BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF:  
DAVID MOON, D.O. 
License No. 705,  
JAVIER AVILA, P.A., 
License No. PA-C121,  
ISAAC TUNNELL, P.A., 
License No. PA-C0160,  
Respondents.

Case No. AD129001 & AD1304002
COMPLAINT FOR DISCIPLINARY ACTION
NV STATE BOARD OF
OSTEOPATHIC MEDICINE

JUL 31 2013
FILED

The Nevada State Board of Osteopathic Medicine, by and through its investigating board member Ronald Hedger, D.O., hereby makes the following complaint for disciplinary action against Dr. David Moon (License No. 705), Javier Avila, P.A. (License No. PA-C121), and Isaac Tunnell, P.A. (License No. PA-C0160) pursuant to NRS 683.541(3) and 682A.300(1). This complaint is made and based upon the following facts and causes of action.

BACKGROUND FACTS

I.

On July 18, 1994, David Moon, D. O. was licensed by the Board to practice osteopathic medicine in Nevada (License No. 705). On August 2, 2003, Javier Avila, P.A. was licensed by the Board to practice as a physician assistant in Nevada (License No. PA-C121). On June 21, 2006, Isaac Tunnell, P.A. was licensed by the Board to practice as a physician assistant in Nevada (License No. PA-C0160).

II.

Dr. Moon is the primary and responsible physician at a practice called Accelerated Rehabilitation & Pain Center, 241 North Buffalo Drive, Building 1, in Las Vegas, Nevada (ARPC). At all times relevant to this matter, Dr. Moon employed and was the supervising physician for Mr. Avila and Mr. Tunnell.

III.
The Board’s records show that Dr. Moon is a board-certified specialist in family and general practice medicine. Dr. Moon publicly represents himself and his practice as specializing in pain management and primary care even though no physician or physician assistant employed at the practice is board-certified in pain management.

IV.

On or about September 14, 2011, the Board initiated an investigation into the practices of Dr. Moon, Mr. Avila, and Mr. Tunnell at ARPC. In furtherance of the investigation, Barbara Longo, the Board’s Executive Director, visited ARPC on November 14, 2011 to obtain medical records related to sixteen patients of ARPC who had been treated by Dr. Moon, Mr. Avila, and Mr. Tunnell.

V.

When Ms. Longo was at ARPC on November 14, 2011, she was assisted in obtaining the requested medical records by Janet Zak, then office administrator of ARPC. Ms. Longo requested complete sets of the medical records for the sixteen patients on her list. Ms. Zak printed out medical records from ARPC’s computerized electronic medical record (EMR) system and presented those records to Ms. Longo as satisfying Ms. Longo’s request. On her November 14, 2011 visit, Ms. Longo was not shown or informed of any paper medical records for the sixteen patients that were not contained in the EMR records provided by Ms. Zak.

VI.

The Board’s staff reviewed the medical records produced by Ms. Zak, including having the records reviewed by two medical experts. The review of the records indicated that there were concerns regarding the practices engaged in by Dr. Moon, Mr. Avila, and Mr. Tunnell at ARPC. Therefore, on September 5, 2012, Ms. Longo sent letters to Dr. Moon, Mr. Avila, and Mr. Tunnell pursuant to NRS 233B.127(3) requesting responses from them regarding concerns noted in the record review (233B Letter #1).

VII.

On November 8, 2012, Ms. Longo and Board Counsel Louis Ling met at the Board’s office with Lance Earl and Matthew Millone, counsel for Dr. Moon, Mr. Avila, and Mr. Tunnell. The subject of the meeting was 233B Letter #1. At the meeting, Mr. Earl and Mr. Millone explained,
among other things, that the records that had been provided to Ms. Longo by Ms. Zak on November
14, 2011 were not, in fact, the complete medical files made and maintained on each of the sixteen
patients and that, instead, there were paper medical records in addition to the EMR records that had
been provided. The parties agreed that Ms. Longo would identify seven patients from the list of
sixteen for which the additional paper medical records would be produced.

VIII.

On November 30, 2012, Dr. Moon, Mr. Avila, and Mr. Tunnel, through Mr. Earl, responded
by letter to 233B Letter #1.

IX.

On April 17, 2013, Dr. Moon was arrested at the McCarran International Airport when he
was trying to board an airplane to Tulsa, Oklahoma. The basis for the arrest was the discovery in Dr.
Moon's luggage of an unregistered pistol and a large quantity of prescriptions drugs, including
controlled substances. Some of the prescription drugs were in vials dispensed by a pharmacy and
were in the names of Dr. Moon, some of his family members, and in various unrelated persons' names.
Some of the prescription drugs were in clear plastic baggies, in unreadable or unmarked vials, or were
mixed in with other drugs in labeled vials. Also contained in the luggage were hypodermic syringes.
The arresting officer listed the potential charges as possession of a hypodermic device, possession of
an unregistered firearm, possession of a controlled substance with intent to sell.

X.

On July 1, 2013, Ms. Longo sent a letter to Dr. Moon pursuant to NRS 233B.127(3)
requesting responses from him regarding concerns related to the facts and circumstances surrounding
his arrest on April 17, 2013 (233B Letter #2).

XI.

On July 19, 2013, Dr. Moon, through Mr. Earl, responded by letter to 233B Letter #2.

CAUSES OF ACTION RELATED TO DR. MOON'S ARREST

FIRST CAUSE OF ACTION

XII.
At the time of his arrest on April 17, 2013, Dr. Moon had the following prescription vials with identifiable labels in his possession (patient names have been reduced to initials):

<table>
<thead>
<tr>
<th>Patient</th>
<th>Prescription Drug</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>LM</td>
<td>Hydrocodone 10/650 tablets</td>
<td>CS III</td>
</tr>
<tr>
<td>VM</td>
<td>Terazosin 2 mg. capsules</td>
<td>DD</td>
</tr>
<tr>
<td>JH</td>
<td>Carvedilol 12 mg. tablets</td>
<td>DD</td>
</tr>
<tr>
<td>LL</td>
<td>Carisoprodol 350 mg. tablets</td>
<td>CS IV</td>
</tr>
<tr>
<td>LL</td>
<td>Oxycodone tablets</td>
<td>CS II</td>
</tr>
<tr>
<td>RC</td>
<td>Suboxone 8 mg./2 mg. tablets</td>
<td>CS III</td>
</tr>
<tr>
<td>CB</td>
<td>Oxycodone tablets</td>
<td>CS II</td>
</tr>
<tr>
<td>VM</td>
<td>Metoclopramide tablets</td>
<td>DD</td>
</tr>
<tr>
<td>VM</td>
<td>Ciprofloxin 500 mg. tablets</td>
<td>DD</td>
</tr>
<tr>
<td>HG</td>
<td>Nuvigil tablets</td>
<td>CS IV</td>
</tr>
<tr>
<td>LM</td>
<td>Triamterene HCTZ tablets</td>
<td>DD</td>
</tr>
<tr>
<td>LM</td>
<td>Zantac tablets</td>
<td>DD</td>
</tr>
</tbody>
</table>

XIII.

The labels on the vials identified in averment XII show that Dr. Moon was the prescriber, and many of the labels showed that the prescriptions had been filled over one or more years earlier.

XIV.

At the time of his arrest, Dr. Moon explained that he did not know that he could not possess old prescription drugs that had been prescribed to his patients. Dr. Moon also explained that he had the prescription drugs in his possession on April 17, 2013 because he traveled frequently and carried the drugs with him to help indigent people (apparently in Oklahoma), including dispensing the prescription medications to inmates in Oklahoma detention centers.

XV.

Dr. Moon's statement at the time of his arrest are consistent with publications by Dr. Moon and ARPC soliciting and inviting patients to bring their unused prescription medications, including controlled substances, to Dr. Moon's practice.

XVI.

In possessing and/or transporting prescribed controlled substances that were prescribed for patients other than Dr. Moon – namely hydrocodone 10/650 tablets (CS III), suboxone 8/2 tablets (CS III), oxycodone tablets (CS II), and Nuvigil tablets (CS IV) – Dr. Moon violated Nevada Revised Statutes (NRS) 633.511(1) and NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(g), and/or NRS
SECOND CAUSE OF ACTION

XVII.

In possessing and/or transporting prescribed dangerous drugs that were prescribed for
patients other than Dr. Moon – namely Terazosin tablets, Carvedilol tablets, metoclopramide tablets,
ciprofloxin tablets, triamterene HCTZ tablets, and Zantac tablets – Dr. Moon violated NRS
633.511(1) and NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(g), and/or NRS 633.131(1)(l), and/or
NRS 454.316(1), and/or NRS 639.268(1), and/or NRS 639.282(1)(a).

THIRD CAUSE OF ACTION

XVIII.

All of the prescriptions listed in averment XII except for the hydrocodone prescription for LM
and the Nuvigil prescription for HG were over one year old and were, therefore, expired.

XIX.

In possessing and transporting dangerous drugs and controlled substances that were expired,
Dr. Moon violated NRS 633.511(1) and NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(g), and/or NRS
633.131(1)(l), and/or NRS 639.282(1)(d).

FOURTH CAUSE OF ACTION

XX.

At the time of his arrest on April 17, 2013, Dr. Moon had the following prescription drugs
contained in prescription vials which had unreadable labels or no labels or in the manufacturer’s
original unit dose packaging to which no prescription label was affixed:

<table>
<thead>
<tr>
<th>Prescription Drug</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prednisolone 4 mg. tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Valtrex tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Clindamycin 300 mg. tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Quinine sulfate 523 mg. tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Hydrochloride tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Levaquin tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Sulfamethoxazole/trimethoprim tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Amoxicillin tablets</td>
<td>DD</td>
</tr>
<tr>
<td>Fexofenadine tablets</td>
<td>DD</td>
</tr>
</tbody>
</table>
Ciprofloxin tablets     DD
Promethazine tablets   DD
Lomotil tablets        DD
Phentermine hydrochloride tablets  CS IV

XXI.

With the exception of the one of the prednisolone 4 mg tablets that were in the manufacturer’s original unit dose packaging, none of the prescription drugs listed in averment XX were contained in original manufacturer’s packaging or had any other labeling that would have identified the drugs’ manufacturer, the expiration date, the name of the drug, the strength of the drug, or any other data that would have indicated that the drugs were fit for human use.

XXII.

At the time of his arrest, Dr. Moon explained that he had the prescription drugs in his possession on April 17, 2013 because he traveled frequently and carried the drugs with him to help indigent people (apparently in Oklahoma), including dispensing the prescription medications to inmates in Oklahoma detention centers.

XXIII.

In possessing and transporting dangerous drugs and controlled substances for which no manufacturer’s or prescription label could identify the drugs’ sources, manufacturers, expiration dates, strength, or any other data that would indicate that the drugs were fit for human use, Dr. Moon violated NRS 633.511(1) and NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(g), and/or NRS 633.131(1)(k), and/or NRS 633.131(1)(l), and/or NRS 454.316(1), and/or NRS 639.268(1), and/or NRS 639.282(1)(d), and/or NRS 639.282(1)(e).

CAUSES OF ACTION RELATED THE PRACTICES OF DR. MOON, MR. AVILA, AND MR. TUNNELL AT ARPC

FIFTH CAUSE OF ACTION

XXIV.

A review of the various records provided by Dr. Moon, Mr. Avila, Mr. Tunnell, and ARPC showed that the EMR records contained clinically significant entries that were consistently replicated without regard to accuracy and were often significantly varied from entries by the treating practitioner, thus rendering the EMR records confusing, unreliable, and inaccurate. In making and
maintaining medical records that were confusing, unreliable, and inaccurate, Dr. Moon, Mr. Avila, and Mr. Tunnell violated NRS 633.511(1) and 633.131(1)(m).

SIXTH CAUSE OF ACTION

XXV.

A review of the various records provided by Dr. Moon, Mr. Avila, Mr. Tunnell, and ARPC showed that the practices of Dr. Moon, Mr. Avila, and Mr. Tunnell were below the standard of care for specialists in pain management based upon the following criteria that were generally noted throughout the records:

(A) The medical records contain no or minimal history and inadequate physical examinations by the treating practitioner.

(B) The medical records contain no or minimal working diagnoses.

(C) The medical records contain no or minimal treatment plans.

(D) The medical records contain no or minimal explanation or rationale for the prescriptions that were written by the treating practitioner.

(E) The medical records contain no or minimal indication that the treating practitioner spoke with the patient regarding how the prescription regimen should properly be taken, the possible side effects, the potential for conflict with other prescriptions or other medications the patient might be taking, and other similar points of discussion regarding the prescription regimen that was being prescribed and repeated through refills.

(F) The medical records contain no or minimal indication that any follow-up examinations or clinical assessments were done by the treating practitioner to determine the efficacy of the treatment being afforded.

(G) Some of the patients' medical records indicate that diagnostic studies (radiographs, MRIs, bodily fluid screens, etc.) were ordered or obtained, but the medical records did not indicate that the studies had ever been reviewed or considered.

(H) Many of the patients' medical records indicate that diagnostic studies should have been ordered or obtained, but the medical records did not indicate that the diagnostic studies were ever considered by the treating practitioner or were suggested to or discussed with the patients.

(I) The medical records showed that all the patients who were being treated for pain were being provided similar or identical treatments, namely osteopathic manipulation, trigger-point therapy, and prescriptions for controlled substances. It appeared that with most of the patients, the treatment eventually devolved into refilling various controlled substances prescriptions with little or no consideration of other treatment option and the patients' lack of improvement, thereby constituting the continued use of ineffective treatment. The medical records show little evidence of consideration of or providing of treatments or modalities other than the three listed in this paragraph.

(J) Many of the medical records show no indication of referrals to or even consideration of referrals to other medical specialists, physical therapists, mental health professionals, or other similar disciplines even when the clinical
information, scant though it often was, seemed to indicate that such referrals might be warranted or beneficial to the patient.

(K) The selection of controlled substances, quantity prescribed, frequency of use, and chronic use of the controlled substances showed no regard for present medical standards of care or concern for the potential for addiction and harm that might come from the chronic prescribing of such controlled substances. Many of the controlled substances prescribed are highly addictive, but no clinical evaluation or attempt to mitigate the potentially addictive properties of the controlled substances appears in the medical records.

(L) The medical records contained numerous instances of internal inconsistencies that made some of the conclusions based upon the information in the medical records suspect or clinically confusing. For example, in some instances the medical records indicate that the patients returned for follow-up visits stating that they were feeling much better or had less pain, or other similar statements and yet they were still prescribed large amounts of narcotics. In other instances, prescription quantities or strengths were increased where the medical records contain no indication of a worsening or change in the patient’s condition or any other clinical indicator that would support an increase in the prescription regimen.

(M) Some patients were allowed to violate their treatment contracts with the practice with no consequences and without interruption in their receipt of prescriptions or refills for controlled substances.

(N) In many of the medical records, there are clinical indicators that the patients may be abusing or misusing their controlled substances, and in some of the medical records there are indications that the patients are using illicit prescription controlled substances or illicit “street” drugs without any indication that such misuse or abuse of controlled substances and “street” drugs was clinically addressed by the treating practitioner, including, but not limited to, a failure to seek and obtain prescription controlled substance profile reports to identify suspect abuse or diversion.

(O) The medical records contain no indication by any of the treating practitioners that any patient was diagnosed with intractable pain, and the medical records contain no indication that any patient was referred to a board-certified pain management specialist for a determination of whether the patient’s pain was intractable.

(P) Regarding most of the patients, the quantity of controlled substances, especially opioids and other narcotics, was excessive and was not justified by the clinical data and indications in the medical records.

XXVI.

As specialists in pain management, the treatment provided by Dr. Moon, Mr. Avila, and Mr. Tunnell where they have represented to the public that they are specialists in pain management as documented in the medical records reviewed by the Board and with the issues set out in averment XXV constitute violations by Dr. Moon, Mr. Avila, and Mr. Tunnell of NRS 633.511(1), and/or NRS 633.511(5), and/or NRS 633.131(1)(f)(2), and/or NRS
633.131(g), and/or NRS 633.131(k), and/or NAC 633.287(1)(f), and/or NAC 633.289(1),
and/or NAC 633.289(2)(c), and/or NAC 633.350(1)(e) and/or NAC 633.350(1)(f).

SEVENTH CAUSE OF ACTION

XXVII.

As specialists in family medicine, the treatment provided by Dr. Moon, Mr. Avila, and Mr.
Tunnell as documented in the medical records reviewed by the Board and with the issues set out in
averment XXV constitute violations by Dr. Moon, Mr. Avila, and Mr. Tunnell of NRS 633.511(1),
and/or NRS 633.511(5), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(g), and/or NRS
633.131(k), and/or NAC 633.287(1)(f), and/or NAC 633.289(1), and/or NAC 633.289(2)(c), and/or
NAC 633.350(1)(e) and/or NAC 633.350(1)(f).

EIGHTH CAUSE OF ACTION

XXVIII.

The Board’s investigation determined that Dr. Moon personally trained Mr. Avila and Mr.
Tunnell in techniques of osteopathic manipulation and/or allowed them to perform osteopathic
manipulations upon patients at ARPC. The medical records reviewed by the Board showed that Mr.
Avila and Mr. Tunnell regularly provided osteopathic manipulations to their patients.

XXIX.

In providing osteopathic manipulation to their patients, Mr. Avila and Mr. Tunnell violated
NRS 633.434(5), and/or NRS 633.511(1), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(k),
and/or NRS 633.131(1)(l), and/or NAC 633.287(1)(d), and/or NAC 633.287(1)(f).

NINTH CAUSE OF ACTION

XXX.

As the supervising physician for Mr. Avila and Mr. Tunnell, Dr. Moon is responsible for the
acts and violations of Mr. Avila and Mr. Tunnell, including training them and allowing their
provision of osteopathic manipulation to patients of ARPC, and, therefore, Dr. Moon violated NRS
633.434(5), and/or NRS 633.511(1), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(k), and/or NRS 633.131(1)(l), and/or NRS 633.469(5), and/or NAC 633.287(1)(d), and/or NAC 633.287(1)(f), and/or NAC 633.289(1).

TENTH CAUSE OF ACTION

XXXI.

A review of the medical records made by Mr. Avila and Mr. Tunnell showed that generally Mr. Avila and Mr. Tunnell did not obtain medical histories of patients, failed to perform adequate physical examinations, failed to obtain and to implement treatment plans created by Dr. Moon, did not monitor the effectiveness of therapeutic interventions, and did not make appropriate referrals. In particular, the Board's investigation determined that the three practices of Dr. Moon, Mr. Avila, and Mr. Tunnell were generally separate and distinct with Dr. Moon providing little or no actual supervision or oversight over the practices of Mr. Avila and Mr. Tunnell.

XXXII.

A review of the medical records showed no case where Dr. Moon created a treatment plan for a patient that was implemented by Mr. Avila or Mr. Tunnell.

XXXIII.

Dr. Moon's lack of supervision of Mr. Avila and Mr. Tunnell violated NRS 633.511(1), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(k), and/or NRS 633.131(1)(l), and/or NAC 633.289(1)(a), and/or NAC 633.289(1)(b), and/or NAC 633.289(1)(d), and/or NAC 633.289(1)(e), and/or NAC 633.289(1)(h).

ELEVENTH CAUSE OF ACTION

XXXIV.

The Board's investigation found no evidence that Dr. Moon had developed or carried out a program to ensure the quality of care provided by Mr. Avila and Mr. Tunnell as required by NAC 633.289(3)(d). Dr. Moon, therefore, violated NRS 633.511(1), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(1)(k), and/or NRS 633.131(1)(l), and/or NAC 633.289(3).
Wherefore, it is hereby requested that appropriate discipline be entered against Dr. Moon, Mr. Avila, and Mr. Tunnell based upon this Complaint pursuant to NRS 633.651 and NAC 633.287.

Signed this 3/ day of July, 2013.

By:

Ronald Hedger, D.O.
Investigating Board Member

NOTICE OF HEARING AND STATEMENT OF RESPONDENT’S RIGHTS

As the Respondent in this action, you have the following rights:

1. A hearing regarding this matter will be held before Hearing Officer Jill Greiner at the following date and place:

   November 7, 8, 9, 2013 at 9:00 a.m. or as soon thereafter as possible
   Board Conference Room
   901 American Pacific Drive, Unit 180
   Henderson, Nevada 89014

   The intent of the hearing of this matter is to determine whether the allegations made against you in the above Complaint have been proven by a preponderance of the evidence, and if so, what discipline is appropriate. All documents you wish to file in this matter must be filed with the Board’s office located at 901 American Pacific Drive, Unit 180, Henderson, Nevada 89014.

2. You may appear at the hearing of this matter. You may be represented by your counsel of choice. The hearing shall be conducted at an open and public hearing of the Board and shall be conducted in conformance with NRS chapters 233B, 622A, and 633 and NAC chapter 633, including your right to present testimony and evidence in support of your case and your right to cross-examine witnesses presented by the Board’s staff.

3. Pursuant to NRS 622A.320(1), you may file an Answer to the above Complaint in this matter. To do so, you must file your Answer in writing with the Board’s office within 20 days of your receipt of the above Complaint. Your failure to timely file an Answer to the Complaint may be deemed by the Hearing Officer or the Board to be an admission to the contents of the Complaint.
5. You may request that the Board issue subpoenas to compel the attendance of witnesses or the production of evidence at the hearing of the matter pursuant to NRS 683.281.

6. Should you choose not to appear at the hearing of the matter, the Board may enter a default against you and still proceed with the hearing of the matter in your absence pursuant to NRS 622A.350.

7. You may seek to negotiate a settlement regarding this matter. If you desire to discuss a potential settlement of the matter, you may contact Louis Ling, Board Counsel, at (775) 233-9099 or at louisling@me.com.
CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Osteopathic Medicine and that on this day I deposited for certified mailing at Henderson, Nevada, postage prepaid, a true and correct copy of the foregoing document addressed to the following:

Dated this _____ day of July, 2013.

[Signature]