



§164.004 of the Act. All procedural rules were complied with, including but not limited to, Board Rules 182 and 187, as applicable.

3. No agreement to settle this matter has been reached by the parties.
4. All jurisdictional requirements have been satisfied.

### III. FACTUAL ALLEGATIONS

Board Staff has received information and relying on that information believes that Respondent has violated the Act. Based on such information and belief, Board Staff alleges:

#### A. PATIENT CARE ISSUES<sup>1</sup>:

1. Patient A:
  - a. On or about September 23, 2008, Patient A presented to Respondent with a partial avulsion to the tip and fingernail bed of Patient A's right thumb, which also had an open comminuted fracture.
  - b. After cleaning and closing the wound, Respondent sutured part of a rubber tip removed from suture kit scissors to the wound on Patient A's right thumb and/or used it as a fixation device.
2. Patient B:
  - a. On or about September, 22, 2008, Patient B presented to Respondent with an injury to his right hand that required a full thickness skin graft.
  - b. Respondent failed to document the extent of Patient B's hand injury, including the range of motion, sensory and motor deficit.
  - c. There is no documentation of a recommendation to either consult with or refer to a plastic surgeon and/or Patient B's refusal for transfer to a higher level of care.
3. Patient C:
  - a. On or about September 9, 2008, Patient C was admitted to the hospital for treatment of an abscess to her left thigh, which was diagnosed as methicillin-resistant Staphylococcus aureus.

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<sup>1</sup> Board staff will provide patient identification to the ALJ and Respondent by separate confidential document under seal.

- b. Respondent applied an olive oil solution on Patient C's abscess.
  - c. The olive oil solution is not approved by the Food and Drug Administration ("FDA") for such purpose, nor was it included in the hospital's formulary.
4. Patient D:
- a. On or about October 9, 2008, Patient D (minor child) presented with complaints of right lower quadrant abdominal pain and a pre-existing history of nausea and vomiting.
  - b. Respondent failed to complete an adequate history and evaluation.
  - c. Respondent's abdominal and rectal examination and laboratory results demonstrated an acute abdomen and/or appendicitis.
  - d. Respondent ordered a CT scan which is unnecessary based on the indications of an acute abdomen and/or appendicitis.
  - e. Respondent ordered an enema, which was inappropriate, given Patient D's condition.
  - f. Respondent discharged the patient prematurely without receiving and reviewing the results of the CT scan that demonstrated an appendicitis.
5. Patient E:
- a. On or about July 31, 2008, Patient E presented to Respondent with headache and stomach distress.
  - b. At the initial presentation, Respondent diagnosed hypothyroidism without any testing, and prescribed thyroid supplement therapy.
  - c. Respondent failed to properly monitor Patient E's thyroid stimulating hormone ("TSH") level at a follow up visit and continued the thyroid medication.
  - d. A thyroid function lab test was later ordered by a different physician, and the results indicated that Patient E was hyperthyroid as a result of the medication prescribed by Respondent.

- e. Respondent performed and billed for unnecessary genitourinary exams at Patient E's follow up visits.
6. Patient F:
  - a. On or about June 11, 2008, Patient F presented to Respondent with symptoms of a sinus infection.
  - b. Patient F was taking a thyroid medication for hypothyroidism upon presentation to Respondent. Respondent ordered lab tests to evaluate the adequacy of the prescribed thyroid treatment.
  - c. Respondent switched the patient to a different thyroid medication, without adequate documentation to support or justify the prescription change.
  - d. Respondent failed to document and/or recommend that Patient F return for follow up testing. Follow up lab testing was not performed.
  - e. Respondent performed and billed for unnecessary genitourinary exams at Patient F's follow up visits.
7. Patient G:
  - a. On or about July 16, 2008, Patient G was initially treated by Respondent for hypertension.
  - b. Respondent diagnosed Patient G with hypothyroidism, despite a normal thyroid function tests, and prescribed a thyroid medication.
  - c. The medical records lack clinical signs or symptoms of hypothyroidism. Respondent's treatment was unsupported and unjustified based on Patient G's laboratory tests and the lack of any other data/documentation indicating Patient G had a thyroid condition.
  - d. Respondent performed and billed for unnecessary genitourinary exams completed at Patient G's follow up visits.
8. Patient H:
  - a. On or about May 19, 2008, Patient H initially presented to a nurse practitioner working in Respondent's practice with complaints of a nodule

to the left side of the jaw. The practitioner diagnosed Patient H with submaxillary lymphadenopathy.

- b. Patient H's next visit was with Respondent, and Respondent failed to adequately document the medical record regarding this visit.
- c. Respondent ordered lab work; however, Respondent did not document communicating the results to Patient H or that he recommend that Patient H make a follow up appointment to discuss the results.
- d. Respondent also performed and billed for unnecessary genitourinary exams completed at Patient H's follow up visits.

9. Patient I:

- a. During 2009, Patient I presented to Respondent a number of times. The patient had a medical history of deep vein thrombosis ("DVT"). Respondent did not document this history for Patient I in the medical record.
- b. Respondent ordered lab work for Patient I, which showed testosterone, estradiol, and progesterone levels within the normal range. Respondent diagnosed Patient I with a hormone imbalance and prescribed the patient hormone replacement therapy ("HRT") drugs, including estrogen.
- c. Respondent's medical records for Patient I are generally illegible and incomplete, including a failure to document history, physical, or lab findings that would indicate HRT was medically indicated.
- d. Estrogen/HRT is contraindicated for females who have a history of DVT due to risk of developing serious complications and/or death, including recurrence of DVT.
- e. After initiating the HRT, Patient I developed a DVT.

B. UNPROFESSIONAL CONDUCT:

1. Witness Intimidation:

a. Respondent was notified of pending Board investigations related to the care and treatment of approximately ten patients at the Winkler County Hospital

b. On or about April 27, 2009, after receiving notice of these investigations, Respondent contacted the Winkler County Sheriff, a personal friend and patient, and requested his assistance to identify the complainant(s), and to file a harassment complaint against the complainant(s).

c. On or about April 28, 2009, Respondent approached a hospital employee and requested the contact information for 10 patients. The 10 patients identified by Respondent were those identified in the Board's notice of investigation.

d. After Respondent received the patient information, he then provided the Sheriff of Winkler County with that information and asked that he assist Respondent in finding out who filed the complaint with the Board.

e. The Sheriff contacted each patient identified in the list given to the Respondent by the hospital employee, and determined that the patients were not the complainants.

f. Upon determining that none of the 10 patients had filed a complaint with the Board, the Sheriff filed an open records request with the Board seeking information regarding the complainant, asserting that he was conducting an investigation that involved Respondent.

g. The Board provided the Sheriff with a copy of the complaint, notifying the Sheriff that the complaints and identity of the complainants were to be treated as confidential and protected by law and only to be used in connection with a criminal investigation of the Respondent.

h. The Sheriff used the copy of the complaint, along with other investigative data, to identify two nurses from Winkler County Hospital as the complainants.

i. As a result of Respondent's actions, the nurses' employment was terminated by the Winkler County Hospital, and each nurse was indicted on a

criminal charge of third-degree felony charges of Misuse of Official Information in violation of Penal Code §39.06.

C. VIOLATIONS:

Respondent's action in these cases is below the standard of care and/or unprofessional due to one or more of the following, but are not limited to: failure to maintain adequate medical records, poor medical judgment, poor decision-making, overbilling, improper coding, non-therapeutic prescribing and/or treatment, and intimidation of witnesses.

The actions of Respondent as specified above violate one or more of the following provisions of the Medical Practice Act:

- Section 164.051(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act prohibited under Section 164.052 of the Act.
- Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's committing or attempting to commit a direct violation of a rule adopted under this subtitle, either as principal, accessory or accomplice. Specifically, Respondent violated Board Rule 165.1, by failing to maintain adequate medical records.
- Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare, as further defined by Board Rule(s): 190.8(1)(A), the failure to treat a patient according to the generally accepted standard of care; Board Rule 190.8(1)(B), negligence in performing medical services; Board Rule 190.8(1)(C), failure to use proper diligence in one's practice; Board Rule 190.8(1)(D), failure to safeguard against potential complications; Board Rule 190.8(1)(H) failure to disclose reasonable alternative treatment to the proposed treatment or treatment; and Board

Rule 190.8(1)(K), prescription or administration of a drug in a manner that is not in compliance with Chapter 200 of this title, or that is either not approved by the FDA for use in human beings or does not meet standards for off-label use, unless an exemption has otherwise been obtained from the FDA.

- Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's commission of unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public, as further defined by Board Rule(s) 190.8(2)(C), providing false information to the Board; 190.8(2)(J), providing medically unnecessary services to a patient or submitting a billing statement to a patient or a third party payer that the licensee knew was improper, [which means] the billing statement is false, fraudulent, misrepresents services provided, or otherwise does not meet professional standards; 190.8(2)(N), failing to maintain the confidentiality of a patient; 190.8(2)(R)(x), commission of the following violations of federal and state laws whether or not there is a complaint, indictment, or conviction, to wit:
  - a. Texas Penal Code Section 38.15(a)(7)(D), a person commits an offense if the person with criminal negligence interrupts, disrupts, impedes, or otherwise interferes with a person who is performing a duty or exercising authority imposed or granted under the Agriculture Code, Health and Safety Code, Occupations Code, or Water Code; and
  - b. Health Insurance Portability and Accountability Act, 42 USC 1320d-6(a) Offense: A person who knowingly and in violation of this part uses or causes to be used a unique health identifier; obtains individually identifiable health information relating to an



individual; or discloses individually identifiable health information to another person;

and 190.8(2)(S), contacting or attempting to contact a complainant or witness regarding an investigation by the board for purposes of intimidation.

- Section 164.053(a)(1) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's commission of an act that violates any law of this state if the act is connected with Respondent's practice of medicine; to wit: Section 311.0025(a) of the Texas Health and Safety Code, A hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payor a bill for a treatment that the hospital, facility, or professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
- Section 164.053(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's prescription or administration of a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.
- Section 164.053(a)(7) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of Section 311.0025 of the Texas Health and Safety Code.

This case involves patient harm; one or more violations that involve more than one patient; economic harm to an individual; history of previous discipline with the Board; intentional and knowing conduct; and multiple violations of the Act and Board rules.

IV. APPLICABLE STATUTES AND RULES FOR THE CONTESTED CASE  
PROCEEDING

The following statutes, rules, and agency policy are applicable to the conduct of the contested case:

- A. Section 164.007(a) of the Act requires that the Board adopt procedures governing formal disposition of a contested case before the State Office of Administrative Hearings.
- B. 22 TEX. ADMIN. CODE, Chapter 187 sets forth the procedures adopted by the Board under the requirement of Section 164.007(a) of the Act.
- C. 1 TEX. ADMIN. CODE, CHAPTER 155 sets forth the rules of procedure adopted by SOAH for contested case proceedings.
- D. 1 TEX. ADMIN. CODE, CHAPTER 155.507, requires the issuance of a Proposal for Decision (PFD) containing Findings of Fact and Conclusions of Law.
- E. Section 164.007(a) of the Act, Board Rule 187.37(d)(2) and Board Rule 190 et. seq., provides the Board with the sole and exclusive authority to determine the charges on the merits, to impose sanctions for violation of the Act or a Board rule, and to issue a Final Order.

V. NOTICE TO RESPONDENT

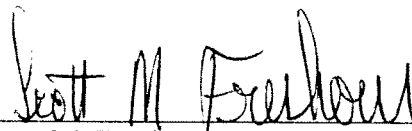
**IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS COMPLAINT WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHING 20 DAYS AFTER THE DATE OF RECEIPT, A DEFAULT ORDER MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. IF YOU FILE A WRITTEN ANSWER, BUT THEN FAIL TO ATTEND THE HEARING, A DEFAULT ORDER MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. A COPY OF ANY ANSWER YOU FILE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ALSO BE PROVIDED TO THE HEARINGS COORDINATOR OF THE TEXAS MEDICAL BOARD.**

**IF YOU FAIL TO ATTEND THE HEARING, THE ADMINSTRATIVE LAW JUDGE MAY PROCEED WITH THE HEARING AND ALL THE FACTUAL ALLEGATIONS LISTED IN THIS NOTICE CAN BE DEEMED ADMITTED, AND THE RELIEF SOUGHT IN THIS NOTICE MIGHT BE GRANTED.**

WHEREFORE, PREMISES CONSIDERED, Board Staff requests that an administrative law judge employed by the State Office of Administrative Hearings conduct a contested case hearing on the merits of the Complaint, and issue a Proposal for Decision ("PFD") containing Findings of Fact and Conclusions of Law necessary to support a determination that Respondent violated the Act as set forth in this Complaint.

Respectfully submitted,

By:



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Texas Medical Board  
Texas State Bar No. 00789299  
333 Guadalupe, Tower 3, Suite 610  
Austin, Texas 78701  
Tele: (512) 305-7096  
Fax: (512) 305-7007

THE STATE OF TEXAS

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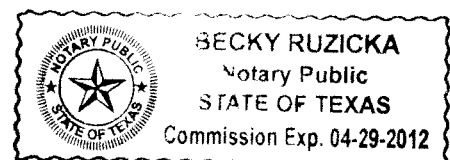
COUNTY OF TRAVIS

§

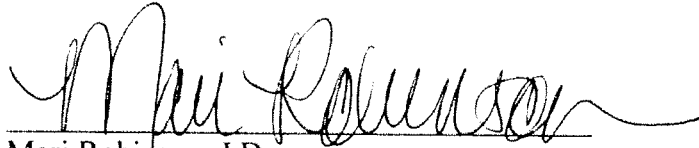
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SUBSCRIBED AND SWORN to before me by the said Scott M. Freshour on this 28<sup>th</sup> day of June, 2010.

  
Notary Public, State of Texas



Filed with the Texas Medical Board on this 22 day of June, 2010.



Mari Robinson, J.D.  
Executive Director  
Texas Medical Board

I certify that on the 28<sup>th</sup> day of June, 2010, a true and correct copy of the foregoing complaint document has been served as follows:

**VIA FAX (512) 475-4993:**

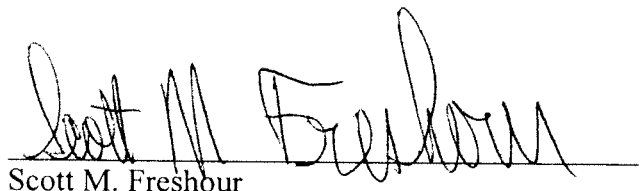
Docket Clerk  
State Office of Administrative Hearings  
William P. Clements Bldg.  
300 W. 15th Street, Suite 504  
Austin, Texas 78701-1649

**VIA FAX (713) 559-3014 and CERTIFIED FIRST CLASS MAIL, RETURN RECEIPT REQUESTED:**

Jennifer L. House  
Bingham Mann House & Gibson  
1415 Louisiana, Suite 3300  
Houston, Texas 77002  
Attorney for Respondent

**BY HAND DELIVERY:**

Sonja Aurelius  
Hearings Coordinator  
Texas Medical Board  
333 Guadalupe, Tower 3, Suite 610  
Austin, Texas 78701



Scott M. Freshour