

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-04-5717
LICENSE NO. G-7790

IN THE MATTER OF THE
COMPLAINT AGAINST:

ANDREW WILLIAM CAMPBELL, M.D.

BEFORE THE

TEXAS MEDICAL BOARD

SECOND AMENDED COMPLAINT

TO THE HONORABLE ADMINISTRATIVE LAW JUDGE PAUL D. KEEPER and
ANN LANDEROS:

COMES NOW, the Staff of the Texas Medical Board f/k/a Texas State Board of Medical Examiners ("the Board"), and files this Second Amended Complaint against Andrew William Campbell, M.D., ("Respondent"), based on Respondent's alleged violations of the Medical Practice Act ("the Act"), TEX. OCC. CODE ANN., Title 3, Subtitle B, Chapters 151-165, and would show the following:

I. Introduction

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

II. Legal Authority and Jurisdiction

Respondent is a Texas Physician and holds Texas medical license number G-7790, issued by the Board on June 9, 1985, which was in full force and effect at all times material and relevant to this Complaint. All jurisdictional requirements have been satisfied.

III. Procedural Background

1. The Board received information that Respondent may have violated the Act and, based on that information, conducted an investigation. The investigation compiled

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evidence that support allegations of a violation.

2. Respondent was invited to attend an Informal Show Compliance Proceeding and Settlement Conference ("ISC"), held on September 16, 2002, which was conducted in accordance with §2001.054(c), GOV'T CODE and §164.004 of the Act. The Board representatives reviewed and considered evidence from the investigation, as well as any information presented by Respondent. They determined that Respondent had not shown compliance with all requirements of the Act.

3. In an attempt to resolve this matter informally, the Panel offered Respondent a proposed Agreed Order, setting forth certain terms and conditions. Respondent failed and/or refused to agree to the proposed settlement offer and no agreement to settle this matter has been reached by the parties.

IV. Factual Allegations

Board Staff has received information and on that information believes that Respondent has violated the Act. Based on such information and belief, Board Staff alleges:

General Allegations

- A. On each and every patient herein, Respondent has relied on junk science to support his medical diagnosis and treatment of illnesses allegedly attributable to mold exposure. Respondent's reliance on junk science in making medical diagnosis, treatment and decisions is below the standard of care. Respondent's position on mold exposure is contrary to the nationally recognized positions of medical and health organizations including, the Texas Medical Association (TMA), Center for Disease Control (CDC), Environmental Protection Agency (EPA), and American College of Occupational and Environmental Medicine (ACOEM).
- B. On each and every patient herein, specified Respondent made medically and scientifically unsupported findings of "toxigenic mold exposure." There is no scientific support, peer reviewed studies, or generally accepted medical studies, literature or testing that has demonstrated a causal connection between mold exposure and neurological and others diseases as diagnosed by Respondent. The

reliance on unproven science when making a medical diagnosis or to reach medically unreasonable conclusions regarding a diagnosis that is not recognized or generally accepted in the medical and scientific community is below the standard of care.

- C. On each and every patient herein specified, Respondent performed inadequate medical history, physical examination and diagnostic testing before reaching a medically unsupported finding of "toxigenic mold exposure" and/or chemical exposure. This is below the standard of care.
- D. On each and every patient herein specified, Respondent ordered medically and scientifically unsupported and costly blood serum testing due to "toxigenic mold exposure," without first performing more basic less costly testing, such as intradermal skin testing. This below the standard of care.
- E. On each and every patient herein specified, the "diagnostic" blood serum testing used by Respondent is not FDA approved, and the reliability of these tests to substantiate a diagnosis of "toxigenic mold exposure" is not generally accepted in the medical community. The reliance of Respondent on testing that is not recognized or generally accepted in the medical community as a diagnostic test is below the standard of care.
- F. On each and every patient herein specified, Respondent ordered blood serum testing for extensive potential "toxic" exposures that were not supported by medical information provided by the patient. Ordering such tests without supporting medical information is below the standard of care, and such tests cannot be used to support to a medical decision or diagnosis.
- G. On each and every patient herein specified, Respondent ordered blood serum testing that he claims demonstrates mold exposure; however, the blood testing ordered does not differentiate if the exposure is from mold or other organisms, it cannot determine if the exposure is old, recent, acute, chronic, or any other information, it can only demonstrate that a patient was exposed to some foreign body that caused the patient to produce an anti-body. The reliance on unproven science or testing when making a medical diagnosis or to reach medically

unreasonable conclusions regarding a diagnosis that is not recognized or generally accepted in the medical and scientific community is below the standard of care.

- H. On each and every patient herein, specified Respondent made medically and scientifically unsupported findings of "toxigenic mold exposure," without any differential diagnosis to rule out other causes of the symptoms. There is no scientific support, peer reviewed studies, or generally accepted medical studies, literature or testing that has demonstrated a causal connection between mold exposure and neurological diseases and the other vague non-specific symptoms of Respondent's patients. The standard of care requires that a differential diagnosis must be made when trying to find a source of a patient's complaint/illness.
- I. On each and every patient herein specified, Respondent made medically and scientifically unsupported jumps in logical conclusions by findings of "toxigenic mold exposure," the conclusions were all derived from "home-brew tests" results that are not FDA approved, from a laboratory in California that Respondent uses exclusively for his "mold" patients. Such leaps in logical conclusions are below the standard of care and are scientifically and medically unsound.
- J. On a number patients herein specified, Respondent made medically unsupported findings/conclusions of "abnormal neurological examination." Respondent performed an incomplete examination and failed to perform the medically necessary diagnostic testing required before arriving at such a diagnosis, pursuant to the guidelines of the American Academy of Neurology. This is below the standard of care.
- K. On a number patients herein specified, after Respondent made medically unsupported findings/conclusions of "abnormal neurological examination," he then ordered medically unnecessary diagnostic testing, including Electroencephalogram (EEG), Visual Audio Evoked Response (VAER), Brain Audio Evoked Response (BAER), Current Perception Threshold (CPT), "Polyneuropathy Test" and Nerve Conduction Velocity (NCV). This is below the standard of care.

- L. On a number patients herein specified, after Respondent made medically unsupported findings/conclusions of "abnormal neurological examination" he then ordered medically unnecessary laboratory testing, including basic serum myelin protein, as a result of his conclusion of "abnormal neurological examination." This is below the standard of care.
- M. On a number patients herein specified, Respondent made medically and scientifically unsupported findings of "demyelinating polyneuropathy," without meeting the medical and diagnostic criteria required before arriving at such a diagnosis, including failing to perform tests pursuant to the guidelines of the American Academy of Neurology to confirm such a diagnosis. The standard of care require that to make a diagnosis of demyelinating polyneuropathy certain tests must be run, and come back with results as outlined by American Academy of Neurology criteria, and Respondent failed to do this required testing.
- N. On a number patients herein specified, Respondent ordered treatment with Sporanex and/or IVIG, without meeting the medical and diagnostic criteria required before prescribing the treatment. The use of IVIG in method prescribed by Respondent for the "medical condition(s)" of the patients is below the standard of care.
- O. Respondent's determinations/diagnosis of toxigenic mold exposure, and various neurological conditions are not supported by peer-reviewed studies or established science. Respondent is making medical decisions, including treatment with Sporanex and IVIG, based on theories, opinions and analysis that have not been sufficiently tested. His approach and conclusions regarding toxigenic mold as a cause of these patient's vague non-specific symptoms is not generally accepted in the medical community, and is not supported by established scientific evidence.
- P. On a number patients herein specified, Respondent coded his office at levels higher than the documents could support, and contrary to recognized criteria in the CPT Coding Books.

- Q. On a number patients herein specified, Respondent coded his office as consultations when they were actually as office visits. Consultations are paid at a higher level of reimbursement than an office visit. This is a form of upcoding to higher levels to increase the level of reimbursement Respondent received. This is unprofessional conduct.
- R. On a number patients herein specified, Respondent coded laboratory testing as global charge, meaning he charged for both performing the test (technical component) and interpreting the results (professional component). However, Respondent failed to provide adequate documentation to provide he performed the professional component. Due to the failure to provide the required documentation Respondent improperly charged the patient for the professional component. This is overbilling and unprofessional conduct.
- S. On a number patients herein specified, Respondent coded laboratory testing as global charge, meaning he charged for both performing the test (technical component) and interpreting the results (professional component). Respondent then also charged a separate professional component. This practice is doubling billing for the same service. Additionally, in these cases Respondent failed to provide adequate documentation to provide he performed the professional component. Due to the failure to provide the required documentation Respondent improperly charged the patient for the professional component twice. This is unprofessional conduct.

Allegation #1 - Patient G.F.

1. On October 25, 1993, Respondent treated Patient G.F. for exposure to paint fumes and previous exposure to asbestos. Due to G.F.'s history of exposure, Respondent ordered and performed an extensive battery of tests. Respondent diagnosed G.F. with polyneuropathy, chemical exposure, and Raynaud's Syndrome. No treatment was prescribed.

2. On July 21, 2000, G.F. returned to see Respondent complaining of blackouts, increased fatigue, lack of energy, low back pain, bilateral elbow discomfort, diarrhea, shortness of breath, dry eyes, ringing of the ears, headaches, occasional heart palpitations and chest pain. Respondent failed to perform a complete physical upon patient presenting to this office.
3. Respondent diagnosed chemical exposure, fatigue, shortness of breath (SOB), cough, severe muscular weakness, and abnormal reflexes. The symptoms of fatigue, shortness of breath (SOB), muscle weakness and abnormal reflexes are not supported by the medical records or by the incomplete findings/physical in the medical records.
4. On July 21, 2000, Respondent performed numerous tests, including Sensory Nerve Conduction Study, and Flow Cytometry. All of these tests are unrelated to the symptoms of G.F. and are excessive diagnostic testing without adequate medical justification. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.
5. On July 21, 2000, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary, except the chemical exposure test. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.

6. Respondent diagnosed chemical exposure despite the fact that all the tests for chemical exposure came back normal. This conclusion "chemical exposure" is made without scientific and medical support, and is a violation of the standard of care.
7. Respondent made medically unsupported findings/conclusions that G.F. had an "abnormal neurological examination." Respondent then ordered medically unnecessary diagnostic testing.
8. Respondent ordered medically unnecessary diagnostic testing, including Current Perception Threshold (CPT) test, "polyneuropathy test" and laboratory testing, including basic serum myelin protein, as a result of his conclusion of "abnormal neurological examination.
9. Respondent made medically unsupported findings/conclusions of "abnormal neurological examination." Respondent performed an incomplete examination and failed to perform the medically necessary diagnostic testing required before arriving at such a diagnosis.
10. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
11. Respondent failed to make any differential diagnosis for this patient, he never ruled out any other possible causes for the symptoms but concluded it was various forms of toxic exposure without exploring any other causes.
12. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.

13. When billing patient G.F. for his July 2000 office visit, Respondent overbilled and/or improperly billed the patient. Respondent billed this visit as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed.
14. Respondent failed to properly file or submit his Health Care Financing Administration (HCFA) bills in 2000. In order to properly bill for services Respondent is required to sign his HCFA bill and his medical records, which he failed to do.

Allegation #2 - Patient (T.A.)

1. On January 3, 2001, Respondent evaluated Patient T.A., a minor. T.A. had a significant medical history of sinus problems, nosebleeds, reactive airway disease, headaches, cough, colds, vomiting, difficulty recalling simple things, hard time sleeping, fatigue, SOB, temper, asthma, and mold allergy.
2. On January 3, 2001, Respondent ordered laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and is not generally accepted in the medical community as being valid diagnostic tests. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.
3. Respondent ordered the following neurological tests on January 3, 2001, EEG, CPT, PFT and "polyneuropathy test." In February 2001, Respondent ordered neurophysiological testing by Brain Stem Auditory Evoked Response (BAER), Visual Evoked Potential (VER), serum protein electrophoresis, and an MRI of the

brain. Each of these tests were ordered without a complete physical and neurological examination or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable

4. In February 2001, Respondent diagnosed T.A. with immune mechanism disorder, mycosis, and polyneuropathy-nonspecific.
5. In February 2001, Respondent made medically and scientifically unsupported findings of "polyneuropathy," or "demyelinating polyneuropathy." The Respondent failed to meet the criteria required for such a diagnosis, including failing to perform tests pursuant to the guidelines of the American Academy of Neurology.
6. Respondent ordered treatment with IVIG, for the polyneuropathy without meeting the medical and diagnostic criteria required before prescribing the treatment. This treatment is not recommended for children. The administration regimen prescribed by Respondent for IVIG is not proper. The Respondent prescribed one dose of IVIG to be administered every week for twelve weeks. The standard of care is administration of IVIG is one dose every three to four weeks.
7. On May 29, 2001, Respondent examined the patient again. The diagnoses were cough, fatigue, headaches, memory loss, sleep disturbance, blurred vision, and abnormal BAER. Respondent ordered medically unsupported testing. The unsupported testing includes diagnostic testing with an EEG and BAER, and laboratory blood serum tests for NK cell activity, T&B cell function and T-helper/suppressor ratio.
8. Respondent ordered treatment with Sporanex in July or August 2001, without meeting the medical and diagnostic criteria required before prescribing the treatment. This treatment is not recommended for children.

9. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam. The billing for medical services from January 3, 2001 to May 2001, is excessive. This was not within the standard of care.
10. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
11. Respondent failed to make any differential diagnosis for this patient, he never ruled out any other possible causes for the symptoms but concluded it was toxic exposure mold.
12. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
15. When billing patient T.A. for his January 2001, February 7, and 20, 2001, office visits Respondent overbilled and/or improperly billed the patient. Respondent billed these visits as consultations. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed.
16. Respondent failed to properly file or submit his HCFA bills. In order to properly bill for services Respondent is required to sign his HCFA bills and have adequate medical records to support the billing, which he failed to do.

17. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
18. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #3 - Patient K.A.

1. Respondent examined Patient K.A. on January 25, 2001. K.A. complained of fatigue, memory problems, headaches, hair loss, depression, anxiety/mood swings, sharp pain in upper right quadrant, and chest tightness. K.A.'s medical history included nosebleeds, sinus problems, severe headaches, and neck pain since 1994. A neurology consult in 1994 included an MRI of the brain and CT scan, which were negative.
2. On January 25, 2001, May 29, 2001 and August 3, 2001, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There were no indications for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.

3. Respondent ordered the following neurological tests on January 25, 2001 EEG, CPT, PFT and "polyneuropathy test." In August 2001, Respondent ordered neurophysiological testing by EEG, BAER, VAER, NCV, PFT, Hearing Test, and a Color Deficiency Test. All these tests were ordered without a complete physical and neurological examination or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
4. The Respondent made medically and scientifically unsupported findings of "polyneuropathy," or "demyelinating polyneuropathy." The Respondent failed to meet the criteria required for such a diagnosis, including failing to perform tests pursuant to the guidelines of the American Academy of Neurology.
5. Respondent ordered treatment with IVIG, for peripheral neuropathy or demyelinating disease without meeting the medical and diagnostic criteria required before prescribing the treatment. The administration regimen prescribed by Respondent for IVIG is not proper. The Respondent prescribed one dose of IVIG to be administered every week for twelve weeks. The standard of care is administration of IVIG is one dose every three to four weeks.
6. On May 29, 2001, Respondent examined the patient again. The diagnoses were cough, fatigue, headaches, memory loss, sleep disturbance, blurred vision, and abnormal BAER. Respondent then ordered medically unsupported testing. The unsupported testing includes diagnostic testing with an EEG and BAER, and blood serum tests from ImmunoScience Labs, Inc.
7. The blood serum test result from January, May, and August are contradictory with inconsistent results that have no medically/clinically meaningful and are not generally accepted in the medical community to support Respondent's diagnosis.

8. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam. The billing for medical services provided to K.A. is excessive. This was not within the standard of care.
9. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
10. Respondent failed to make any differential diagnosis for this patient, he never ruled out any other possible causes for the symptoms but concluded it was toxic exposure mold without exploring any other causes.
11. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
12. When billing patient K.A. for his January 2001; February 20, 2001; May 17 and 29, 2001; June 20, 2001; July 23, 2001; August 3, 2001, and September 24, 2001, office visits Respondent overbilled and/or improperly billed the patient. Respondent billed these visits as consultations. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed. Respondent double billed for EEG testing on January 25, 2001 and August 3, 2001. Respondent charged both a global charge and then again for the professional component charge for the August 3, 2001 EEG.
13. Respondent failed to properly file or submit his HCFA bills. In order to properly bill for services Respondent is required to sign his HCFA bills and have adequate medical records to support the billing, which he failed to do.

14. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
15. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #4 - Patient J.S.

1. Respondent examined Patient J.S. on December 13, 2000. J.S. had a significant medical history of explosive diarrhea, cramping, fever, night sweats, 65-pound weight loss in an 8-month period, loss of appetite, and smoking.
2. On December 13, 2000, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary except the chemical exposure test. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.

3. Respondent ordered an EEG on December 13, 2000. This test was ordered without a complete physical, neurological examination, clinical indication, patient history or complaints. This test is not medically indicated and is unnecessary and unreasonable.
4. J.S. had an elevated GGT on laboratory tests from Quest Laboratory from samples submitted on December 13, 2000. This may indicate some possible liver damage, Respondent never addressed this problem.
5. Despite the chemical exposure tests all coming back as normal, Respondent ordered treatment with IVIG for without meeting the medical and diagnostic criteria required before prescribing the treatment. The administration regimen prescribed by Respondent for IVIG is not proper, The Respondent prescribed one dose of IVIG to be administered every week for twelve weeks. The standard of care is administration of IVIG is one dose every three to four weeks.
6. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam. The billing for medical services provided to J.S. is excessive. This was not within the standard of care.
7. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
8. Respondent failed to make any differential diagnosis for this patient, he never ruled out any other possible causes for the symptoms but concluded it was chemical exposure mold without exploring any other causes.

9. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
10. When billing patient J.S. for his December 2000 office visit, Respondent overbilled and/or improperly billed the patient. Respondent billed this visit as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate.
11. Respondent failed to properly file or submit his HCFA bills. In order to properly bill for services Respondent is required to sign his HCFA bills and have adequate medical records to support the billing, which he failed to do.
12. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
13. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #5 - Patient M.S.

1. On June 26, 2001, Respondent evaluated Patient M.S. for possible mold exposure. M.S. had a significant medical history that included an evaluation by 2 ENT specialists for cough symptoms of 2 years duration. In October 2000, M.S. had prior diagnostic testing including chest x-ray, pulmonary function tests, barium swallow, and allergy testing. The diagnosis in October of 2000 was cough secondary to allergic rhinitis.
2. On June 26, 2001, Respondent saw and diagnosed M.S. with "exposure to molds, cough-chronic, headaches, abnormal neurological exam, allergies, and blurred vision."
3. On June 26, 2001, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.
4. On June 26, 2001, Respondent ordered the following neurological tests EEG, CPT, BAER, Audiometry, VER, Somatosensory Evoked Response (SSEP), and a Visual Color Examination. All these tests were ordered without a complete physical and neurological examination being performed or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
5. The diagnosis Respondent made medically and scientifically unsupported findings of "toxigenic mold exposure."

6. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam. The billing for medical services provided to M.S. is excessive. This was not within the standard of care.
7. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
8. Respondent failed to make any differential diagnosis for this patient, he never ruled out any other possible causes for the symptoms but concluded it was toxic exposure mold.
9. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
10. When billing patient M.S. for her June 26, 2001, and August 8, 2001, office visits Respondent overbilled and/or improperly billed the patient. The office visits on these two days were coded as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed. This is overbilling.
11. Respondent failed to properly file or submit his HCFA bills. In order to properly bill for services Respondent is required to sign his HCFA bills and have adequate medical records to support the billing, which he failed to do.
12. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent

are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

13. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.
14. On a number of occasions Respondent recorded visits as consultations, when there was no referral. Respondent billed these as consultations, which requires a referral and is a higher level of service than a follow-up visit. The use of a higher level of service is inconsistent with proper CPT coding practices. The practice of billing a service using a higher CPT code to increase reimbursement is term upcoding and not within standard of care.

Allegation #6 - Patient MT

1. On February 8, 2002, Respondent examined Patient M.T. for symptoms related to alleged toxic mold exposure. M.T.'s medical history was significant for fatigue, memory disturbances, depression, anxiety, headaches, sleep disturbances, visual changes, muscle aches/weakness, flu like illnesses, nose bleeds, shortness of breath, numbness and tingling to back of head that radiates to shoulder.
2. On February 8, 2002, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Even though these tests were canceled they are not

medically necessary they should not be ordered and this constitutes unprofessional conduct.

3. On February 8, 2002, Respondent ordered the following neurological tests: EEG, BAER, VAER, PFT and NCV. All these tests were ordered without a complete physical and neurological examination being performed or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
4. Respondent's diagnosis is made without completing a differential diagnosis and without performing any diagnostic or laboratory tests for any type of toxic exposure including mold. Respondent's failure to make any differential diagnosis for this patient, and never ruling out any other possible causes for the symptoms but concluding it was toxic exposure mold is below the standard of care.
5. The finding of toxic mold exposure is found despite a "Mold Contamination & Assessment Report" that indicates air samples in the home, "identified that total fungal spore concentrations were within the range of values typically measured in residences and lower than the equivalent outdoor counts." Respondent had this report to review on the day of the exam.
6. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam.
7. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.

8. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
9. When billing patient M.T. for his February 8, 2002, office visit Respondent overbilled and/or improperly billed the patient. Respondent billed this visit as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed.
10. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
11. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #7 - Patient MT2

1. On February 8, 2002, Respondent examined Patient M.T2., the daughter of Patient M.T., for symptoms related to alleged toxic mold exposure. M.T2.'s medical history was significant for fatigue, memory disturbances, depression, anxiety, personality changes, mood swings, headaches, sleep disturbances, visual

changes, muscle aches/weakness, bruises easily, allergies, fevers, dry eyes and mouth and lower back pain.

2. On February 8, 2002, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Even though these tests were canceled they are not medically necessary they should not be ordered and this constitutes unprofessional conduct.
3. On February 8, 2002, Respondent ordered the following neurological tests: EEG, PFT, and NCV. All these tests were ordered without a complete physical and neurological examination being performed or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
4. Respondent's diagnosis is made without completing a differential diagnosis and without performing any diagnostic or laboratory tests for any type of toxic exposure including mold. Respondent's failure to make any differential diagnosis for this patient, and never ruling out any other possible causes for the symptoms but concluding it was toxic exposure mold is below the standard of care.
5. The finding of toxic mold exposure is found despite a "Mold Contamination & Assessment Report" that indicates air samples in the home, "identified that total fungal spore concentrations were within the range of values typically measured in residences and lower than the equivalent outdoor counts." Respondent had this report to review on the day of the exam.

6. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam.
7. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
8. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
9. When billing patient A.T. for his February 8, 2002, office visit Respondent overbilled and/or improperly billed the patient. Respondent billed this visit as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed.
10. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
11. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #7 - Patient AT

1. On February 8, 2002 Respondent examined Patient A.T., daughter of patient M.T., for symptoms related to toxic mold exposure. A.T.'s medical history was significant for fatigue, memory disturbances, depression, anxiety, personality changes, mood swings, headaches, muscle aches/weakness, allergies, dry eyes and mouth, back, chest and abdominal pain.
2. On February 8, 2002, Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There was no indication for these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Even though these tests were canceled they are not medically necessary they should not be ordered and this constitutes unprofessional conduct.
3. On February 8, 2002, Respondent ordered the following neurological tests: EEG, BAER, VAER, PFT and NCV. All these tests were ordered without a complete physical and neurological examination being performed or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
4. Respondent's diagnosis is made without completing a differential diagnosis and without performing any diagnostic or laboratory tests for any type of toxic exposure including mold. Respondent's failure to make any differential diagnosis for this patient, and never ruling out any other possible causes for the symptoms but concluding it was toxic exposure mold is below the standard of care.
5. The finding of toxic mold exposure is found despite a "Mold Contamination & Assessment Report" that indicates air samples in the home, "identified that total

fungal spore concentrations were within the range of values typically measured in residences and lower than the equivalent outdoor counts." Respondent had this report to review on the day of the exam.

6. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam.
7. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
8. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
9. When billing patient A.T. for his February 8, 2002, office visit Respondent overbilled and/or improperly billed the patient. Respondent billed this visit as a consultation. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed.
10. Respondent's billings for the excessive evaluations, excessive diagnostic and laboratory tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions of the Respondent are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

11. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #8 - Patient CB

1. Respondent treated Patient C.B. for multiple complex symptoms, and related probable immune dysfunction from November 1995 through April 2003. C.B.'s medical history was significant for complained of fatigue, memory problems, headaches, hair loss, depression, anxiety/mood swings, sharp pain in upper right quadrant, and chest tightness
2. From November 1995 until approximately May 1997, Respondent makes various diagnosis including, autoimmune disease, fatigue, headaches, mycosis, hypothyroidism and arthralgia. These diagnoses are made without complete physical examinations or adequate diagnostic testing.
3. Respondent placed C.B. on Sporanex in 1996 and continued this through July 2002, without adequate medical support or diagnosis.
4. On August 28, 2002, Respondent ordered the following neurological tests: EEG, BAER, VAER, Audiometry, SSEP and Visual Color Examination. All these tests were ordered without a complete physical and neurological examination being performed or clinical indication. These tests are not medically indicated and are unnecessary and unreasonable.
5. From November 1995 through March 2002, on at least four or more occasions Respondent ordered the laboratory tests through ImmunoScience Labs, Inc. each of these tests were medically unnecessary and are not generally accepted in the medical community as being valid diagnostic tests. There was no indication for

these tests based on an incomplete physical examination or patient history or complaints. This testing was excessive and not within the standard of care. Because these tests are not medically necessary they should not be billed, and this constitutes overbilling and unprofessional conduct.

6. The blood serum test result from 1995 through 2002 have inconsistent results that have no medically/clinically meaningful and are not generally accepted in the medical community to support Respondent's diagnosis.
7. On or about May 15, 1997 Respondent makes findings of "polyneuropathy;" and on November 28, 2001, of "sensory neuropathy." These findings are made without supporting medical and scientific evidence, and without meeting the criteria required before arriving at such a diagnosis. The Respondent failed to perform tests pursuant to the guidelines of the American Academy of Neurology in reaching his findings. This is below the standard of care.
8. The diagnosis Respondent made based on medically and scientifically unsupported findings of "polyneuropathy," or "sensory neuropathy" without meeting the criteria required before arriving at such a diagnosis. This is below the standard of care.
9. In April 2002, Respondent ordered treatment with IVIG for polyneuropathy or sensory neuropathy without meeting the medical and diagnostic criteria required before prescribing the treatment. The administration regimen prescribed by Respondent for IVIG is not proper. The Respondent prescribed one dose of IVIG to be administered every week for twelve weeks. The standard of care is administration of IVIG is one dose every three to four weeks.

10. Respondent failed to perform simple diagnostic testing prior to ordering extensive and inappropriate testing. The tests that were performed were improper and not indicated based on medical history or physical exam. The billing for medical services provided to C.B. is excessive. This was not within the standard of care.
11. Respondent failed to maintain adequate medical records to justify the necessity of the above listed diagnostic evaluations and testing.
12. Upon a report of mold being found in Respondent's residence, Respondent concluded it was toxic exposure, and failed to make any differential diagnosis for this patient. He never ruled out any other possible causes for the symptoms but mold without exploring any other causes.
13. The practice of ordering excessive and/or marginal tests without scientific and/or medical support is inconsistent with public health and welfare, represents non-therapeutic prescribing, and flagrant or persistent over-treating and over-charging, which is unprofessional conduct. This is below the standard of care.
14. When billing patient C.B. for her November 2001 and February 2002, office visit Respondent overbilled and/or improperly billed the patient. Respondent billed these visits as consultations. Because there was no referral from a primary care physician as required, this must be coded as an office visit, which is billed at a lower rate than Respondent billed. This is overbilling and unprofessional conduct.
16. When billing patient C.B. for her March 2002, June 2002, October 2002, and December 2002, office visit Respondents overbilled and/or improperly billed the patient. Respondent billed these visit as a Level V office visits. Level V require a prolonged face-to-face meeting. Respondent failed to conduct a prolonged face-to-face meeting. There is inadequate documentation to support this billing.

17. Respondent's billings for the excessive evaluations, excessive diagnostic tests, and consultations were improper, unreasonable, and/or for services not medically or clinically necessary. These actions are a violation of Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
18. Respondent improperly used Current Procedure Terminology (CPT) codes for services rendered by using incorrect or improper codes based on level of service rendered or performed.

Allegation #9 - Misleading Advertisement

1. Respondent has posted on his website the following certifications:

American Board of Family Practice;
American Board of Forensic Medicine; and
American Board of Forensic Examiners.
2. These claims of certification are misleading because the American Board of Forensic Medicine and the American Board of Forensic Examiners are not included in the boards of the American Board of Medical Specialties.
3. The American Board of Forensic Examiners is not a medical specialty board. It is open to members from many fields. There is no requirement for any medical training to receive this certification. The American Board of Forensic Medicine is a part of the American Board of Forensic Examiners for MD's and DO's.

4. The patient untrained in either medicine or law would have difficulty determining the qualifications of the Respondent. The general public would be misled by the Respondent's advertising his certification by the American Board of Forensic Examiners and the American Board of Forensic Medicine.

Respondent's treatment and testing of these patients demonstrates a pattern of inadequate medical history and examination to substantiate the diagnoses listed. The testing ordered and conducted is excessive and medically unrelated to the patient's chief complaints. Many of tests are not supported by history, complaints or findings in the patient's records. Respondent's relies on theories, opinions that have no scientific support, peer reviewed studies, and are not generally accepted medical studies. There is no literature, testing or studies that has demonstrated a causal connection between mold exposure and neurological diseases and the other vague non-specific symptoms Respondent's attributes to mold.

Many of the charges are excessive. Documentation guidelines regarding level of service were not met to support the billing or the coding of bills. Respondent upcoded charges by charging more for the level of service indicated in the medical records. Respondent misuses CPT codes. Consultations were coded billed improperly in all cases. Offices visits were coded at higher levels than documentation could support. This is deceptive billing and unprofessional conduct. Respondent also is deceptive in his claims of certification on his website.

This practice demonstrates a potential for patient harm, economic harm to the patients or entity, increased potential to harm the public through this continuing pattern of practice, attempted concealment of the conduct, the conduct was premeditated, intentional conduct, and was motivated for enrichment of Respondent with a disregard for patient well-being, this pattern shows likelihood of similar future conduct, all of which increase the potential harm and seriousness of the violations.

V. Applicable Statutes, Rules, and Agency Policy

Respondent's conduct, as described above, constitutes grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any other authorized means of discipline upon the Respondent. The following Statutes, Rules, and Agency Policy are applicable to this matter:

A. PROCEDURES FOR THE CONDUCT OF THIS HEARING:

1. Section 164.007(a) of the Act requires that the Board adopt procedures governing formal disposition of a contested case before the State Office of Administrative Hearings.
2. 22 TEX. ADMIN. CODE, Chapter 187 sets forth the procedures adopted by the Board under the requirement of Section 164.007(a) of the Act.
3. 1 TEX. ADMIN. CODE §155.3(c) provides that the procedural rules of the state agency on behalf of which the hearing is conducted govern procedural matters that relate to the hearing as required by law, to wit: Section 164.007(a) of the Act, as cited above.
4. 1 TEX. ADMIN. CODE, CHAPTER 155 sets forth the rules of procedure adopted by SOAH for contested case proceedings.

B. VIOLATIONS WARRANTING DISCIPLINARY ACTION:

1. Respondent is subject to disciplinary action pursuant to Section 164.051(a)(1) of the Act based on Respondent's commission of an act prohibited under Section 164.052 of the Act.
2. Respondent is subject to disciplinary action by the Board pursuant to Section 164.051(a)(6) of the Act by failing to practice medicine in an acceptable professional manner consistent with public health and welfare.
3. Board Rule 190.8(1)(a) provides that the failure to practice medicine in an acceptable manner consistent with public health and welfare includes the failure to treat a patient according to the generally accepted standard of care.

4. Respondent has committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(5) of the Act by prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.
5. Respondent has committed a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act based upon unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.
6. Respondent has committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(1) of the Act by Respondent's commission of an act that violates any law of this state if the act is connected with Respondent's practice of medicine. In accordance with Section 164.053(b), a complaint, indictment, or conviction of a violation of law is not necessary for enforcement of Section 164.053(a)(1).
7. Respondent has committed a prohibited act or practice within the meaning of Section 3.08(4)(G) of TEX. REV. CIV. STAT. ANN. art. 4495(b) by violating section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.
8. Respondent has committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(7) of the Act by violating Section 311.0025 of the Texas Health & Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

9. Respondent has committed a prohibited act or practice, and is subject to discipline pursuant to Sections 101.203 of the Act, which provides that a health care professional may not violate Section 311.0025 of the Health and Safety Code.

C. SANCTIONS THAT MAY BE IMPOSED

1. Section 164.001 of the Act authorizes the Board to impose a range of disciplinary actions against a person for violation of the Act or a Board rule. Such sanctions include: revocation, suspension, probation, public reprimand, limitation or restriction on practice, counseling or treatment, required educational or counseling programs, monitored practice, public service, and an administrative penalty.
2. Chapter 165, Subchapter A of the Act sets forth statutory requirements for the amount and basis of an administrative penalty.
3. 22 TEX. ADMIN. CODE § 187.39 authorizes the Board to assess, in addition to penalty imposed, costs of the investigation and administrative hearing in the case of a default judgment or upon adjudication that Respondent is in violation of the Act after a trial on the merits.
4. 22 TEX. ADMIN. CODE Chapter 190 provides disciplinary guidelines intended to provide guidance and a framework of analysis for administrative law judges in the making of recommendations in contested licensure and disciplinary matters and to provide guidance as to the types of conduct that constitute violations of the Act or board rules. The 190 guidelines also include a list aggravating factors that need to be considered in making a sanction recommendation. The aggravating factors present in this case include harm to the patient and severity of harm, economic harm to the patient and the severity, attempted concealment of conduct, prior misconduct, disciplinary history, and relevant circumstances increasing the seriousness of the misconduct.

VI. NOTICE TO RESPONDENT

IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS NOTICE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHING 20 DAYS OF THE DATE NOTICE OF SERVICE WAS MAILED, A DEFAULT JUDGMENT MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. IF YOU FILE A WRITTEN ANSWER, BUT THEN FAIL TO ATTEND THE HEARING, A DEFAULT JUDGMENT MAY BE ENTERED AGAINST YOU, WHICH MAY INCLUDE THE DENIAL OF LICENSURE OR ANY OR ALL OF THE REQUESTED SANCTIONS INCLUDING THE REVOCATION OF YOUR LICENSE. A COPY OF ANY RESPONSE YOU FILE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ALSO BE PROVIDED TO THE HEARINGS COORDINATOR OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS.

PURSUANT TO 22 TEX. ADMIN. CODE § 187.27(2), A WRITTEN ANSWER SHALL SPECIFICALLY ADMIT OR DENY EACH FACTUAL ALLEGATION MADE AGAINST THE RESPONDENT.

WHEREFORE, PREMISES CONSIDERED, Board Staff requests that an administrative law judge employed by the State Office of Administrative Hearings conduct a contested case hearing on the merits of the Complaint, in accordance with Section 164.007(a) of the Act. Upon final hearing, Board Staff requests that the Honorable Administrative Law Judge issue a Proposal for Decision ("PFD") that reflects Respondent's violation of the Act as set forth in this Complaint. Following issuance of the PFD, Board Staff requests that the Board enter an Order to revoke or suspend Respondent's medical license or that any other means of discipline authorized by statute be imposed.

Board Staff further requests that the Board assess, in addition to any administrative penalty imposed, the costs of the Administrative hearing.

Respectfully submitted,

TEXAS MEDICAL BOARD

By:

Scott M Freshour

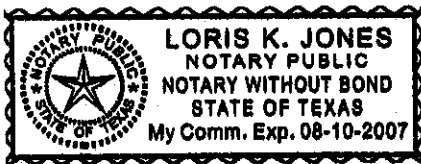
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THE STATE OF TEXAS

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§
§

COUNTY OF TRAVIS

SUBSCRIBED AND SWORN to before me by the said Scott M. Freshour on February
10, 2006.



Loris K Jones
Notary Public, State of Texas

Filed with the Texas Medical Board on February 10, 2006.

Jerry Walker
Jerry Walker
Deputy Executive Director
Texas Medical Board

CERTIFICATE OF SERVICE

I hereby certify that on this the 10th day of February, 2006, a true and correct copy of the Second Amended Complaint has been served on the following individuals at the locations and in the manner indicated below:

VIA HAND DELIVERY/PERSONAL SERVICE

Ace Pickens
Brown McCarroll, L.L.P.
111 Congress Ave., Ste. 1400
Austin, Tx 78071
Attorney for Andrew William Campbell, M.D.

VIA COURIER DELIVERY

Docket Clerk
State Office of Administrative Hearings
William P. Clements Building
300 West Fifteenth Street, Room 502
Austin, Texas 78701

VIA HAND DELIVERY

Hearings Coordinator
Texas Medical Board
33 Guadalupe, Tower 3, Suite 610
Austin, Texas 78701



Scott M. Freshour