

BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER INVOLVING PHIL YUAN-
CHUNG CHEN, D.O., LICENSE NO. 871,
RESPONDENT.

CASE NO. AD

1102002
NEVADA STATE BOARD OF
OSTEOPATHIC MEDICINE

FEB 02 2011

FILED

COMPLAINT

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

I.

COUNT ONE (JURISDICTION)

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

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

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

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

(f) Engaging in any:

- 1 (1) Professional conduct which is intended to deceive or
2 which the board by regulation has determined is unethical;
3 (2) Medical practice harmful to the public or any conduct
4 detrimental to the public health, safety or morals which does
5 not constitute gross or repeated malpractice or professional
6 incompetence. . . .
7 (k) Willful disobedience of the regulations of the State Board of
8 Health, the State Board of Pharmacy or the State Board of
9 Osteopathic Medicine
10 (m) Failure of a licensee to maintain timely, legible, accurate
11 and complete medical records relating to the diagnosis,
12 treatment and care of a patient . . .
13 (o) Making or filing a report which the licensee knows to be
14 false.

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

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

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

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

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

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

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

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

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

18 **II.**

19 **COUNT TWO (CARE &**
20 **TREATMENT OF PATIENT A – “E.C.”)**

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

24 12. That Patient A is a young female who underwent outpatient surgery for
25 reconstruction of the anterior cruciate ligament of her left knee on November 2, 2007.
26 Approximately one year post-operatively (October 2008), she fell onto her left knee and was
27 allegedly told by the Emergency Room (“ER”) physician to return to her orthopedic surgeon.

28 13. That a University Medical Center of Southern Nevada, Department of Radiology,
report of an x-ray of the patient’s left knee, dated October 3, 2008, was within Dr. Chen’s

1 medical records on this patient. The radiologist's impression was "ACL repair. No acute
2 abnormalities." Yet based upon this x-ray and report, Dr. Chen began his treatment of this
3 patient on November 11, 2008, solely with opiates. No referrals were made for any additional
4 x-rays, MRIs, or CT scans; and no referrals were made for physical therapy or further surgical
5 intervention.

6 14. That the patient claimed she could not return to the orthopedic surgeon as she did
7 not have money or insurance coverage. Yet, she allegedly continued to pay cash for routine
8 visits to Dr. Chen from November 18, 2008 until June 18, 2009, during which time, her
9 dosage of opioids were increased to a point that the patient required an inpatient
10 rehabilitation program(s). Prior to seeing Dr. Chen, the patient apparently had sufficient funds
11 to see Dr. Abdel Malick Khalek during the month of October 2008 for prescriptions of
12 controlled substances and according to that physician's records, (a) the patient had insurance
13 coverage and (b) paid large sums of money for the actual opiate prescriptions received from
14 Dr. Khalek and Dr. Chen.

15 15. That the female patient had a "Narcotic and Pain Related Medication Agreement"
16 signed November 11, 2008, in which the patient "understand[s] that if "[the patient] breaks this
17 Agreement, my doctor will stop prescribing these pain-control medicines." The document
18 continues (a) that the patient will "not attempt to obtain any controlled medicines, including
19 opioid pain medicines, controlled stimulants, or antianxiety [sic] medicines from any other
20 doctor," (b) that "refills of my prescription for pain medicine will be made only at the time of an
21 office visit or during regular office hours," (c) that the patient will not use any illegal controlled
22 substances, including marijuana or cocaine, and (d) that the patient will not share, sell or
23 trade any medication with anyone.

24 16. That the female patient apparently had no requirement for opioids for one year
25 following the surgery, but starting in November 2008 through June 2009, she was escalated
26 from a dose of occasional 5 mg oxycodone to a dose of oxycodone at 30 mg qid (which
27 occurred within one month of treatment by Dr. Chen), in addition to sustained-release
28 morphine, 30 mg per day, along with benzodiazepines and Soma, without having an

1 orthopedic workup to determine if there was any true orthopedic problem that could have
2 been treated at its source, allowing for the opioids to be tapered off and/or discontinued.

3 17. That as a result of the patient's visit on December 9, 2008, the following
4 prescriptions were allegedly given to the patient: Geodon 26 mg #28; Klonopin 5 mg #60,
5 Mobic 15 mg #30, Roxicodone 30 mg #120, and Soma 250 mg #120. Yet, the Drug
6 Utilization report indicates that the following prescriptions written by Dr. Chen were filled by
7 the patient on December 9, 2008: two prescriptions for Roxicodone 30 mg #120 and two
8 prescriptions for Klonopin 5 mg #60.

9 18. That the patient not filling her prescriptions and obtaining opiates from another
10 physician as mentioned above are violations of the patient's "Narcotic and Pain Related
11 Medication Agreement" yet Dr. Chen did not cease writing opiate prescriptions to the patient;
12 and such is inconsistent with the standard of care for patients being treated with opiates.

13 19. That Dr. Chen's office notes from December 9, 2008 indicated that the patient had
14 "vague pain or tenderness over knee area" and that the severity was "mild to moderate." The
15 pain level is left blank; however, Dr. Chen's inconsistently notes that she had limited range of
16 motion of knee region with pain and tenderness around knee joint. It was at this visit that the
17 Roxicodone was increased from 15 mg to 30 mg per day. The notes also indicate that the
18 patient is to return in one month and that she should see her orthopedic surgeon.

19 20. That the patient did not see Dr. Chen again until May 1, 2009. Although it is noted
20 in the medical records for this visit that she missed an appointment due to financial reasons,
21 the Drug Utilization report indicates that the patient saw Dr. Abdel Malick Khalek during the
22 month of April 2009 and received prescriptions for Lortab 10 mg #150 and Soma #120, i.e., a
23 violation of the patient's pain management contract with Dr. Chen, yet Dr. Chen failed to
24 cease issuing prescriptions for opiates to this patient. In contradiction to the claims of
25 financial problems, the patient was still able to continue paying for office visits to physicians
26 and paying large amounts of money for the prescriptions, and Dr. Chen failed to discuss
27 these concerns with the patient and/or stop issuing prescriptions for opiates.

28 21. That the pain level on the visit of May 1, 2009 with Dr. Chen is not noted in the

1 records and her medical problems are still noted as "vague pain or tenderness over knee
2 area." She was again instructed to follow up with her orthopedic surgeon, with no discussion
3 held between the patient and Dr. Chen regarding her failure to do so as instructed at the
4 December 8, 2008 visit.

5 22. That the patient saw Dr. Chen on May 22, 2009 with complaints of left knee pain
6 and anxiety. This time, the pain level is noted as 6/10. The other descriptions, however, did
7 not change, i.e., "vague pain or tenderness over knee area" with the severity inconsistently
8 noted as "mild to moderate." The patient was instructed again to see the orthopedic surgeon,
9 with no discussion held between the patient and Dr. Chen regarding the patient's continued
10 failure to do so.

11 23. That the female patient had a urine toxicology screen in May 2009 which showed
12 no benzodiazepines or Soma in her system, both of which were being prescribed by Dr.
13 Chen. Despite these findings which are clear indicators that the patient was non-compliant
14 with the pain management contract with Dr. Chen, Dr. Chen continued to prescribe all of such
15 medications to her nor are there any references within Dr. Chen's medical records that he
16 discussed such findings with the patient.

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

21 25. That the patient saw Respondent, Dr. Chen, from November 2008 until June 2009,
22 merely prescribing high dosages of opiates (a) without requiring the patient to return to her
23 orthopedic surgeon or holding any discussions between himself and the patient regarding her
24 failure to do so, (b) without requiring her to undergo physical therapy, (c) without requiring her
25 to undergo further X-rays, MRIs, CT scans, or other similar tests to determine her true
26 medical condition, (d) without requiring her to use a TENS unit, (e) without attempting to taper
27 off the medication, and (f) or without utilizing any other recognized and established pain
28 management procedure for the diagnosis and treatment of a medical condition. He also

1 failed to terminate the doctor-patient relationship when she violated the narcotics' agreement
2 entered into with Dr. Chen.

3 26. That Dr. Chen's medical records are inconsistent and inaccurate; namely, the x-ray
4 of the patient's left knee, dated October 3, 2008, reviewed "no acute abnormalities," his notes
5 indicate only "vague pain or tenderness over knee area" with only a severity of "mild to
6 moderate" and notes that she is functioning better and/or is improved, yet based upon this
7 information, Dr. Chen began his treatment of this patient on November 11, 2008, solely with
8 high dosages of opiates which continued through June 2009.

9 27. Furthermore, the Board requested medical records on this patient from Dr. Chen;
10 and on July 1, 2010, Connie Chen, on behalf of the Respondent, signed a "Certificate of
11 Records Custodian" and provided medical records to the Board. The Certificate states that
12 the affiant had "examined the original of those records/information/files maintained by this
13 office, entity, and/or institution and has made a true and exact copy of them. The production
14 of such medical records is attached hereto as Exhibit A and is true and complete." On the
15 19th day of November, 2010, Dr. Chen's attorneys provided the alleged complete medical
16 records file on this patient; and such production contained certain documents/papers not
17 previously provided by Dr. Chen and his office. This is a violation of NRS 629.061(g).

18 **III.**

19 **COUNT THREE**
20 **(Alleged Violations – Unethical Conduct)**

21 28. That the Investigative Board Member repeats and realleges those claims and
22 allegations contained in Paragraphs 1 through 10, inclusive, of Count I, Jurisdiction; and
23 Paragraphs 11 through 27, inclusive, of Count II, Care & Treatment, contained within this
24 Complaint as if the same were more fully set forth herein.

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

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8 30. That the unethical conduct by Respondent, as described in this Complaint,
9 warrants discipline pursuant to NRS 633.651.

10 **IV.**

11 **COUNT FOUR**
12 **(Alleged Violations – Unprofessional Conduct)**

13 31. That the Investigative Board Member repeats and realleges those claims and
14 allegations contained in Paragraphs 1 through 10, inclusive, of Count I, Jurisdiction;
15 Paragraphs 11 through 27, inclusive, of Count II, Care & Treatment; and Paragraphs 28
16 through 30, inclusive, of Count III, Violations/Unethical Conduct, contained within this
17 Complaint as if the same were more fully set forth herein.

18 32. That Respondent has engaged in unprofessional conduct, pursuant to NRS
19 633.511, in that (a) he excessively prescribed controlled substances/dangerous drugs without
20 confirming and/or verifying that Patient A was indeed injured and/or suffering from injuries-
21 illnesses through MRIs, x-rays and/or CT Scans and other such recognized and established
22 testing or examinations; (b) that he created and/or maintained illegible, inaccurate,
23 incomplete, and/or contradictory medical records; and (c) pursuant to NRS 633.131(g), he
24 has committed unprofessional conduct by not providing this licensing Board with a true,
25 accurate, and complete copy of the medical records on the patient at issue herein.
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27 33. That Respondent has engaged in unprofessional conduct, pursuant to NRS
28 633.511 as described above; and discipline is warranted under the circumstances.

V.

COUNT FIVE
(Alleged Violations – Malpractice)

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4 34. That the Investigative Board Member repeats and realleges those claims and
5 allegations contained in Paragraphs 1 through 10, inclusive, of Count I, Jurisdiction;
6 Paragraphs 11 through 27, inclusive, of Count II, Care & Treatment; Paragraphs 28 through
7 30, inclusive, of Count III, Violations/Unethical Conduct; and Paragraphs 31 through 33,
8 inclusive, of Count IV, Violations/Unprofessional Conduct, contained within this Complaint as
9 if the same were more fully set forth herein.

10 34. That Respondent has committed “gross malpractice” as defined in NRS 633.041 in
11 that Respondent has disregarded established medical practices in this community as
12 discussed above and has willfully and consistently utilized medical procedures, services, and
13 treatments of Patient A which are considered to be inappropriate in this medical community
14 for the treatment of pain patients with opiates. As such, Respondent has failed to exercise
15 the degree of care, diligence, and skill ordinarily exercised by osteopathic physicians, in good
16 standing in this community, in violation of NRS and NAC chapters 633, and in particular NRS
17 633.041.
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19 35. That Respondent has committed professional incompetence pursuant to NRS
20 633.111 by (a) failing to exhibit the ability to safely and skillfully practice osteopathic medicine
21 in this state by prescribing excessively to Patient A without ordering the appropriate tests
22 and/or examinations, including but not limited to any MRIs, X-rays, CT Scans, and lab tests,
23 to verify any legitimate medical problems, illnesses, and/or injuries; (b) by failing to follow-up
24 on referrals made to Patient A or in the alternative, (c) by failing to refer Patient A for
25 appropriate treatment by other health care providers for pain management, especially after
26 the patient’s blatant violations of the Narcotics Agreement signed by the patient at issue in
27 this matter.
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1 36. That based upon the conduct described in Paragraphs 34 and 35, discipline is
2 warranted as well as a medical competency examination pursuant to NAC 633.370.

3 VI.

4 PRAYER

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

7 1. That the Nevada State Board of Osteopathic Medicine schedule a hearing pursuant
8 to the Board's authority found in NRS and NAC chapters 633, as well as NRS chapter 233B,
9 NRS chapter 622, and NRS chapter 622A, and affirmatively find that the public's health,
10 safety, and welfare require action against Respondent, Phil Yuan-Chung Chen, D.O., and his
11 license to practice Osteopathic Medicine in the State of Nevada;

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

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

23 4. That Respondent, Phil Yuan-Chung Chen, D.O., be ordered to pay reasonable
24 attorney's fees and costs incurred during the investigation and during the disciplinary
25 proceedings; and
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1 4. For such other and further relief that the Board deems appropriate under the
2 circumstances of this case.

3 DATED this 2nd day of February, 2011.

4 NEVADA STATE BOARD OF
5 OSEOPATHIC MEDICINE

6 By: 

7 JAMES ANTHONY, D.O. / J.D. / MBA
8 Investigating Member of the
Nevada Board of Osteopathic Medicine

9 Submitted by:

10 NEVADA STATE BOARD OF
11 OSTEOPATHIC MEDICINE

12 By: 

13 Dianna Hegeduis, # 5616
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