Public

STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

BPMC No. 13-196

**IN THE MATTER**

**OF**

**CHAU KHUU, M.D.**
**CO-13-01-0154-A**

**COMMISSIONER'S SUMMARY ORDER**

**TO:** Chau Khuu, M.D.
REDACTED

The undersigned, Nirav R. Shah, M.D., M.P.H., Commissioner of Health, pursuant to New York Public Health Law §230, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, has determined that the duly authorized professional disciplinary agency of another jurisdiction, the Disciplinary Panel of the Texas Medical Board, has made a finding substantially equivalent to a finding that the practice of medicine by **CHAU KHUU, M.D.**, Respondent, New York license number 237238, in that jurisdiction, constitutes an imminent danger to the health of its people, as is more fully set forth in the Order of Temporary Suspension, dated April 10, 2013, and allied papers, attached, hereto, as Appendix "A," and made a part, hereof.

It is, therefore:

ORDERED, pursuant to New York Public Health Law §230(12)(b), that effective immediately, **CHAU KHUU, M.D.** shall not practice medicine in the State of New York or in any other jurisdiction where that practice is predicated on a valid New York State license to practice medicine.

**ANY PRACTICE OF MEDICINE IN THE STATE OF NEW YORK IN VIOLATION OF THIS ORDER SHALL CONSTITUTE PROFESSIONAL MISCONDUCT WITHIN THE MEANING OF NEW YORK EDUCATION LAW §6530(29) AND MAY CONSTITUTE UNAUTHORIZED MEDICAL PRACTICE, A FELONY DEFINED BY NEW YORK EDUCATION LAW §6512.**

This Order shall remain in effect until the final conclusion of a hearing which shall commence within thirty (30) days after the final conclusion of the disciplinary proceeding in Texas.

The hearing will be held pursuant to the provisions of New York Public Health Law §230, and New York State Administrative Procedure Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on a date and at a location to be set forth in a written Notice of Referral Proceeding to be provided to Respondent after the final conclusion of the Texas Medical Board proceeding. Said written Notice may be provided in person, by mail or by other means. If Respondent wishes to be provided said written notice at an address other than that set forth above, Respondent shall so notify, in writing, both the attorney whose name is set forth in this Order, and the Director of the Office of Professional Medical Conduct, at the addresses set forth below.

**RESPONDENT SHALL NOTIFY THE DIRECTOR OF THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT, NEW YORK STATE DEPARTMENT OF HEALTH, RIVERVIEW CENTER, 150 BROADWAY, SUITE 510, ALBANY, NY 12204-2719, VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED, OF THE FINAL CONCLUSION OF THE PROCEEDING IMMEDIATELY UPON SUCH CONCLUSION.**

**THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW §230-A. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.**

DATE: Albany, New York
6/20, 2013

REDACTED

Nirav R. Shah, M.D., M.P.H.
Commissioner of Health
New York State Department of Health

Inquires should be directed to:

Jude B. Mulvey
Associate Counsel
Bureau of Professional Medical Conduct
Corning Tower – Room 2512
Empire State Plaza
Albany, New York 12237
(518) 473-4282

# Appendix A

LICENSE NO. M-4838

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| IN THE MATTER OF | BEFORE THE DISCIPLINARY PANEL |
| THE LICENSE OF | OF THE |
| CHAU DOAN KHUU, M.D. | TEXAS MEDICAL BOARD |

ORDER OF TEMPORARY SUSPENSION
(WITH NOTICE OF HEARING)

On April 10, 2013, at the direction and approval of Irvin E. Zeitler, Jr., D.O., President of the Board, three members of the Texas Medical Board ("Board") were appointed to sit as a Disciplinary Panel ("Panel") in this matter, pursuant to §164.059(a) of the Medical Practice Act ("the Act") and 22 TEX. ADMIN. CODE §187.56. Chau Doan Khuu, M.D. ("Respondent") appeared in person and with counsel, Louis Leichter. Susan Rodriguez represented Board Staff. Based on evidence submitted, the Board through this Panel makes the following Findings of Fact and Conclusions of Law and enters this Order of Temporary Suspension:

FINDINGS OF FACT

1. Respondent was employed at Life's Good Medical Clinic ("Clinic"), located at 6060 Bellaire Blvd., Suite A, Houston, Texas 77081.

2. On or about October 25, 2012, Board staff, in conjunction with the Drug Enforcement Administration ("DEA") executed a search warrant at the Clinic. The DEA had a search warrant supported by an affidavit that demonstrated illegal operation of the Clinic as it related to prescribing of controlled substances.

3. During the execution of the warrant, further evidence was obtained that demonstrated the Clinic was being operated illegally as it related to the method and manner of prescribing of controlled substances.

4. The evidence demonstrates Respondent illegally operated the Clinic based on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance, a violation of state law and the Medical Practice Act.

5. Respondent failed to provide adequate supervision to mid-levels working under his delegation and prescriptive authority.



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6. Based upon evidence obtained during the execution of the search warrant at the Clinic, and Respondent's statements to the DEA and Board staff at that time, a search warrant was obtained for and executed at a residence with which Respondent is associated.

7. The execution of the search warrant at the residence led to the discovery of the following items: approximately $10,000 in cash; numerous vials of expired injectable medications; expired kits for trigger point injections; copies of drivers' licenses from various states; and numerous checks and money order from patients, some that were more than a year old and were not cashed.

8. Respondent's continued practice of medicine, including improper and illegal operation of a pain clinic, and the method and manner in which controlled substances were prescribed, poses a continuing threat to public welfare.

## CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Panel concludes the following:

1. Section 164.059 of the Act authorizes the Disciplinary Panel to temporarily suspend or restrict the medical license of Respondent if the Disciplinary Panel determines from evidence presented to it that the Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

2. Based on the evidence presented and the Findings of Fact set forth herein, the Disciplinary Panel finds that Respondent violated various sections of the Medical Practice Act, specifically:

a. 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.

b. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a Board rule, specifically, Board Rule 195.4(d), operation of a pain management clinic.

c. 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 190.8(1). Specifically, Board Rule 190.8(1)(L)

failure to establish a proper physician-patient relationship prior to prescribing a dangerous drug or controlled substance.

d. Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public, as further defined by Board Rule 190.8(2), commission of a violation of state or federal law whether or not there is a complaint, indictment, or conviction.

e. Section 164.053(a)(1) of the Act authorize the Board to take disciplinary action against Respondent based on Respondent commission of an act that violates state or federal law if the act is connected to the practice of medicine.

f. Section 164.053(a)(8), of the Act authorize the Board to take disciplinary action against Respondent based on Respondent's failure to supervise adequately the activities of those acting under the supervision of the physician.

g. Section 107.052(1) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent prescribing or administering a dangerous drug or controlled substance that is not for a legitimate medical purpose.

h. Section 107.052(2) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent prescribing or administering a dangerous drug or controlled substance if the physician knows or should have known the person is using drugs for a non-therapeutic purpose.

i. Section 168.202(a) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent violation of statutes or rules related to the operation of a pain management clinic.

3. Based on the evidence presented and the above Findings of Fact and Conclusions of Law, the Panel determines Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

## ORDER

Based on the above Findings of Fact and Conclusions of Law, the Panel ORDERS that:

1. Respondent's Texas medical license is hereby temporarily suspended.

2. This Order of Temporary Suspension With Notice of Hearing is effective on the date rendered.

3. This Order of Temporary Suspension With Notice of Hearing shall remain in effect until it is superseded by an Order of the Board.

Signed and entered this 10th day of April, 2013.

REDACTED

Melinda McMichael, M.D., Chair
Disciplinary Panel
Texas Medical Board

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-13-1863.MD
TEXAS MEDICAL LICENSE NO. M-4838

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|---|---|
| IN THE MATTER OF THE | |
| COMPLAINT AGAINST | BEFORE THE |
| CHAU DOAN KHUU, M.D. | TEXAS MEDICAL BOARD |

## COMPLAINT

TO THE HONORABLE TEXAS MEDICAL BOARD AND THE HONORABLE ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED:

COMES NOW, the Staff of the Texas Medical Board (the "Board"), and files this Complaint against Chau Doan Khuu, M.D., ("Respondent"), based on Respondent's alleged violations of the Medical Practice Act ("the Act"), Title 3, Subtitle B, Texas Occupations Code, and would show the following:

## I. INTRODUCTION

The filing of this Complaint and the relief requested are necessary to protect the health and public interest of the citizens of the State of Texas, as provided in Section 151.003 of the Act.

## II. LEGAL AUTHORITY AND JURISDICTION

1. Respondent is a Texas Physician and holds Texas Medical License No. M-4838, originally issued by the Board on October 6, 2006. Respondent's license was in full force and effect at all times material and relevant to this Complaint.

2. Respondent received notice of an Informal Settlement Conference ("ISC"). The Board complied with all procedural rules, 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, based on that information, believes that Respondent has violated the Act. Based on such information and belief, Board Staff alleges:

### A. GENERAL ALLEGATIONS:

1. Respondent was the supervising physician at various medical clinics in the Houston area for three mid-level providers: Christopher Quirante, P.A., Rose Omamogho, P.A., and Anna Marie McClellan, P.A.

2. Respondent was the supervising physician for Mr. Quirante from June 14, 2010, to March 7, 2011.

3. Respondent was the supervising physician for Ms. Omamogho from June 14, 2010, to April 17, 2011.

4. Respondent was the supervising physician for Ms. McClellan from June 30, 2010, to January 10, 2011.

5. Respondent and/or his mid-level providers treated 10 patients: 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.[1]

6. Respondent failed to adequately document his supervision of the mid-level practitioners. Specifically, Respondent failed to document: the names of patients whose records were discussed during daily status reports; the dates and times he was on site at each clinic; and/or a summary of what he did while he was on site at each clinic. Such failure constitutes violations of the Act as set forth in Section IV, Statutory Violation Nos. 2 and 8.

7. Respondent failed to notify the Board of his intent to supervise and/or delegate prescriptive authority to Rizwan Sami Khan, P.A., from January 5, 2011, to February 28, 2011. Respondent did delegate prescriptive authority to Mr. Khan during this time period.

### B. SPECIFIC PATIENTS:

#### 1. PATIENT 1:

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 1 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below,

[1] Identification of the patients will be provided by separate document submitted under seal.

constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Beginning in February 2011, Respondent/and or his mid-level providers treated Patient 1 for various conditions including, but not limited to, low back pain radiating down both legs.

b. Although Patient 1's past medical history included fibromyalgia, Respondent and/or his mid-level providers did not consider whether that condition could have caused, or contributed to, Patient 1's pain, nor was that condition considered in Patient 1's differential diagnosis.

c. Patient 1 complained additionally of neck pain, right shoulder pain, and pain radiating into both legs, but Respondent and/or his mid-level provider failed to document that a physical examination of those areas was performed. Respondent and/or his mid-level providers failed to perform and/or document Patient 1's complete medical history and a complete problem-focused physical examination specific to Patient 1's complaints.

d. Respondent and/or his mid-level providers diagnosed Patient 1 with chronic low back pain, but the documentation does not support such a diagnosis. Respondent and/or his mid-level providers subsequently prescribed narcotics to Patient 1 for the unsupported diagnosis of chronic low back pain.

e. Respondent and/or his mid-level providers failed to obtain and review Patient 1's prior medical records to evaluate her prior treatments, including whether such treatments were successful.

f. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 1, including short-term and/or long-term goals for treatment.

g. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities, other than narcotic medications, were discussed with Patient 1.

h. Respondent and/or his mid-level providers failed to discuss with Patient 1 the risks and benefits of the proposed treatment.

i. Respondent and/or his mid-level providers failed to monitor Patient 1 for abuse or diversion, adequately assess Patient 1's risk for abuse or diversion, or document any discussion or counseling about abuse or diversion even though Patient 1 reported being on Hydrocodone for 10 years, but that her previous physician would no longer prescribe controlled substances to her.

Respondent and/or his mid-level providers did not inquire as to why Patient 1's previous provider was no longer providing treatment.

2. PATIENT 2:

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 2 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Beginning in February 2011, Respondent/and or his mid-level providers treated Patient 2 for low back pain.

b. Respondent and/or his mid-level providers failed to obtain and review Patient 2's prior medical records to evaluate his prior treatments, including whether such treatments were successful, even though Patient 2 reported that another physician had been prescribing narcotics for pain control for approximately one year. Respondent and/or his mid-level providers did not inquire as to why Patient 2's previous provider was no longer providing treatment.

c. Respondent and/or his mid-level providers indicated that Patient 2 would be referred for an MRI, but no such referral is documented in the records.

d. The medical records kept by Respondent and/or his mid-level providers for Patient 2 are unreliable. For instance, Patient 2 reported on one form that he suffered decreased sleep, loss of energy, and concentration deficits, but on another form denied problems with sleep, energy, or concentration. Additionally, Patient 2 indicated that walking activities increase his pain to 10/10, but reported working as a hairstylist. Respondent and/or his mid-level providers did not document any discussion with Patient 2 regarding these inconsistencies. Respondent and/or his mid-level providers prescribed narcotics to Patient 2 despite the apparently inconsistent and unreliable statements of Patient 2 regarding his medical condition.

e. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 2, including short-term and/or long-term goals for treatment.

f. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities, other than narcotic medications, were discussed with Patient 2.

g. Respondent and/or his mid-level providers failed to discuss with Patient 2 the risks and benefits of the proposed treatment.

h. Respondent and/or his mid-level providers failed to monitor Patient 2 for abuse or diversion, adequately assess Patient 2's risk for abuse or diversion, or document any discussion or counseling about abuse or diversion, even though Patient 2 reported being on Hydrocodone for at least one year.

3. **PATIENT 3:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 3 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Beginning in August 2010, Respondent/and or mid-level providers treated Patient 3 for various conditions including, but not limited to, right hip pain and upper back pain.

b. On or about August 19, 2010, Patient 3 complained of right hip pain. Despite that complaint, no examination of the right hip was documented by Respondent and/or his mid-level providers, nor was the complaint of right hip pain otherwise addressed during the office visit.

c. Respondent and/or his mid-level providers failed to perform and/or document Patient 3's complete medical history and a problem-focused physical examination specific to Patient 3's complaints.

d. Respondent and/or his mid-level providers diagnosed Patient 3 with generalized anxiety disorder, but did not document any examination that would support such a diagnosis. Respondent and/or his mid-level providers documented that Patient 3 tried Ambien, Lunesta, and Trazadone, but did not document why Patient 3 had taken those medications or who prescribed them. Respondent and/or his mid-level providers also documented that Patient 3 "takes Valium to sleep," but did not document who was prescribing that medication. Respondent and/or his mid-level providers then prescribed Valium to Patient 3 for the unsupported diagnosis of generalized anxiety disorder, even though Patient 3 was getting that medication from another provider.

e. Respondent and/or his mid-level providers indicated that Patient 3 would be referred to a psychologist, but no such referral is documented in the records and verification of Patient 3's compliance with this recommendation is not documented at subsequent office visits.

f. Respondent and/or his mid-level providers failed to obtain and review all of Patient 3's prior medical records to evaluate his prior treatments, including whether such treatments were successful.

g. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 3, including short-term and/or long-term goals for treatment.

h. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities, other than narcotic medications, were discussed with Patient 3.

i. Respondent and/or his mid-level providers failed to discuss with Patient 3 the risks and benefits of the proposed treatment.

j. Respondent and/or his mid-level providers failed to adequately evaluate Patient 3 for effectiveness of treatment and document such findings.

k. Respondent and/or his mid-level providers failed to monitor Patient 3 for abuse or diversion, adequately assess Patient 3's risk for abuse or diversion, or document any discussion or counseling about abuse or diversion despite knowing that Patient 3 was getting medications from at least one other physician.

4. **PATIENT 4:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 4 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 4 in September 2010 for complaints of low back pain and leg pain.

b. On or about November 6, 2010, Patient 4 complained of left knee pain. Despite such complaint, Respondent and/or his mid-level providers failed to document a physical examination of the left knee on that visit or subsequent visits.

c. On or about February 12, 2011, Patient 4 complained of, among other things, mid-back pain. Despite that complaint, Respondent and/or his mid-level providers failed to document a physical examination specific to that complaint. On that visit, Patient 4 was diagnosed with chronic low back pain and given a prescription for narcotic pain medications

even though he had made no complaint of low back pain, and there is no documentation of a physical examination specific to that complaint.

d. Despite Patient 4's past medical history of osteoarthritis and/or rheumatoid arthritis, Respondent and/or his mid-level providers failed to obtain updated laboratory studies or diagnostic imaging to determine if these conditions were the cause of, or contributing to, Patient 4's chronic pain.

e. Respondent and/or his mid-level providers failed to obtain and review all of Patient 4's prior medical records to evaluate his prior treatments, including whether such treatments were successful.

f. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 4, including short-term and/or long-term goals for treatment.

g. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 4.

h. Respondent and/or his mid-level providers failed to discuss with Patient 4 the risks and benefits of the proposed treatment.

i. Respondent and/or his mid-level providers failed to adequately evaluate Patient 4 for effectiveness of treatment and document such findings.

j. Respondent and/or his mid-level providers failed to monitor Patient 4 for abuse or diversion, adequately assess Patient 4's risk for abuse or diversion, or document any discussion or counseling about abuse or diversion despite knowing that Patient 4 was getting medications from at least one other physician.

5. **PATIENT 5:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 5 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 5 in November 2010 for, among other things, complaints of upper and low back pain and anxiety.

b. On or about November 6, 2010, Patient 5 presented with a blood pressure of 164/99, which was not addressed by Respondent and/or his mid-level providers at that visit.

b. Respondent and/or his mid-level providers failed to obtain and review all of Patient 5's prior medical records to evaluate her prior treatments, including whether such treatments were successful.

c. Respondent and/or his mid-level providers diagnosed Patient 5 with "L4-5 disc [with] radiculopathy" even though no complaints of leg pain are documented and no physical examination that could support such a diagnosis is documented. Respondent and/or his mid-level providers subsequently prescribed narcotics to Patient 5 for the unsupported diagnosis of "L4-5 disc [with] radiculopathy."

d. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 5, including short-term and/or long-term goals for treatment.

e. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 5.

f. Respondent and/or his mid-level providers failed to discuss with Patient 5 the risks and benefits of the proposed treatment.

g. Respondent and/or his mid-level providers failed to adequately evaluate Patient 5 for effectiveness of treatment and document such findings.

h. Respondent and/or his mid-level providers failed to monitor Patient 5 for abuse or diversion, adequately assess Patient 5's risk for abuse or diversion, or document any discussion or counseling about abuse or diversion, despite knowing that Patient 5 was taking her husband's narcotic pain medications.

6. **PATIENT 6:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 6 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 6 in February 2011 for complaints of low back pain.

b. Respondent and/or his mid-level providers failed to obtain and review Patient 6's prior medical records to evaluate her prior treatments, including whether such treatments were

successful, despite knowing that Patient 6 had previously been to other pain management clinics for treatment.

c. Respondent and/or his mid-level providers failed to verify either medical records or pharmacy visits for Patient 6 prior to prescribing him controlled substances, despite having an office policy that such records would be verified.

d. Respondent and/or his mid-level providers diagnosed Patient 6 with generalized anxiety disorder, but did not document any examination that would support such a diagnosis. Respondent and/or his mid-level providers then prescribed Xanax to Patient 6 for the unsupported diagnosis of generalized anxiety disorder.

e. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 6, including short-term and/or long-term goals for treatment.

f. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 6.

g. Respondent and/or his mid-level providers failed to discuss with Patient 6 the risks and benefits of the proposed treatment.

h. Respondent and/or his mid-level providers failed to adequately evaluate Patient 6 for effectiveness of treatment and document such findings.

i. Respondent and/or his mid-level providers failed to monitor Patient 6 for abuse or diversion, or adequately assess Patient 6's risk for abuse or diversion.

7. **PATIENT 7:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 7 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 7 in February 2011 for various complaints, including right shoulder pain and low back pain.

b. Respondent and/or his mid-level providers diagnosed Patient 7 with, among other things, "frozen shoulder," but did not document a physical examination that would support such a diagnosis. Patient 7 was nonetheless given a prescription for Lorcet.

c. Respondent and his mid-level providers did not perform and document a physical examination of Patient 7's low back in spite of Patient 7 complaint of low back pain since 2008.

d. Patient 7's past medical history includes rheumatoid arthritis and fibromyalgia. Respondent and/or his mid-level providers, however, failed to consider whether those conditions caused, or contributed, to Patient 7's chronic pain problems. Additionally, those conditions were not part of Patient 7's differential diagnosis.

e. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 7, including short-term and/or long-term goals for treatment.

f. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 7.

g. Respondent and/or his mid-level providers failed to discuss with Patient 7 the risks and benefits of the proposed treatment.

h. Respondent and/or his mid-level providers failed to adequately evaluate Patient 7 for effectiveness of treatment and document such findings.

i. Respondent and/or his mid-level providers failed to monitor Patient 7 for abuse or diversion, or adequately assess Patient 7's risk for abuse or diversion.

8. **PATIENT 8:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 8 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 8 in February 2011 for low back pain radiating to his knees.

b. Despite Patient 8's complaint of knee pain, no physical examination of Patient 8's knees was documented by Respondent and/or his mid-level providers.

c. Respondent and/or his mid-level providers obtained an x-ray of Patient 8's lumbar spine from 2007, which noted "mild degenerative changes of the lumbar spine involving L4-5 and L5-S1 levels." Without obtaining updated imaging studies, and in spite of an unremarkable physical examination, Respondent and/or his mid-level providers diagnosed Patient 8 with

lumbar degenerative disk disease and prescribed controlled substances to Patient 8 for that unsubstantiated diagnosis.

d. Respondent and/or his mid-level providers documented that Patient 8's liver function test in 2010 was within normal limits, yet no copy of those test results is found in Patient 8's chart, and no effort to obtain those results is documented.

e. Respondent and/or his mid-level providers failed to address Patient 8's mental health or refer him to a specialist, in spite of Patient 8's acknowledgement that his pain interferes with his relationships, enjoyment of life, and mood, that he has lost interest in normal activities, and that he has decreased interest or pleasure in his favorite things.

f. Patient 8 reported that one of his current medications was Coumadin, but Respondent and/or his mid-level providers did not document any discussion about this medication, or why Patient 8 was taking it, and Respondent and/or his mid-level providers did not obtain Patient 8's prior medical records to obtain more information about his medical history.

g. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 8, including short-term and/or long-term goals for treatment.

h. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 8.

i. Respondent and/or his mid-level providers failed to discuss with Patient 8 the risks and benefits of the proposed treatment.

j. Respondent and/or his mid-level providers failed to adequately evaluate Patient 8 for effectiveness of treatment and document such findings.

k. Respondent and/or his mid-level providers failed to monitor Patient 8 for abuse or diversion, or adequately assess Patient 8's risk for abuse or diversion.

9. **PATIENT 9:**

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 9 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 9 in September 2010 for, among other things, low back pain radiating down both legs. Patient 9's home address

was in Nacogdoches, Texas, approximately 145 miles away from the clinic where Respondent and/or his mid-level providers treated her.

b. Respondent and/or his mid-level providers increased the number of pills of Norco and Soma prescribed to Patient 9 on various occasions without documenting an explanation or rationale for the increase. Patient 9 eventually reported that her pain was better controlled while taking lesser amounts of medication, but Respondent and/or his mid-level providers continued to provide the higher number of pills to Patient 9.

c. Patient 9 indicated on a pain drawing that she had pain in her neck, thoracic spine, head, ankle, and shins. Respondent and/or his mid-level providers, however, failed to document any physical examination of those areas.

d. Respondent and/or his mid-level providers diagnosed Patient 9 with chronic low back pain and lumbar derangement syndrome but did not document a physical examination that would support such diagnoses. Respondent and/or his mid-level providers then prescribed controlled substances for those unsupported diagnoses.

e. Respondent and/or his mid-level providers failed to refer Patient 9 for mental health treatment or document any discussion of Patient 9's depression, which was considered "severe" based on Patient 9's Beck Depression Inventory scores. Respondent and/or his mid-level providers prescribed fluoxetine to Patient 9 at her first office visit only. The records for Patient 9 lack any indication, rationale or discussion as to why fluoxetine was never prescribed to Patient 9 again even though she reported ongoing depression.

f. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 9, including short-term and/or long-term goals for treatment.

g. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 9.

h. Respondent and/or his mid-level providers failed to discuss with Patient 9 the risks and benefits of the proposed treatment.

i. Respondent and/or his mid-level providers failed to adequately evaluate Patient 9 for effectiveness of treatment and document such findings.

j. Respondent and/or his mid-level providers failed to monitor Patient 9 for abuse or diversion, or adequately assess Patient 9's risk for abuse or diversion, despite evidence that Patient 9 was at risk for aberrant opioid use.

10. PATIENT 10:

Summary of Allegations: Respondent and/or his mid-level providers failed to meet the standard of care in his treatment of Patient 10 by prescribing medications in a nontherapeutic manner, keeping inadequate medical records, and failing to follow the Board's guidelines for the treatment of pain. These actions, more fully described below, constitute violations of the Act. Specifically, see Section IV, Statutory Violation Nos. 1 – 8.

a. Respondent and/or his mid-level providers began treating Patient 10 in February 2010 for various complaints including low back pain and anxiety. Patient 10 listed two different home addresses on his initial visit: Biloxi, Mississippi, and D'Iberville, Mississippi, both of which are approximately 400 miles away from the clinic where Respondent and/or his mid-level providers treated him.

b. Patient 10 was subject to a random urine drug screen on or about March 18, 2010, at which time he tested positive for Methadone, which was not being prescribed by Respondent and/or his mid-level providers, and negative for Lortab, Soma, and Xanax, which were being prescribed. Despite Patient 10's abnormal drug screen, Respondent and/or his mid-level providers gave Patient 10 prescriptions for Lortab, Soma, and Xanax the same day. Respondent and/or his mid-level providers failed to document any discussion with Patient 10 regarding these abnormal results.

c. Patient 10 was subject to a random urine drug screen on or about June 30, 2010, at which time he tested positive for Methadone, which was not being prescribed by Respondent and/or his mid-level providers, and was negative for Lortab, which was being prescribed by Respondent and/or his mid-level providers. Despite such abnormal drug testing results, Respondent and/or his mid-level providers continued to prescribed controlled substances to Patient 10 until at least October 2010. Respondent and/or his mid-level providers failed to document any discussion with Patient 10 regarding these abnormal results.

d. Respondent and/or his mid-level providers failed to develop and document a specific treatment plan for Patient 10, including short-term and/or long-term goals for treatment.

e. Respondent and/or his mid-level providers failed to document whether alternative treatment modalities other than narcotic medications were discussed with Patient 10.

f. Respondent and/or his mid-level providers failed to discuss with Patient 10 the risks and benefits of the proposed treatment.

g. Respondent and/or his mid-level providers failed to adequately evaluate Patient 10 for effectiveness of treatment and document such findings.

## IV. STATUTORY VIOLATIONS

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

1. . 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.

2. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a Board Rule, specifically, Board Rules 165.1(a), which requires the maintenance of adequate medical records; 170.3, failure to adhere to those established guidelines and requirements for the treatment of pain; and 193, related to supervision of mid-level practitioners.

3. 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 Rules: 185.15, related to supervision of physician assistants; 190.8(1)(A), failure to treat a patient according to the generally accepted standard of care; 190.8(1)(B), negligence in performing medical services; 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications; 190.8(1)(G), failure to disclose reasonably foreseeable side effects of a procedure or treatment; 190.8(1)(H), failure to disclose reasonable alternative treatments to a proposed procedure or treatment; and 190.8(1)(L), prescription of any dangerous drug or controlled substance without first establishing a proper professional relationship with the patient.

4. Section 164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

5. Section 164.053(a)(1) of the Act authorizes the Board to take disciplinary action again Respondent based upon Respondent's commission of an act that violates any state or federal law if the act is connected with the physician's practice of medicine, specifically, Texas

Health and Safety Code §481.129(c), related to prescribing controlled substances without a valid medical purpose.

6. Section 164.053(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent prescribing or administering a drug or treatment that is nontherapeutic.

7. Section 164.053(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent prescribing, administering, or dispensing in a manner inconsistent with public health and welfare dangerous drugs as defined by Chapter 483, Health and Safety Code; or controlled substances scheduled in Chapter 481, Health and Safety Code, or the Comprehensive Drug Abuse Prevention and Control Act of 1970, (21 U.S.C. Section 801 et seq.).

8. Section 164.053(a)(8) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's failure to supervise adequately the activities of those acting under the supervision of the physician.

## V. AGGRAVATING FACTORS

Board Rule 190.15 provides that the Board may consider aggravating factors in reaching a determination of sanctions. In this case, the facts warrant more severe or restrictive disciplinary action. This case includes the following aggravating factors: multiple violations of the Act; harm to one or more patients; severity of patient harm; one or more violations that involve more than one patient; increased potential for harm to the public; intentional, premeditated, knowing, or grossly negligent act constituting a violation; and previous disciplinary action by the Board, any government agency, peer review organization, or health care entity. Specifically, on December 10, 2012, the Board entered an Order of Temporary Suspension Without Notice of Hearing after determining that Respondent's continuation in the practice of medicine presented a continuing threat to the public health and welfare.

## VI. APPLICABLE STATUTES, RULES, AND AGENCY POLICY

The following statutes, rules, and agency policy are applicable to the procedures for this matter:

1. 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.

2. 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.

3. 22 TEX. ADMIN. CODE, Chapter 190 sets forth aggravating factors that warrant more severe or restrictive action by the board.

4. 1 TEX. ADMIN. CODE, CHAPTER 155 sets forth the rules of procedure adopted by SOAH for contested case proceedings.

5. 1 TEX. ADMIN. CODE, CHAPTER 155.507, requires the issuance of a Proposal for Decision ("PFD") containing Findings of Fact and Conclusions of Law.

6. 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.

## VII. NOTICE TO RESPONDENT

**IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS COMPLAINT WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHIN 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. 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.**

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 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,

TEXAS MEDICAL BOARD

By: REDACTED

Susan Rodriguez, J.D., Staff Attorney
Texas State Bar No. 24055397
Telephone: (512) 305-7088
FAX # (512) 305-7007
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

SUBSCRIBED AND SWORN to before me by the said Susan Rodriguez, J.D., on January 9, 2013.

REDACTED

Notary Public, State of Texas

CHERYL A. GRAHAM
Notary Public
STATE OF TEXAS
My Comm. Exp. 02-22-2014
Notary without Bond

Filed with the Texas Medical Board on Dec. 21, 2012.

REDACTED

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



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## CERTIFICATE OF SERVICE

On this 9th day of January, 2013, I certify that a true and correct copy of this Complaint has been served on the following individuals at the locations and the manner indicated below.

**BY CERTIFIED MAIL RETURN RECEIPT REQUESTED and FIRST CLASS MAIL:**
Chau Doan Khuu, M.D.
12335 Jaguar Drive
Stafford, Texas 77477

**BY FAX TRANSMISSION TO: 512-482-0164**
Louis Leichter
1602 East 7th Street
Austin, Texas 78701

**BY EMAIL TO: DOCKETING@SOAH.STATE.TX.US**
Docket Clerk
State Office of Administrative Hearings
300 West 15th #504
Austin, Texas 78701

**BY HAND DELIVERY:**
Sonja Aurelius
Hearings Coordinator
Texas Medical Board
333 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701

REDACTED

Susan Rodriguez, J.D.