 Order, the Board may receive oral and written communications from its staff and/or the Attorney
25 General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any
26 member thereof, and/or any other person from future participation in this or any other matter
27 affecting or involving respondent. In the event that the Board, in its discretion, does not approve
28 and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph,

1 the Stipulated Settlement and Disciplinary Order shall not become effective, shall have no
2 evidentiary value, and shall not be relied upon or introduced in any disciplinary action by either
3 party hereto. Respondent further agrees that if the Board rejects this Stipulated Settlement and
4 Disciplinary Order for any reason, respondent will assert no claim that the Board, or any member
5 thereof, was prejudiced by its, his, or her review or consideration of this Stipulated Settlement
6 and Disciplinary Order, or of any matter related to it.

7 **ADDITIONAL PROVISIONS**

8 12. This Stipulated Settlement and Disciplinary Order is intended by the parties
9 herein to be an integrated writing representing the complete, final and exclusive embodiment of
10 the agreements of the parties in the above-entitled matter.

11 13. The parties agree that facsimile copies of this Stipulated Settlement and
12 Disciplinary Order, including facsimile signatures of the parties, may be used in lieu of original
13 documents and signatures and, further, that facsimile copies and signatures shall have the same
14 force and effect as originals.

15 14. In consideration of the foregoing admissions and stipulations, the parties agree
16 the Board may, without further notice to or opportunity to be heard by respondent, issue and enter
17 the following Disciplinary Order:

18 **DISCIPLINARY ORDER**

19 **A. PUBLIC REPRIMAND**

20 IT IS HEREBY ORDERED that respondent Paul J. Cimoch, M.D., Physician's and
21 Surgeon's Certificate No. A 46088, shall be and is hereby Publicly Reprimanded pursuant to
22 California Business and Professions Code section 2227, subdivision (a)(4). This Public
23 Reprimand is issued in connection with respondent's care and treatment of patient D.H., as set
24 forth in Accusation No. 04-2006-173926, is as follows:

25 Between December, 2001 and June, 2004, while you owned and were President
26 of the Center for Special Immunology (CSI) and had other physicians affiliated with
27 CSI who provided care and treatment for patient D.H., you failed to ensure that your
28 registered nurse who performed intravenous infusions on patient D.H. was being

1 adequately supervised, thereby allowing the nurse to create and maintain inadequate
2 medical records related to the patient's infusions, and you failed to adequately
3 monitor the overall care and treatment of patient D.H. in accordance with the standard
4 of practice in the medical community, as described in Accusation No. 04-2006-
5 173926.

6 **B. MEDICAL RECORD KEEPING COURSE**

7 Within 60 calendar days of the effective date of this Decision, respondent shall enroll
8 in a course in medical record keeping, at respondent's expense, approved in advance by the Board
9 or its designee. Failure to successfully complete the course within 180 calendar days of the
10 effective date of this Decision shall constitute unprofessional conduct and grounds for further
11 disciplinary action.

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

17 Respondent shall submit a certification of successful completion to the Board or its
18 designee not later than 15 calendar days after successfully completing the course, or not later than
19 15 calendar days after the effective date of the Decision, whichever is later.

20 **C. PRESCRIBING PRACTICES COURSE**

21 Within 60 calendar days of the effective date of this Decision, respondent shall enroll
22 in a prescribing practices course, at respondent's expense, approved in advance by the Board or
23 its designee. Failure to successfully complete the course within 180 calendar days of the effective
24 date of this Decision shall constitute unprofessional conduct and grounds for further disciplinary
25 action.

26 A prescribing practices course taken after the acts that gave rise to the charges in the
27 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
28 or its designee, be accepted towards the fulfillment of this condition if the course would have

1 been approved by the Board or its designee had the course been taken after the effective date of
2 this Decision.

3 Respondent shall submit a certification of successful completion to the Board or its
4 designee not later than 15 calendar days after successfully completing the course, or not later than
5 15 calendar days after the effective date of the Decision, whichever is later.

6 **D. ETHICS COURSE**

7 Within 60 calendar days of the effective date of this Decision, respondent shall enroll
8 in a course in ethics, at respondent's expense, approved in advance by the Board or its designee.
9 Failure to successfully complete the course within one year of the effective date of this Decision
10 shall constitute unprofessional conduct and grounds for further disciplinary action.

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

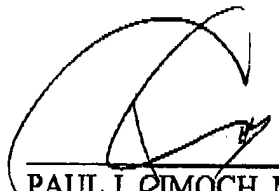
15 Respondent shall submit a certification of successful completion to the Board or its
16 designee not later than 15 calendar days after successfully completing the course, or not later than
17 15 calendar days after the effective date of the Decision, whichever is later.

18 **ACCEPTANCE**

19 I, Paul J.Cimoch, M.D., have carefully read this Stipulated Settlement and
20 Disciplinary Order and, having the benefit of counsel, enter into it freely, voluntarily,
21 intelligently, and with full knowledge of its force and effect on my Physician's and Surgeon's
22 Certificate No. A46088. I fully understand that after signing this stipulation, I may not withdraw
23 from it, that it shall be submitted to the Board for its consideration, and that the Board shall have
24 a reasonable period of time to consider and act on this stipulation after receiving it. By entering
25 into this stipulation, I fully understand that, upon formal acceptance by the Board, I shall be
26 publically reprimanded by the Board and shall be required to comply with all of the terms and
27 conditions of the Disciplinary Order set forth above. I also fully understand that any failure to
28 comply with the terms and conditions of the Disciplinary Order set forth above constitute

1 unprofessional conduct and will subject my Physician's and Surgeon's Certificate No. A 46088 to
2 disciplinary action.

3
4 DATED: 10/16/09

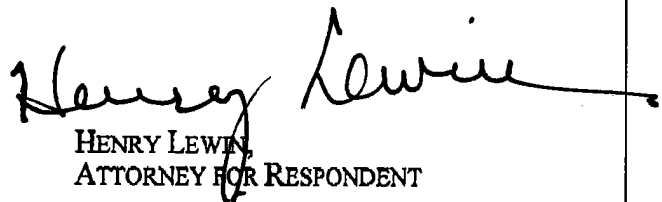


PAUL J. CIMOCH, M.D.
Respondent

6 I have read and fully discussed with respondent Paul J.Cimoch, M.D., the terms and
7 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.
8 I approve its form and content.

9
10 Dated: 10/16/09

LEWIN & LEVIN



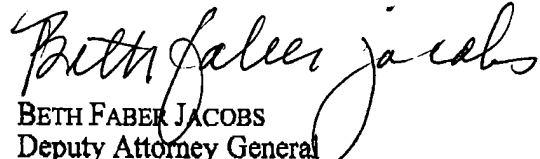
HENRY LEWIN
ATTORNEY FOR RESPONDENT

ENDORSEMENT

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

19 Dated: October 19, 2009

EDMUND G. BROWN JR.
Attorney General of California
STEVEN V. ADLER
Supervising Deputy Attorney General



BETH FABER JACOBS
Deputy Attorney General
Attorneys for Complainant

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Attachment "A"
Accusation No. 04-2006-173926

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 STEVEN V. ADLER,
Supervising Deputy Attorney General
3 BETH FABER JACOBS, State Bar No. 89145
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8 Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO December 1, 2008
BY Alexis Moa ANALYST

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

12 In the Matter of the Accusation Against:

13 PAUL JOSEPH CIMOCH, M.D.
14 11190 Warner Avenue
Suite 411
Fountain Valley, CA 92708
15 Physician's and Surgeon's Certificate No.
A46088

Case No. 04-2006-173926

OAH No.

ACCUSATION

16
17 Respondent.

18 Complainant alleges:

19 **PARTIES**

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

23 2. On or about May 15, 1989, the Medical Board of California issued
24 Physician's and Surgeon's Certificate Number A46088 to Paul Joseph Cimoch, M.D.
25 (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times
26 relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.

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JURISDICTION

1
2 3. This Accusation is brought before the Medical Board of California, under
3 the authority of the following sections of the Business and Professions Code ("Code):

4 4. Section 2220 of the Code states:

5 "Except as otherwise provided by law, the Division of Medical Quality¹
6 may take action against all persons guilty of violating this chapter [Chapter 5, the
7 Medical Practice Act]. The division shall enforce and administer this article as to
8 physician and surgeon certificate holders, and the division shall have all the
9 powers granted in this chapter"

10 5. Under section 2227 of the Code, a licensee who is found guilty under the
11 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
12 one year, placed on probation and required to pay the costs of probation monitoring, or have such
13 other action taken in relation to discipline as the Board deems proper.

14 6. Section 2234 of the Code states:

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

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

21 "(b) Gross negligence.

22 "(c) Repeated negligent acts. To be repeated, there must be two or more
23 negligent acts or omissions. An initial negligent act or omission followed by a
24

25
26 1. California Business and Professions Code section 2002, as amended effective January 1,
27 2008, provides in part that the term "Board" as used in the Medical Practice Act (Business and
28 Professions Code, section 2000, et seq.) means the "Medical Board of California," and that
references to the "Division of Medical Quality" and the "Division of Licensing" in the Act or
any other provision of law shall be deemed to refer to the Board.

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

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

6 “(2) When the standard of care requires a change in the
7 diagnosis, act, or omission that constitutes the negligent act
8 described in paragraph (1), including, but not limited to, a
9 reevaluation of the diagnosis or a change in treatment, and the
10 licensee’s conduct departs from the applicable standard of care,
11 each departure constitutes a separate and distinct breach of the
12 standard of care.

13 “(d) Incompetence.

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

17 “(f) Any action or conduct which would have warranted the denial of a
18 certificate.”

19 7. Section 2264 of the Code states:

20 “The employing, directly or indirectly, the aiding, or the abetting of any
21 unlicensed person or any suspended, revoked, or unlicensed practitioner to engage
22 in the practice of medicine or any other mode of treating the sick or afflicted
23 which requires a license to practice constitutes unprofessional conduct.”

24 8. Section 2266 of the Code states: “The failure of a physician and surgeon
25 to maintain adequate and accurate records relating to the provision of services to their patients
26 constitutes unprofessional conduct.”

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28 ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 9. Respondent is subject to disciplinary action pursuant to Section 2234,
4 subdivision (b) of the Code, in that Respondent was grossly negligent in his care, treatment and
5 management of his patient, D.H. The circumstances are as follows:

6 A. At all relevant times, respondent served as President of the Center
7 for Special Immunology (CSI), the medical practice he owned. Respondent's
8 practice focused on the care of HIV patients, though he also had patients with
9 other immunodeficiencies or autoimmune ailments.

10 B. In early 1998, D.H., a 40 year female, became a CSI patient. She
11 had a history of several conditions, including but not limited to Hashimoto
12 thyroiditis², multiple sclerosis, and asthma, and she complained of fatigue, muscle
13 weakness, numbness, eye pain, and poor balance. Dr. F.A., a physician hired by
14 respondent to work at CSI, evaluated D.H. and diagnosed her with an immune
15 deficiency - IgG3 subclass deficiency. Dr. F.A. recommended treatment with a
16 course of intravenous gamma globulin (IVIg) replacement at 15 grams every two
17 weeks beginning in April of 1998. Thereafter, she raised the dose to 20 grams
18 every 2 weeks. Dr. F.A. left her position with CSI in late 2001.³

19 C. Of the approximately 54 IVIg infusions patient D.H. received at
20 CSI from April, 1998 until on or about June 4, 2004, about 45 IVIg infusions were
21 performed on patient D.H. between December 1, 2001 and June 4, 2004, when
22 respondent was her physician at CSI. All of D.H.'s IVIg infusions were
23 performed by registered nurse, Wendy Fasone, who was also Vice President of

24
25 2. Hashimoto thyroiditis, also referred to as "Hashimoto Disease" is an autoimmune
26 disorder involving infiltration of the thyroid gland with lymphocytes and in part resulting in
hypothyroidism (diminished production of the thyroid hormone).

27 3. Allegations pertaining to the care, treatment and management of D.H. prior to
28 December 1, 2001 are informational only. Respondent's conduct with respect to patient D.H.
prior to December 1, 2001, is not a basis for discipline.

1 CSI. Nurse Fasone performed these infusions without any direct supervision by
2 respondent or any other physician.

3 D. Respondent failed to provide to Nurse Fasone with any protocol,
4 instructions or orders (written or oral) regarding administration of the infusions
5 given at CSI, including those given to patient D.H. In addition, respondent failed
6 to provide any orders or instructions regarding pre-medications, the infusion rate
7 or dose to be given, or procedures to follow in case of an adverse event.

8 E. On or about May 3, 2001, D.H. had her first IgG blood level test at
9 CSI. Such an IgG blood level would be used to evaluate the effect of the IVIg
10 infusions. Despite respondent having the responsibility to supervise the provision
11 of IVIg infusions, ensure yearly IgG labs, and monitor if such infusions were
12 effective, respondent failed to do so. He also failed to order (or instruct another
13 CSI physician to order) IgG labs for patient D.H. for May 2002, the year
14 following her first IgG level taken at CSI.

15 F. Respondent's only meeting with patient D.H. was on March 14,
16 2003. He did not conduct a physical or examine her. He did not discuss the
17 patient with Dr. F.A. While he ordered labs to determine her IgG level, he did not
18 review the patient's infusion records.

19 G. Respondent did not appreciate the nature of the immune problem
20 suffered by D.H. nor the significance of the results of the IgG level he ordered on
21 March 14, 2003. He should have seen that the patient, supposedly getting IgG
22 levels at 30 grams infused twice a month since January 2003, had virtually the
23 same IgG levels as she had when supposedly infused with 20 grams twice a month
24 throughout 2002, and that this was essentially unchanged from her level prior to
25 starting IVIg infusions. The results should have alerted respondent that something
26 with the infusions or treatment course was wrong.

27 H. Respondent knew or should have known that patient D.H. was not
28 getting the amount of IVIg recorded in CSI records.

1 I. Respondent's records regarding D.H.'s IVIg infusions were
2 inadequate and poorly documented. They are so flawed that it is impossible to
3 know what amount of IVIg was given to patient D.H. on any specific occasion or
4 how it was administered on any specific occasion. The records do not list the
5 time started nor the time the infusion was completed. On many occasions, the
6 IVIg infusion therapy and nursing notes from a prior visit were photocopied onto
7 the new notes so that with the exception of current vital signs, all prior
8 information was brought forward to the record for the current infusion date as
9 though it was true and accurate for that new date. In many cases the lot number
10 for the vial used was incorrect because it referred to a vial number used in a prior
11 infusion on a prior date.

12 J. Respondent did not chart dose amounts or the rate of infusions,
13 give orders for changes in the dose amounts or the rate of infusion, nor chart any
14 order to change dosage or infusion rate. Nonetheless, in many instances, D.H.'s
15 infusion records were altered by writing over dose amounts given, and dose
16 amounts were changed from 20 grams to 30 grams. The dosing changes were not
17 initialed by the person making the change.

18 K. Respondent knew or should have known his staff was using
19 photocopied records with false and misleading information regarding the infusion
20 notes, lot numbers for the vials of medication infused and the altered dose
21 amounts.

22 L. Despite the importance of properly recording the lot numbers of
23 the IGIg bottles used for an infusion so that an adverse reaction can be traced or a
24 problem identified by the manufacturer can be cross referenced to the recipient
25 patient, respondent failed to record, failed to instruct his staff to record, and failed
26 to ensure his staff recorded the exact lot number of the bottles used for the
27 infusion of IVIg in the patient's infusion record.

28 ///

1 M. The vial labels for the bottles of IVIg used for patient D.H. were
2 not affixed to the request for payment. To the extent multiple vials were used,
3 neither respondent nor his staff affixed labels from all the vials used to the request
4 for payment.

5 N. Despite respondent's failure to supervise the patient's infusions,
6 from approximately December 1, 2001 through June 2004, approximately 50 bills
7 were submitted to the insurance company (Excellus Blue Cross/Blue Shield
8 [BC/BS]) for the patient's IVIg infusions, identifying respondent as the patient's
9 physician and/or indicating the infusions were "doctor supervised." Respondent
10 submitted these inaccurate billings, knew they were being submitted on his behalf,
11 or should have known they were being submitted.

12 10. Respondent committed acts of gross negligence in his care, treatment and
13 management of patient D.H. by reason of, but not limited to, the following:

14 A. Complainant incorporates by reference the allegations in paragraph
15 9 and its subparagraphs above as though fully set forth herein.

16 B. Respondent failed to provide written orders for the IVIg infusions,
17 failed to provide any standard operating procedure for the infusions, including
18 pre-medications and procedures to undertake in case of an adverse event and
19 failed to sign the patient's physician supervised infusion notes.

20 C. Respondent failed to create or maintain a flow chart of the drugs
21 administered to D.H. including the start and stop time for when she was receiving
22 infusion therapy and failed to instruct his staff to do this.

23 D. Respondent failed to record in D.H.'s infusion records the exact lot
24 number of the infusion bottles used, and failed to instruct his staff to do this.

25 E. Respondent knew or should have known his staff was using
26 photocopies of infusion notes from prior visits that were then brought forward to
27 the current date as if the information was true and accurate as to that date.

28 ///

1 F. Though Respondent billed for D.H.'s IVIg infusions as her treating
2 physician, Respondent only saw D.H. on one occasion the entire time she had
3 infusions at CSI - on March 14, 2003. Between December 1, 2001 and June 2004,
4 Respondent had his staff provide approximately 45 IVIg infusions to D.H. without
5 writing any orders. Respondent never saw D.H. during her infusions, did not
6 review the infusion notes, and failed to create or maintain any records showing
7 such treatment or review.

8 G. It is the standard of care for a patient with humoral
9 immunodeficiency requiring IVIg infusions to check the patient's IgG levels
10 several times during the first year of treatment. After the level of IgG has
11 stabilized, levels should be checked at least once a year. Respondent's staff first
12 checked D.H.'s IgG levels on May 3, 2001, three years after she first started
13 infusions of IgG at CSI.⁴ Respondent should have ensured levels were repeated
14 within a year, by May 2002. He did not do this. Rather, the first time he
15 evaluated the patient in any way was on March 14, 2003, when he ordered new
16 IgG levels taken. He did conduct a physical nor discuss her treatment or care with
17 any prior treating physicians, nor did he consult with a physician with an expertise
18 in immunodeficiency. Respondent's failure to closely monitor the patient's IgG
19 levels contributed to his lack of awareness that D.H.'s IgG levels did not increase
20 as expected. Respondent did not appreciate or understand the red flag raised by
21 D.H.'s blood level remaining essentially unchanged regardless of whether she
22 received 20 or 30 grams twice a month.

23 H. The standard of care requires a physician to supervise IVIg
24 infusions. Respondent did not supervise patient D.H.'s IVIg infusions. He
25 submitted billings stating he supervised her infusions, but he did not so.

27
28 4. Allegations pertaining to the care, treatment and management of D.H. prior to
December 1, 2001 are informational only and are not alleged as a basis for discipline.

1 I. Respondent failed to properly supervise his nurse, Wendy Fasone,
2 R.N. As a result, Ms. Fasone was running the CSI infusion center on her own.
3 She used photocopied infusion notes from prior infusions and passed them off as
4 current notes, she gave pre-medications to D.H. without any orders from
5 respondent or any other physician, she gave IVIg infusions to D.H. without proper
6 physician orders, she altered medical records as to the amount of IVIg given
7 during the infusions, and modified D.H.'s doses without physician orders.

8 J. Respondent knew or should have known that patient D.H. was not
9 getting the amount of IVIg that appeared to be charted and billed to the insurance
10 company.

11 K. Respondent submitted or knew his staff submitted approximately
12 50 bills to the insurance company (Excellus Blue Cross/Blue Shield [BC/BS]) for
13 patient D.H.'s IVIg infusions, where respondent identified himself or was
14 identified as the patient's physician, and/or the billings falsely indicated the
15 infusions were "doctor supervised."

16 **SECOND CAUSE FOR DISCIPLINE**

17 **(Repeated Negligence)**

18 11. Respondent is subject to disciplinary action pursuant to section 2234,
19 subdivision (c), in that, respondent committed repeated acts of negligence in his care, treatment
20 and management of patient D.H. as described above in paragraphs 9 and 10, and their
21 subsections, which are incorporated by reference as though fully set forth.

22 **THIRD CAUSE FOR DISCIPLINE**

23 **(Incompetence)**

24 12. Respondent is subject to disciplinary action pursuant to section 2234
25 subdivision (d), in that respondent was incompetent in his care, treatment and management of
26 patient D.H. as described above in paragraphs 9 and 10, and their subsections, which are
27 incorporated by reference herein.

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1 **FOURTH CAUSE FOR DISCIPLINE**

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

3 13. Respondent is subject to disciplinary action failure to maintain adequate
4 and accurate records relating to D.H, in violation of Business and Professions Code section 2266,
5 as set forth above in paragraphs 9 and 10, and their subsections, which are incorporated herein.

6 **FIFTH CAUSE FOR DISCIPLINE**

7 **(Aiding and Abetting Unlicensed Practice of Medicine)**

8 14. Respondent is subject to disciplinary action pursuant to section 2264 in
9 that he aided and abetted his employee, Wendy Fasone, R.N., to practice medicine without a
10 license and to provide care, treatment and medical management of patient D.H.

11 A. Paragraphs 9 and 10 and their subsections are re-alleged and
12 incorporated by reference herein.

13 B. Respondent aided and abetted the unlicensed practice of medicine
14 by permitting and authorizing Wendy Fasone, registered nurse and CSI Vice
15 President, to control all aspects of IVIg infusions at CSI, including determining
16 the dose to be infused, the type of and dose of any pre-medications, determining
17 the rate of infusion, performing the actual infusion, recording all aspects of the
18 infusion for patient D.H. and other patients at CSI, and billing for the infusions
19 under respondent's name.

20 **PRAYER**

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

23 1. Revoking or suspending Physician's and Surgeon's Certificate Number
24 A46088, issued to Paul Joseph Cimoch, M.D;

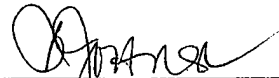
25 2. Revoking, suspending or denying Paul Joseph Cimoch, M.D. the authority
26 to supervise physician assistants, pursuant to section 3527 of the Code;

27 3. Ordering Paul Joseph Cimoch, M.D. to pay the Medical Board of
28 California the costs of probation monitoring, should he be placed on probation; and

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

DATED: December 1, 2008



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