HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-18-5383.MD
TEXAS MEDICAL LICENSE NO. G-3541

IN THE MATTER OF THE	BEFORE THE
COMPLAINT AGAINST	
FRANK ELMER LANE, M.D.	TEXAS MEDICAL BOARD

BOARD STAFF'S SECOND AMENDED COMPLAINT

TO THE HONORABLE TEXAS MEDICAL BOARD AND THE HONORABLE ADMINISTRATIVE LAW JUDGE HENRY D. CARD:

The Staff of the Texas Medical Board (Board) files this Board Staff's Second Amended Complaint against Frank Elmer Lane, M.D. (Respondent), for alleged violations of the Medical Practice Act (the Act), Title 3, Subtitle B, Texas Occupations Code and the Board's Rules, and would show the following:

I. SUMMARY OF FACTUAL ALLEGATIONS

Respondent violated the standard of care and failed to maintain adequate medical records for a patient and further failed to cooperate with the Board's investigation by choosing not to disclose all of his medical records during the investigation.

II. LEGAL AUTHORITY AND JURISDICTION

1. Respondent is a Texas physician and holds Texas Medical License No. G-3541, which was originally issued by the Board on February 27, 1983. Respondent's license was in full force and effect at all times material and relevant to this Complaint.

2. Respondent received notice of one or more Informal Settlement Conferences (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.

5. 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.

III. APPLICABLE STATUTES AND STATUTORY VIOLATIONS

The following Statutes, Rules, and Agency Policy are applicable to the procedures for conduct of the hearing in this matter:

A. General Statutes and Rules:

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, Ch.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, Ch. 190 sets forth aggravating factors that warrant more severe or restrictive action by the Board.

4. 1 Tex. Admin. Code, Ch. 155 sets forth the rules of procedure adopted by SOAH for contested case proceeding.

5. 1 Tex. Admin. Code, Ch. 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 *et seq.* and Board Rule 190 *et seq.*, provide 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.

B. Specific Violations Cited:

Respondent has violated 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 Rule 165.1, which requires the maintenance of adequate medical records.

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 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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, as further defined by Board Rules 187.15, failure to comply with reasonable request to produce records, documents, or other information requested by Board Staff; 190.8(2)(B), failure to comply with Board request for information; 190.8(2)(D), failure to cooperate with Board Staff; 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 or should have known was improper.

5. 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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

IV. FACTUAL ALLEGATIONS

Based on information and belief, Board Staff alleges:

Medical Records

1. On or about June 28, 2013, Respondent began treating Patient for bipolar disorder.

2. Respondent treated Patient on approximately 20 separate occasions between June 28, 2013, and June 3, 2014.

3. Respondent billed approximately $4,751.35 for the visits.

4. Respondent created medical records for Patient documenting her care and treatment; however, interspersed among these medical records are psychotherapy notes.

5. Psychotherapy notes must be stored separate from the rest of an individual's medical record.

6. The rest of Patient's medical record created by Respondent contemporaneously documenting her care and treatment amounts to an unsigned, undated, handwritten paragraph from their first visit.

7. Respondent's medical records for Patient violate the Act and Board Rules, specifically:

> 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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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; and, 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications.

Failure to Cooperate

8. On or about September 11, 2017, Board Investigators sent Respondent a Subpoena Duces Tecum requesting that within 14 days he "provide a complete and accurate copy of the medical and billing records" for Patient.

9. Respondent failed to provide the requested records.

10. On or about September 27, 2017, a Board Investigator called Respondent and left him a voicemail following up on the Subpoena Duces Tecum.

11. On or about October 6, 2017, a Board Investigator called Respondent and left a voicemail following up on the Subpoena Duces Tecum.

12. Respondent returned the call the same day and Respondent assured the Board Investigator that he would get the records to her within the week.

13. Instead, on or about October 12, 2017, Respondent sent Board Investigators an email advising that he mailed the medical records with a three-page cover letter "stacked upon the voluminous medical record of [Patient]"

14. Respondent's email further stated that included in the packet was a Clinical Summary, which he produces in all his cases, and that "I rarely ever turn over the complete medical record (which I've provided to you)."

15. On or about October 17, 2017, Board Investigators received a packet from Respondent consisting of 87 pages of records, but no business records affidavits.

16. On or about October 18, 2017, Board Investigators emailed Respondent following up on the Subpoena Duces Tecum and asking him to produce the records with a business records affidavit.

17. On or about October 24, 2017, Respondent sent Board Investigators a letter containing a business records affidavit for 147 pages of medical records, which had purportedly previously been sent, and Patient's billing records with a business records affidavit.

18. Respondent included a bill for $36 for compiling the records.

19. On or about November 14, 2017, Board Investigators contacted Respondent to advise that the business records affidavit provided for Patient stated that there were 147 pages of records, but that only 87 pages had been provided.

20. On or about November 27, 2017, Respondent emailed Board Investigators and advised that he would produce the records and a corrected business records affidavit shortly.

21. On the same day, Respondent provided 148-pages of medical records along with a business records affidavit.

22. On February 9, 2018, in response to Board Staff's Request for Production, Respondent admitted that he has 30 pages of psychotherapy notes for Patient that were not provided to Board Investigators.

23. Respondent asserted a psychotherapy notes privilege and withheld the records until the week before trial.

24. The records withheld by Respondent were not psychotherapy notes, but instead traditional medical records interspersed with psychotherapy notes.

25. Respondent falsely represented to the Board and the Court that the entirety of these records were psychotherapy notes.

26. Respondent's failure to timely provide records to the Board and failure to provide complete copies of all of Patient's medical and billing records violates the Act and Board Rules, specifically:

> 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)(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)(C), failure to use proper diligence in one's professional practice.
>
> 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 Rules 187.15, failure to comply with reasonable request to produce records, documents, or other information requested by Board Staff; 190.8(2)(B), failure to comply with Board request for information; 190.8(2)(D), failure to cooperate with Board Staff; and, 190.8(2)(C), providing false information to the Board.

Fabrication of Medical Records

Board Staff allege the following, in the alternative:

27. Respondent did not assert the psychotherapy notes privilege at any point during the Board's investigation.

28. Respondent did not assert the psychotherapy notes privilege when Board Staff filed this SOAH matter.

29. Instead, Respondent asserted the psychotherapy privilege for the first time in 2019, after hiring an attorney, David Tuckfield.

30. Respondent fabricated medical records for each of his sessions with Patient, inserting the occasional process (psychotherapy) note.

31. Respondent represented that these records were psychotherapy notes documenting and analyzing the contents of his sessions with Patient that were kept apart from the rest of her medical record to explain why they had not been provided to the Board previously.

32. Respondent's false statements and fabrication of medical records violates the Act and Board Rules, specifically:

> 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.
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> 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 165.1, which requires the maintenance of adequate medical records.
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> 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 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.
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> 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 Rules 187.15, failure to comply with reasonable request to produce records, documents, or other information requested by Board Staff; 190.8(2)(B), failure to comply with Board request for information; 190.8(2)(D), failure to cooperate with Board Staff; 190.8(2)(C), providing false information to the Board; and, 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 or should have known was improper.
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> 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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

Medical Records

Board Staff allege the following, in the alternative:

33. On or about June 28, 2013, Respondent began treating Patient for bipolar disorder.

34. Respondent saw Patient for 45 minutes at his office for an evaluation.

35. Patient partially filled out the Patient Information forms.

36. Patient completely filled out Insurance and HIPAA Release forms.

37. Respondent claims that he completed an initial assessment for Patient during the visit, but the record is unsigned and undated.

38. Respondent failed to create and maintain contemporaneous medical records for the visit.

39. Respondent billed Patient and Medicare approximately $250 for the visit.

40. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

> 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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of adequate medical records.
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> 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 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.
>
> 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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

41. On or about August 27, 2013, Respondent saw Patient for 60 minutes during an office visit for treatment.

42. Respondent failed to create and maintain contemporaneous medical records for the visit.

43. Respondent billed Patient, Medicare, and Secondary Insurance approximately $218 for the visit.

44. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

45. On or about October 16, 2013, Respondent saw Patient for 45 minutes during an office visit for treatment.

46. Respondent failed to create and maintain contemporaneous medical records for the visit.

47. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

48. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

49. On or about January 15, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

50. Respondent wrote Patient a prescription for Cerefolin NAC, a prescription nutritional supplement, during the visit.

51. Respondent failed to create and maintain contemporaneous medical records for the visit.

52. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

53. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

54. On or about January 16, 2014, Respondent submitted a Request for Medicare Prescription Drug Coverage Determination for Patient requesting a coverage determination for Cerefolin NAC.

55. On or about January 26, 2014, Medicare denied coverage for the prescription Cerefolin NAC.

56. On or about January 28, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

57. Respondent failed to create and maintain contemporaneous medical records for the visit.

58. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

59. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

60. On or about February 6, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

61. Respondent failed to create and maintain contemporaneous medical records for the visit.

62. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

63. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

64. On or about March 7, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

65. Respondent failed to create and maintain contemporaneous medical records for the visit.

66. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

67. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

> 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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of adequate medical records.
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> 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 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.
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> 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)(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 or should have known was improper.
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> 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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

68. On or about April 1, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

69. Respondent also billed for group medical psychotherapy and interactive complexity during the same visit.

70. Respondent failed to create and maintain contemporaneous medical records for the visit.

71. Respondent billed Patient, Medicare, and Secondary Insurance approximately $179 for the visit.

72. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

> 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.
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> 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 165.1, which requires the maintenance of adequate medical records.
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> 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 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.
>
> 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)(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 or should have known was improper.
>
> 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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

73. On or about April 8, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

74. Respondent failed to create and maintain contemporaneous medical records for the visit.

75. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

76. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

> 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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.
>
> 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)(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 or should have known was improper.
>
> 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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

77. On or about April 10, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

78. Respondent failed to create and maintain contemporaneous medical records for the visit.

79. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

80. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility,

mental health facility, or health care professional may not submit to a patient or a third party payer 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.

81. On or about April 15, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

82. Respondent failed to create and maintain contemporaneous medical records for the visit.

83. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

84. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

85. On or about April 18, 2014, Respondent saw Patient for 60 minutes during an office visit for an evaluation and management and for family medical psychotherapy without the patient.

86. Respondent failed to create and maintain contemporaneous medical records for the visit.

87. Respondent billed Patient, Medicare, and Secondary Insurance approximately $291 for the visit.

88. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

89. On or about April 22, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

90. Respondent failed to create and maintain contemporaneous medical records for the visit.

91. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

92. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

93. On or about April 29, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

94. Respondent failed to create and maintain contemporaneous medical records for the visit.

95. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

96. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

97. On or about May 5, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

98. Respondent failed to create and maintain contemporaneous medical records for the visit.

99. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

100. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed

consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

101. On or about May 6, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

102. Respondent failed to create and maintain contemporaneous medical records for the visit.

103. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

104. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

105. On or about May 20, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

106. Respondent failed to create and maintain contemporaneous medical records for the visit.

107. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

108. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

109. On or about May 28, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

110. Respondent failed to create and maintain contemporaneous medical records for the visit.

111. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

112. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

113. On or about May 30, 2014, Respondent saw Patient for 45 minutes during an office visit for an evaluation and management.

114. Respondent failed to create and maintain contemporaneous medical records for the visit.

115. Respondent billed Patient, Medicare, and Secondary Insurance approximately $150 for the visit.

116. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

117. On or about June 3, 2014, Respondent saw Patient for group medical psychotherapy and interactive complexity.

118. Respondent failed to create and maintain contemporaneous medical records for the visit.

119. Respondent billed Patient, Medicare, and Secondary Insurance approximately $29 for the visit.

120. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

121. In totality, Respondent billed Patient, Medicare, and Secondary Insurance approximately $4,929 for these visits.

122. The entirety of Respondent's treatment records for the patient over the course of these visits consist of a single handwritten note that is undated and unsigned.

123. Respondent prescribed to Patient during the course of his treatment, but failed to document the prescriptions in his contemporaneous medical records.

124. On or about July 10, 2014, in response to a records request from Patient, Respondent created a one-page summary of the treatment and care he purportedly provided to Patient.

125. Respondent's treatment, care, billing, and medical records from the visit violate the Act and Board Rules, specifically:

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 violation of a Board rule; specifically Board Rule 165.1, which requires the maintenance of 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 Rules 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)(I), failure to obtain informed consent from the patient or other person authorized by law to consent to treatment on the patient's behalf before performing tests, treatments, or procedures.

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)(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 or should have known was improper.

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 & Safety Code, which provides that a hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payer 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.

V. AGGRAVATING FACTORS

On August 13, 2004, the Board entered into an Agreed Order requiring required Respondent to pay a $500 administrative penalty for failing to timely release patient records pursuant to a written request.

Board Rule 190.14(1) provides that the Board may impose more restrictive sanctions when there are multiple violations of the Act.

Board Rule 190.15 provides that the Board may consider aggravating factors that warrant more severe or restrictive disciplinary action. This case includes the following aggravating factors: (4) economic harm to any individual or entity and the severity of such harm; (5) increased potential for harm to the public; (6) attempted concealment of the act constituting a violation; (7) intentional, premeditated, knowing, or grossly negligent act constituting a violation; (8) prior similar violations; (9) previous disciplinary action by the board, any government agency, peer review organization, or health care entity; and, (11) other relevant circumstances increasing the seriousness of the misconduct.

Board Staff is aware of no mitigating factors that apply and demand that Respondent submit proof to substantiate any alleged mitigating factors.

VI. PRAYER

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

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ATTORNEYS FOR THE BOARD

THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

SUBSCRIBED AND SWORN to before me by the said Johnathan Stone on May 30, 2019.

JESSICA PARRAS
Notary Public-State of Texas
Notary ID #13075319-3
Commission Exp. JULY 26, 2020
Notary without Bond

Notary Public, State of Texas

Filed with the Texas Medical Board on May 30, 2019

per Scott M Freeman

per Stephen 'Brint' Carlton, J.D.
Executive Director
Texas Medical Board

by per Nelson

CERTIFICATE OF SERVICE

I certify that on May 30, 2019, a true and correct copy of the foregoing document has been served as follows:

By Electronic Upload:

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