1 BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

2 IN THE MATTER INVOLVING PHIL YUAN-) CASE NO. AD 1102001
3 CHUNG CHEN, D.O., LICENSE NO. 871,) (S. S.)
4 RESPONDENT.)
5)

NV STATE BOARD OF OSTEOPATHIC MEDICINE

FEB 02 2011

FILED

6 **COMPLAINT**

7 Pursuant to the provisions of Chapters 233B, 622A, and 633 of the Nevada Revised
8 Statutes, as well as NAC Chapter 633, and by virtue of the authority vested in it by said
9 statutes and regulations, James Anthony, D.O., the Investigative Board Member ("IBM") of the
10 Nevada State Board of Osteopathic Medicine ("Board") in this matter, having a reasonable
11 basis to believe that PHIL YUAN-CHUNG CHEN, D.O., hereinafter referred to as
12 "Respondent" or "Dr. Chen," has violated the provisions of said chapters, hereby issues this
13 formal Complaint, stating the Investigative Board Member's charges and allegations, as
14 follows:

15 **I.**

16 **COUNT ONE (JURISDICTION)**

17 1. That Respondent has an active license to practice osteopathic medicine in the state
18 of Nevada; and at all times alleged herein, was so licensed by the Nevada State Board of
19 Osteopathic Medicine pursuant to the provisions of Chapter 633 of the Nevada Revised
20 Statutes. Respondent has practiced consistently and continuously within Clark County,
21 Nevada.

22 2. That pursuant to NRS 633.151, "[t]he purpose of licensing osteopathic physicians
23 and physician assistants is to protect the public health and safety and the general welfare of
24 the people of this State. Any license issued pursuant to this chapter is a revocable privilege,
25 and a holder of such a license does not acquire thereby any vested right."

26 3. That NRS 633.511(1) provides that unprofessional conduct is a ground for the
27 initiation of disciplinary proceedings by this Board.

28 4. That NRS 633.131(1) defines "unprofessional conduct," in part, as follows:

(f) Engaging in any:

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(1) Professional conduct which is intended to deceive or which the board by regulation has determined is unethical;
(2) Medical practice harmful to the public or any conduct detrimental to the public health, safety or morals which does not constitute gross or repeated malpractice or professional incompetence. . . .

(k) Willful disobedience of the regulations of the State Board of Health, the State Board of Pharmacy or the State Board of Osteopathic Medicine . . . .

(m) Failure of a licensee to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient . . .

(o) Making or filing a report which the licensee knows to be false.

5. That pursuant to NAC 633.350, a licensee engages in unethical conduct if he engages in any conduct that the Board determines constitutes an unfitness to practice osteopathic medicine; and pursuant to NAC 633.350, a licensee engages in unethical conduct if he willfully makes and files false reports, records, or claims in the licensee's osteopathic medicine practice, or if the licensee fails to generate or create medical records relating to the diagnosis, treatment, and care of a patient, or if the licensee prescribes a controlled substance in a manner or an amount that the Board determines is excessive.

6. That NRS 633.511(5) provides that professional incompetence, malpractice, and gross malpractice are grounds for the initiation of disciplinary proceedings against an osteopathic physician by this Board.

7. That "gross malpractice" is defined in NRS 633.041(2) through (4) as malpractice situations in which the failure to exercise the requisite degree of care, diligence or skill consists of:

Gross negligence;
Willful disregard of established medical procedures; or
Willful and consistent use of medical procedures, services or treatment considered by osteopathic physicians in the community to be inappropriate or unnecessary in the cases where used.

8. That NRS 633.111 defined professional incompetence as including the lack of ability to safely and skillfully practice osteopathic medicine.

9. That pursuant to NAC 633.370, if a medical competency examination determines

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that a licensee is not competent to practice osteopathic medicine with reasonable skill and safety to patients, the Board will consider that determination to constitute a rebuttal presumption of profession incompetence with regard to the licensee.

10. That NRS 633.651 states, in part, as follows:

> 1. If the Board finds a person guilty in a disciplinary proceeding, it shall by order take one or more of the following actions:
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> a. Place the person on probation for a specified period or until further order of the Board.
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> b. Administer to the person a public reprimand.
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> c. Limit the practice of the person to, or by the exclusion of, one or more specified branches of osteopathic medicine.
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> d. Suspend the license of the person to practice osteopathic medicine for a specified period or until further order of the Board.
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> e. Revoke the license of the person to practice osteopathic medicine.
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> f. Impose a fine not to exceed $5,000 for each violation,
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> g. Require supervision of the practice of the person,
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> h. Require the person to perform community service without compensation,
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> i. Require the person to complete any training or educational requirements specified by the Board,
>
> j. Require the person to participate in a program to correct alcohol or drug dependence or any other impairment.
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> The order of the Board may contain such other terms, provisions or conditions as the Board deems proper and which are not inconsistent with law.
>
> 2. The Board shall not administer a private reprimand.

II.

COUNT TWO (CARE & TREATMENT OF PATIENT B – "J.S.")

11. That the allegations raised in Paragraphs 1 through 10, inclusive, of Count I, Jurisdiction, of this Complaint are incorporated herein by this reference as though such allegations were more fully set forth herein.

12. That Patient B is a young male who allegedly suffered a sports injury in 1997 and was then hit by an automobile in 1998. The automobile incident caused a tibial fracture and a proximal humerus fracture, requiring surgical intervention.

13. That Dr. Chen noted in his records that Patient B had been seen by Dr. Yeh and Dr. Kim in the past; and that the patient was discharged from their practices. Dr. Kim, a physician board certified in pain management, indicated in his records concerning this patient

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that he did not notice any chronic problem in the area of the right shoulder, right tibia, or thigh region. The patient also did not provide Dr. Kim with any "kind of MRI or x-ray studies" for him to review. Dr. Kim's records, contained within Dr. Chen's records, provide the following impression by Dr. Kim: "This is a 22 year old gentleman who came in complaining of pain in the right tibia and right shoulder area. However, this is a very old problem. I do not believe that this is causing him pain. If there was significant pain since that accident then patient may have had some atrophy of the muscle in the tibia and shoulder area that would be demonstrated at this [time]. However, I do not see any atrophy, and the patient's behavior is pretty classic of narcotic seeking behavior. At this time I believe the patient has what we consider a narcotic addiction problem. We had a lengthy discussion about the narcotic problem with the patient. However, the patient did not seem to be receptive to his problem. . . . There is no clear cut justification [for Oxycontin 80 mg] as far as I can tell. Unless he can present some medical documentation to clarify the medication, I do not believe the medical problem necessitates the use of such high dose of narcotic at this time."

14. That additionally, Dr. Albert Yeh's notes from June 9, 2005, contained within Dr. Chen's records, indicate that the patient was "formally discharge[d] from [that medical] Office due to inability to provide reports and imaging studies from previous treatments. One month of meds will be provided. Patient needs to Detox."

15. That the medical records received from Dr. Chen also indicate that the patient told him that he [the patient] was obtaining oxycontin "from the streets." Yet, Dr. Chen's notes for that first visit with this patient, on January 16, 2007, indicate that the patient denies illicit drug use. Such is contradictory and should have placed this Respondent on notice of the drug-seeking behavior of this patient.

16. That based upon the information received from Dr. Yeh and Dr. Kim, and directly from the patient about illicit drug use, Dr. Chen began his treatment of this patient on January 16, 2007 solely with opiates.

17. That Dr. Chen ordered blood work on this patient; and when the patient failed to comply with such an order for blood work, Dr. Chen's notes do not indicate that he cautioned

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the patient regarding his failure to comply with the doctor's instructions but merely continued writing prescriptions for controlled substances.

18. That Dr. Chen's records indicate that the pain level for this patient was consistently 2 out of 10 and that the patient was complaining of vague pain but yet Dr. Chen continued prescribing opiates for this patient without any proof or substantiation of an underlying medical need for such opiates other than the patient's remarks of "vague pain" that was rated only at 2 out of 10.

19. That the patient told Dr. Chen that he received Methadone from a friend, i.e., taking drugs not prescribed for him. The records also indicate that the patient was arrested for driving while intoxicated/under the influence and for possession/sale of marijuana; yet Dr. Chen continued to prescribe opiates for this patient without attempting to taper off the medication to this patient or referring this patient to a rehabilitative facility for detoxification pursuant to a Narcotics Agreement entered into by the patient and Dr. Chen and pursuant to the standard of medical care in this community.

20. That the patient continued to use marijuana although his registration for medical marijuana had expired approximately one year prior to the visits with Dr. Chen.

21. That on the visit of September 4, 2008, the pain level is noted as 2/10. Dr. Chen also notes that the patient denied that he "crushed and snored[1]" the controlled substances. The patient's two brothers allegedly showed up in Dr. Chen's office "the other day [and] told [Dr. Chen] that he did that. Patient stated his two brothers are the persons abus[ing] the medications and selling marijuana."

22. That Dr. Chen ordered certain x-rays on January 16, 2007. On May 9, 2007, West Valley Imaging reported a normal lumbar spine; it also reported that the patient had a normal right shoulder series (no abnormal calcifications, no fractures, or dislocations); and the x-ray results of the pelvis were "unremarkable" with no fracture, dislocation, or degenerative change. Even with this radiological evidence, Dr. Chen continued his excessive prescribing of

[1] The word "snored" was misspelled continuously in the medical records; and that misspelling in the medical records is not corrected in this document since it is a quotation. It is assumed the physician meant "snorted."

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opiates to this patient.

23. That even though Dr. Chen began seeing the patient in January 2007, he did not obtain a report from the State's Prescription Monitor Program ("PMP") until August 29, 2008, i.e., not at the beginning of treatment. He subsequently obtained the report on the following dates: 10/2/08, 12/22/08, 1/20/09, 2/17/09, 3/17/09, and 5/12/09. Typically, pain management physicians will run the PMP report on new patients at the time of the initial consultation and periodically thereafter to assure compliance with the patient's treatment plan.

24. That the urine toxicology screen for March 19, 2009, was positive for Oxycodone and Xanax. Although Soma was prescribed to the patient, Xanax was not. The office notes do not contain any mention of a discussion between the patient and the physician regarding this discrepancy.

25. That at the next visit (April 2009), Dr. Chen indicated that he "will write him refill of the medication once he give me the documentation to confirm his story" [sic] yet, according to the medical records, Dr. Chen refilled the patient's prescriptions for Roxicodone, Oxycontin, and Soma along with Xanax and Strattera.

26. That the urine toxicology screen for February 17, 2009, showed positive for Oxycodone and the range comparison is noted as "above range." The patient was prescribed Oxycodone, Soma, and Roxicodone. This notation of "above range" should have raised some suspicions since the patient admitted that he previously obtained drugs "from the streets" but yet the records are void of any mention of discussions at the next office visit between the patient and the physician regarding this discrepancy.

27. That the urine toxicology screen for August 8, 2008, showed positive for Oxycodone and Oxymorphone and is noted as "above range." The urine toxicology screen for March 24, 2008, showed positive, "in range" for Oxycodone but Oxymorphone by GCMS was "unable to confirm due to unidentified interferent" which should raise suspicion for potential abuse of other medications. The records of the following office visit (September 2008) are void of any mention of discussions between the patient and the physician regarding this discrepancy.

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28. That the urine toxicology screen for January 22, 2008, indicated the presence of methadone as well as Oxycodone "above range," and also showed the presence of THC. Although Soma was prescribed, it is not noted in the report. The records of the office visit on February 21, 2008, indicate that the patient admitted to using Methadone obtained illegally and/or improperly from a friend. This is in violation of the Narcotics Agreement entered into by the patient and the physician, yet Dr. Chen did not terminate the treatment of this patient based upon the continued violation of the Agreement.

29. That Dr. Chen's medical practice is "Advanced Pain Management and Family Care Associates." Such may imply that Dr. Chen's primary practice is that of pain management. Although Dr. Chen is AOA Board Certified in the area of general practice / family practice, he is not board certified in pain management.

30. That the patient entered into a "Narcotic and Pain Related Medication Agreement" with Dr. Chen, in which the patient "understand[s] that if "[the patient] breaks this Agreement, my doctor will stop prescribing these pain-control medicines." This Narcotic Agreement continues (a) that the patient will "not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety [sic] medicines from any other doctor," (b) that "refills of my prescription for pain medicine will be made only at the time of an office visit or during regular office hours," (c) that the patient will not use any illegal controlled substances, including marijuana or cocaine, and (d) that the patient will not share, sell or trade any medication with anyone.

31. That at no time did Dr. Chen terminate the doctor-patient relationship based upon the patient's violations of the "Narcotic and Pain Related Medication Agreement." Failure to terminate the doctor-patient relationship after violation of such an agreement falls below the standard of care for pain management physicians in this medical community as well as violates the contractual agreement between the patient and the physician in this matter.

32. That in response to the Board's request for medical records on this patient, Dr. Chen responded on May 20, 2009, that he did not "have time to keep responding to this kind of unnecessary complaint." On June 28, 2010, Dr. Chen signed a "Certificate of Records

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Custodian" and provided medical records to the Board. The Certificate states that Dr. Chen "has examined the original of those records/information/files maintained by this office, entity, and/or institution and has made a true and exact copy of them. The production of such medical records is attached hereto as Exhibit A and is true and complete." On the 19th day of November, 2010, Dr. Chen's attorneys provided the alleged complete medical records file on this patient; and such production contained certain papers/documents not previously provided by Dr. Chen. This is a violation of NRS 629.061(g).

III.

COUNT THREE
(Alleged Violations – Unethical Conduct)

33. That the Investigative Board Member repeats and realleges those claims and allegations contained in Paragraphs 1 through 10, inclusive, of Section I, Jurisdiction; and Paragraphs 11 through 32, inclusive, of Section II, Care & Treatment, contained within this Complaint as if the same were more fully set forth herein.

34. That Respondent has engaged in unethical conduct, pursuant to NAC 633.350, as follows: (a) by creating inaccurate and/or false medical records regarding the diagnosing and treatment of Patient B without conducting any type of examination or established testing to verify or confirm the existence of such medical condition or ailment; (b) Respondent has excessively prescribed controlled substances-dangerous drugs in dangerous levels as identified hereinabove and in violation of the narcotics agreement entered into by the patient and Dr. Chen; and (c) by failing to comply with the standards of this medical community in the care and treatment of this patient and by failing to comply with his own Narcotics Agreement, Dr. Chen has shown an unfit to practice osteopathic medicine, especially in the area of chronic pain patients and/or pain management.

35. That the unethical conduct by Respondent, as described throughout this Complaint, warrants discipline pursuant to NRS 633.651.

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IV.

COUNT FOUR
(Alleged Violations – Unprofessional Conduct)

36. That the Investigative Board Member repeats and realleges those claims and allegations contained in Paragraphs 1 through 10, inclusive, of Section I, Jurisdiction; Paragraphs 11 through 32, inclusive, of Section II, Care & Treatment; and Paragraphs 33 through 35, inclusive, of Section III, Violations/Unethical Conduct, contained within this Complaint as if the same were more fully set forth herein.

37. That Respondent has engaged in unprofessional conduct, pursuant to NRS 633.511, in that (a) he excessively prescribed controlled substances/dangerous drugs without confirming and/or verifying that Patient B was indeed injured and/or suffering from injuries-illnesses through MRIs, x-rays and/or CT Scans and other such recognized and established testing or examinations; (b) that he created and/or maintained illegible, inaccurate, incomplete, and/or contradictory medical records; and (c) pursuant to NRS 633.131(g), he has committed unprofessional conduct by not providing this licensing Board with a true, accurate, and complete copy of the medical records file on the patient at issue herein.

38. That Respondent has engaged in unprofessional conduct, pursuant to NRS 633.511 as described above; and discipline is warranted under the circumstances.

V.

COUNT FIVE
(Alleged Violations – Malpractice)

39. That the Investigative Board Member repeats and realleges those claims and allegations contained in Paragraphs 1 through 10, inclusive, of Section I, Jurisdiction; Paragraphs 11 through 32, inclusive, of Section II, Care & Treatment; Paragraphs 33 through 35, inclusive, of Section III, Violations/Unethical Conduct; and Paragraphs 36 through 38, inclusive, of Section IV, Violations/Unprofessional Conduct, contained within this Complaint

as if the same were more fully set forth herein.

40. That Respondent has committed "gross malpractice" as defined in NRS 633.041 in that Respondent has disregarded established medical practices in this community as discussed above and has willfully and consistently utilized medical procedures, services, and treatments of Patient B which are considered to be inappropriate in this medical community. As such, Respondent has failed to exercise the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians, in good standing in this community, in violation of NRS and NAC chapters 633, and in particular NRS 633.041.

41. That Respondent has committed professional incompetence pursuant to NRS 633.111 by (a) failing to exhibit the ability to safely and skillfully practice osteopathic medicine in this state by prescribing excessively to Patient B without ordering the appropriate tests and/or examinations, including but not limited to any MRIs, X-rays, CT Scans, and lab tests, to verify any legitimate medical problems, illnesses, and/or injuries; (b) by failing to follow-up on referrals made to Patient B or in the alternative, and (c) by failing to refer Patient B for appropriate treatment by other health care providers for pain management, especially after the patient's blatant violations of the Narcotics Agreement signed by the patient at issue in this matter.

42. That based upon the conduct described in Paragraphs 40 and 41, discipline is warranted as well as a medical competency examination pursuant to NAC 633.370.

VI.

PRAYER

WHEREFORE, the Investigative Member of the Nevada State Board of Osteopathic Medicine, James Anthony, D.O. / J.D. / MBA, prays as follows:

1. That the Nevada State Board of Osteopathic Medicine schedule a hearing pursuant to the Board's authority found in NRS and NAC chapters 633, as well as NRS chapter 233B,

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NRS chapter 622, and NRS chapter 622A, and affirmatively find that the public health, safety, and welfare require action against Respondent, Phil Yuan-Chung Chen, D.O., and his license to practice Osteopathic Medicine in the State of Nevada;

2. That, pursuant to NRS 633.651, Respondent, Phil Yuan-Chung Chen, D.O., be publicly reprimanded and/or the license of said Respondent be revoked, suspended, limited, or placed on probation with conditions and terms as the Nevada State Board of Osteopathic Medicine may deem just and proper and which are not inconsistent with law, and/or fined in an amount not to exceed $5,000 per violation, and/or require supervision of his medical practice, and/or require the Respondent to perform community service without compensation, and/or require the Respondent to complete any additional training or educational requirements specified by the Board;

3. That, pursuant to NAC 633.370, that a medical competency examination be ordered to determine whether or not this physician is competent to practice osteopathic medicine in the State of Nevada;

4. That Respondent, Phil Yuan-Chung Chen, D.O., be ordered to pay reasonable attorney's fees and costs incurred during the investigation and during the disciplinary proceedings; and

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5. For such other and further relief that the Board deems appropriate under the circumstances of this case.

DATED this 2nd day of February, 2011.

NEVADA STATE BOARD OF
OSEOPATHIC MEDICINE

By: ____________________
JAMES ANTHONY, D.O. / J.D. / MBA
Investigating Member of the
Nevada Board of Osteopathic Medicine

Submitted by:

NEVADA STATE BOARD OF
OSTEOPATHIC MEDICINE

By: ____________________
Dianna Hegeduis, # 5616
Board Counsel
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