

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

FINAL ORDER AFTER REMAND

During open meeting at Austin, Texas, the Texas Medical Board ("Board") finds that after proper and timely notice was given, the above-styled case was heard by Administrative Law Judges ("ALJ") at the State Office of Administrative Hearings ("SOAH"). ALJ Paul Keeper and ALJ Sarah Ramos presided over the case, and prepared a Proposal For Decision ("PFD"), containing proposed Findings of Fact ("F of F") and Conclusions of Law ("C of L"). The PFD was properly served on all parties, and all parties were given an opportunity to file exceptions and replies as part of the record herein. Both parties filed exceptions to the PFD and replies to the exceptions. The ALJs, after due consideration of these exceptions and replies, issued Amended Findings of Facts and Conclusions of Law that were properly served on all parties.

The Board, after review and due consideration of the PFD, exceptions to the PFD, and replies to exceptions, adopted the Amended Findings of Fact and Conclusions of Law of the ALJs, with the exception of Finding of Fact No. 187, on June 6, 2007 ("2007 Final Order").

The enforcement of the 2007 Final Order was the subject of an injunction. The injunction prohibited the Board from enforcing the 2007 Order against Respondent until the administrative appeal was heard.

The administrative appeal was heard on November 21, 2008, by the Travis County District Court. A ruling on the administrative appeal was entered on July 2, 2009. A Final Order was issued by the presiding Judge Triana-Doyal on July 2, 2009. The Final Order reversed the Board's order in part and remanded to the Board; however, the remainder of the Board's decision and Order was supported by substantial evidence. The Final Order stated that certain sanctions and a conclusion of law were not supported by the record. The Board acting consistent with the

order of the District Court entered an Amended Final Order on November 6, 2009 (Amended Final Order).

Subsequent to the entry of the Amended Final Order, Respondent filed an appeal of that Amended Final Order in Travis County District Court. The administrative appeal was heard on November 8, 2010, by the Travis County District Court, Judge Triana-Doyal presiding. Judge Triana-Doyal heard the previous appeal on this matter. Judge Triana-Doyal issued a Final Judgment on March 4, 2011. The Final Judgment reversed the Board's Final Amended Order in part and remanded to the Board; however, the remainder of the Board's decision and Final Amended Order was supported by substantial evidence.

Specifically, Judge Triana-Doyal ruled that the assessment of the transcript cost of \$8,396.50, in the Final Amended Order was not proper. Judge Triana-Doyal specifically found that the remainder of the Amended Final Order was supported by substantial evidence.

The Board is herein entering a Final Order, after remand consistent with the ruling articulated in the Final Order of the District Court issued on March 4, 2011. The Board, consistent with Judge Triana-Doyal's Final Judgment, is removing the requirement for Respondent to pay the transcript cost of \$8,396.50. The other change is adjustment of the starting date and payment schedule of the administrative penalty of \$64,000.00.

FINDINGS OF FACT

1. Andrew William Campbell, M.D., Respondent, is a licensed Texas physician with a medical office in Spring, Texas, near the Houston Intercontinental Airport.
2. Dr. Campbell is a board-certified family practitioner who practices exclusively in the area of clinical immunotoxicology.
3. Dr. Campbell treats patients with a history of exposure to toxic substances, including molds and chemicals.
4. Dr. Campbell has been the primary or contributing author in more than four dozen articles or chapters of texts on medical topics, many on the subject of human toxicologic responses and immunological disease. He has presented over sixty lectures on similar topics.
5. Dr. Campbell has served as the chairman of the board of trustees of Sam Houston Memorial Hospital (Houston), was a founder of the St. John Vianney Clinic for the Indigent (Houston), and served as a member of the executive committees of the Texas Academy of Family Physicians, the Georgia Academy of Family Physicians, and the Medical College of Georgia.

6. From 1985 to 1995, Dr. Campbell received the American Medical Association's Physician's Recognition Award in Continuing Medical Education, and in 1994 received a Consumer's Choice Award as one of fifteen outstanding physicians in Harris County. He serves as a member of the medical staff of Memorial City Medical Center (Houston), Spring Branch Medical Center (Houston), and South Texas Health Care System (Harlingen).
7. Dr. Campbell is referred patients from other physicians, the Department of Defense, the National Institutes of Health, the Department of Labor, the National Institutes of Dental Research, environmental engineers, attorneys, and state and local health departments.
8. Dr. Campbell is involved in medical research, lecturing, and publishing in the field of immunotoxicology.
9. Dr. Campbell's intake procedure is unusually thorough and may last for a period of four hours.
10. Dr. Campbell or his staff review the patient's medical and surgical history, pharmacological history, work history, and history of exposure to mold and toxic substances. His patients are required to submit all prior medical records or to authorize the release of their medical records by their current or former treating physicians.
11. Each patient is given a physical examination, including a neurological evaluation.
12. Dr. Campbell orders highly specialized blood tests, many of which are available only through ImmunoSciences Laboratory (ISL) of Los Angeles, California, to determine exposure to toxic substances.
13. Dr. Campbell uses these specialized tests to determine whether his patients have developed IgG, IgA, IgM, and IgE antibodies for specific molds, chemicals, bacteria, and other substances.
14. Dr. Campbell's use of ISL antibody testing is sufficiently frequent that ISL created panels of antibody tests with his name. Campbell's Auto-Immune Panel includes antibody tests for Anti-Nuclear AB by Hep-2, Anti-Native DNA, Anti-SSA, Anti-SSB, Anti-SM, Anti-RNP, Anti-Centromere, Anti-Striated Muscle, Anti-Smooth Muscle, and Rheumatoid Factor. Campbell's Fungal 1 Panel includes IgG and IgE antibody tests for *Histoplasma*, *Blastomyces*, and *Coccidioides*. Campbell's Fungal 2 Panel includes IgG and IgE antibody testing for *Asper niger*, *Asper fumigatus*, *Cladosporium herbarium*, *Alternaria tenuis* +A, *Pencillium notatum*, *Phoma herbarium*, *Rhodotorula glutinis*, *Epicoccum nigrum*, *Geotrichum candidum*, *Pullularia pullulans*, and *Rhizopus nigricans*.
15. Dr. Campbell also orders and performs tests for neurological injuries that may have resulted from toxic exposure.

16. These tests may include an electroencephalogram (EEG), a brain stem auditory evoked potential (BAEP), brain stem auditory evoked response (BAER), a visual evoked potential (VEP), a visual evoked response (VER), a color blindness test, a somatosensory evoked potential (SSEP) test, or a nerve conduction velocity test (NCV). Dr. Campbell may also conduct a pulmonary function test (PFT).
17. Dr. Campbell's treatments for toxic exposure include Sporanox, a prescription medication for fungal infections, and infusions of intravenous immunoglobulin (IVIg), a refined human blood product.
18. At the conclusion of the first patient meeting but before any non-office testing is ordered, Dr. Campbell meets with the patient to outline the scope of his initial assessment of his or her medical condition, his recommendations about the need for further testing and possible treatment, and the total projected costs. Patients may ask additional questions and decide whether to agree to proceed immediately or to consider their options further.
19. If the patient agrees to proceed, then Dr. Campbell schedules the tests as soon as possible.
20. Tests are usually completed within three or four weeks of the initial patient meeting.
21. After tests are completed, Dr. Campbell makes a diagnosis based on his review of all of the information available to him, including previous medical records, physical examination, and test results. Dr. Campbell then meets with the patient again and gives his diagnosis and treatment recommendations.

Diagnostic and treatment overview:

22. A number of types of molds are capable of causing human health problems, including illness and death.
23. The methods by which some molds cause human health problems depend upon the inherent properties of the molds themselves, their byproducts (including toxins that they may produce), and the sensitivities of the individuals who are exposed to them.
24. Among the hundreds of thousands of molds in the biosphere, some number produce mycotoxins.
25. Molds suspected of being toxigenic include *Penicillium*, the *Aspergillus* organisms, *Cladosporium*, *Alternaria*, and *Stachybotrys chartarum*.

26. Although mold exposure may cause allergic reactions, upper or lower respiratory reactions, or hypersensitivity pneumonia, the relation between illness and mold is still under investigation.
27. Proper diagnostic testing for mold infestation may include an environmental assessment of a patient's environment.
28. If the presence and types of mold have been identified, then a physician may order tests of the patient's body to determine whether the patient has registered any reactions or responses to the exposure.
29. In examining individual human responses, a physician may test a patient for the presence and type of antibodies produced by a patient's immunological system in response to mold.
30. Virtually all humans have been exposed to molds, and mold antibodies persist in the blood for months after exposure to an antigen.
31. The daily exposure to molds results in the restimulation of antibodies.
32. Routine blood serum testing is not a generally accepted means of assessing a patient's exposure to mold.
33. The U.S. Food and Drug Administration (FDA) has not established minimum or maximum limits for serum test results on mold-related antibodies.
34. Some testing laboratories, including ISL, have established their own standard ranges.
35. Although test results may accurately reflect the presence and levels of mold-related antibodies in a patient's blood, no governmentally accepted standards have been established to determine whether the results are within or outside acceptable limits.
36. No standards have been established for testing the presence of mycotoxins through serological assay.

37. More work is needed to confirm the strength of the association between levels of the antibodies and conclusions about the probability of health impairment.
38. Myelin basic protein testing has no validity within the neurological community in confirming peripheral neuropathy or in determining the presence of any neurological disease in general.
39. In patients in whom a physician provisionally identifies a serious neurological disease, the physician may be required to administer a combination of tests to make a confirming diagnosis.
40. A test for deep tendon reflexes produces subjective information that may be of value to the physician in making an initial assessment of the patient's neurological condition.
41. A finding of decreased deep tendon reflexes has no medical significance in the absence of other tests to confirm neurological impairment.
42. There is no neurological significance to bilateral pupil sluggishness following the removal of a light stimulus; unilateral sluggishness may indicate a benign neurological disorder.
43. A simple PFT measures a patient's ability to move air in and out and measures the volume of air that is moved.
44. A valid test is one in which the patient's performance is within five percent of each of three efforts.
45. PFT equipment is required to be calibrated daily.
46. The use of both a nerve conduction velocity (NCV) test and an electromyogram (EMG) is required to make a definite diagnosis of polyneuropathy under the generally accepted standard of care for a reasonably prudent physician.
47. Most neurologists have abandoned the use of the electroencephalograph (EEG) as a diagnostic tool except in assessing altered states of consciousness and epilepsy.

48. A subgroup of electroencephalography is neurometric or quantitative encephalography (QEEG).
49. A QEEG test compares the average number of certain types of brain waves that occur in different parts of the brain.
50. A QEEG test provides no specific diagnostic advantage over a standard EEG test and is used primarily for investigational purposes.
51. A neurometer is used to diagnose neuropathy through the use of vibratory sensations.
52. Evoked potential, evoked response, and somatosensory studies provide data about sensory impairments in the auditory nerves, the optic nerves, and in other parts of the body; the studies have been largely abandoned and have limited utility in only a few circumstances.
53. The most common treatment for symptoms associated with a patient's exposure to mold is isolation: either the removal of the patient from the mold-infused environment or the removal of the mold from the environment.
54. For mold-related human health problems that are not controlled by simple isolation, medications are available, including Sporanox, a prescription medication and antifungal agent that is used to treat a wide variety of mold infections.
55. Sporanox is used for the treatment of infection and not for the treatment of mere exposure to mold.
56. Exposure and infection are substantially different conditions and require different types of treatment.
57. The human blood product IVIg is used in the treatment of a limited number of neurologic disorders; mold-related health problems are not among them.
58. In the treatment of neurologic diseases, IVIg is typically used in treating Guillain-Barré (the rapid onset of weakness following some type of infectious process) and is

also used on a first-time basis to treat chronic inflammatory demyelinating polyneuropathy (CIDP).

59. As a human blood product, IVIg contains the limited risk of transmitting hepatitis or AIDS; although blood products are screened, the production of a unit of IVIg requires the pooling of the plasma of 20,000-50,000 donors.
60. A small number of patients have been reported to have had adverse reactions to the medication, including heart failure and renal failure.
61. IVIg is in limited supply; the prescription of IVIg for some patients may deny other patients the opportunity to receive IVIg.
62. IVIg is expensive; the typical charge for a single infusion is \$3,000-\$5,000, and the typical course of therapy involves multiple infusions.
63. The standard dose of IVIg for treatment of a neuropathy is two grams per kilogram.
64. Medical opinions vary widely about the utility of IVIg in the treatment of neuropathy.

Patient GF:

65. GF was born in 1943 and began working as a welder before 1960; he smoked 1-1/2 to 2 packs of cigarettes daily for more than thirty years. Since 1983, GF had a history of urinary tract infections, emphysema, and upper respiratory problems.
66. Dr. Campbell saw GF in 1993 at the request of an attorney for the purpose of evaluation of toxic exposure during his employment.
67. Dr. Campbell ordered a panel of highly specialized ISL blood tests and recommended that he see his local physician for a colonoscopy.
68. Dr. Campbell reported to the attorney that GF had "metal fume fever," a condition caused by toxic exposure metal fumes; Dr. Campbell also reported to GF that, based on his antibody test results, GF might have an ongoing parasite infection, *Toxoplasma gondii*.
69. In 2000, Dr. Campbell conducted sensory nerve conduction threshold testing (SNCT) and ordered additional blood assays for GF.

70. Following GF's office visit in 2000, Dr. Campbell issued an invoice to GF's health coverage carrier for a Level V consultation for a new patient, neurometry at fourteen sites, and specialized blood tests; the charge was \$11,064.00.
71. GF's problems did not include neuropathy.
72. For Patient GF, Dr. Campbell's: (1) ordering the battery of tests from ISL was not within the standard of care, and (2) failure to address GF's need for care of more pressing medical problems (other than potential neurological impairment) was not within the standard of care.

Patient JS:

73. JS worked as a diver and welder/brazier metallurgist for twenty years.
74. As part of his work, JS was exposed to metal fumes, chemicals, acids, grindings, and x-rays, and for many years he used no safety equipment.
75. In 1999, JS was hospitalized twice for extreme stomach cramps and explosive diarrhea.
76. JS' physicians were unable to determine the cause of his problems.
77. By the end of 1999, JS was also suffering from night sweats, low-grade fevers, fatigue, and weight loss.
78. In 2000, JS was examined by a number of physicians, none of whom could diagnose or successfully treat his condition.
79. In December 2000, Dr. Campbell examined JS and ordered a series of serological assays from ISL; the charge for the laboratory work and day's services, including a Level V consultation, was \$11,400.00.
80. Dr. Campbell found elevated total cholesterol, gamma glutamyl transferase (GGT), T-3 uptake, protein band in the gamma globulins, white blood cell count, red blood cell count, mean cell hemoglobin (MCH), absolute neutrophils, IgG immune complex, IgA myelin basic protein, and percentages of T3 positive cells, CD3+ and CD26+ cells; the percentage of JS' immunocompetent NKHT3+ cells were diminished.
81. Dr. Campbell diagnosed JS' problem as a severe gastrointestinal type problem and prescribed twelve weeks of IVIg infusions with B12 and B complex as part of the infusion fluid.
82. JS cancelled the scheduled IVIg infusions before they began.

83. For Patient JS, Dr. Campbell's reliance on an expensive course of antibody testing was not within the standard of care, and Dr. Campbell's ordering of IVIg treatments was not within the standard of care.

Patient MS:

84. Dr. Campbell examined MS, a 38-year-old white female, five months pregnant, in 2001.
85. MS complained of fatigue, sleep disturbance, frequent unusual nightmares, headaches, blurred vision, lightheadedness with cough, sores that would not heal, bruising easily, recurrent flu-like illnesses, bloody discharge from nose, and coughing to the point of choking.
86. MS was concerned about potential threats to her health and the health of her fetus because she had seen mold growing in a leaky window at her office, and her husband's office building had been quarantined for mold.
87. Dr. Campbell found deep tendon reflexes diminished in both upper extremities and ordered an audiometry test, color deficiency test, urinalysis, PFT, an Immuno Tox fungal battery of tests, a comprehensive bioscan, a urinalysis, and testing for IgA, IgM, IgG, and IgE; the fee for the tests and services was \$9,775.00.
88. Dr. Campbell determined that MS did not have a problem related to toxicity to molds or mycotoxins.
89. MS' conditions did not require the type of testing ordered by Dr. Campbell.
90. For Patient MS, Dr. Campbell's ordering of extensive laboratory tests and neurological tests was not medically necessary and was below the standard of care.

Patient CB:

91. Dr. Campbell examined CB, a 46-year-old woman, in October 1995, and diagnosed her condition as immune dysregulation and chronic mycosis.
92. At the time of her diagnosis, CB already had an extensive medical history that included diagnoses and treatments from a gastroenterologist, urologist, internist, cardiologist, and rheumatologist.
93. Dr. Campbell ordered tests for antibodies, myelin basic protein, phospholipid antibodies, Natural Kill (NK) cell activity, lymphocyte subpopulation, percentage of T3 positive cells, T-helper/T-suppressor ratio, T and B Cell Function, and DHEA sulfate serum.

94. Dr. Campbell prescribed Sporanox twice in 1996, but CB discontinued using it following adverse reactions.
95. In 2001, CB returned to Dr. Campbell's care, after having been under the care of an endocrinologist and a neurologist.
96. Dr. Campbell ordered a new series of laboratory tests, including a fungal panel, comprehensive bioscan, and antibody testing; the charge for these new services was \$7,879.00, including a Level V consultation.
97. In 2002, Dr. Campbell: (1) ordered several additional series of laboratory testing, including another fungal panel and comprehensive bioscan, (2) diagnosed CB's conditions as inflammation, toxic neuropathy, malaise, and fatigue, and (3) ordered twelve weeks of IVIg therapy.
98. CB had an adverse reaction to the administration of IVIg.
99. After the IVIg therapy, CB reported the same list of symptoms and conditions with which she had been presenting for several years.
100. In June 2002, mold was found in CB's home, and Dr. Campbell began treating CB with Sporanox again.
101. In August 2002, Dr. Campbell treated CB for many of the same symptoms that she had experienced in previous years and again ordered a number of laboratory tests; CB's charges, including a Level V office visit, were \$9,090.00.
102. In September, October, November, and December 2002, Dr. Campbell prescribed Sporanox for a variety of symptoms and complaints and ordered additional neurological and serological testing.
103. For Patient CB, Dr. Campbell's prescription for the antibody tests and for IVIg therapy was neither warranted nor within the standard of professional care.

Patient KA:

104. KA was a 41-year-old woman who worked with her husband in their home where they operated a rubber stamp manufacturing business.
105. KA and her husband moved into their home with their children in 1994, and she began to have nosebleeds and sinus problems.
106. In 1995, KA's family began remodeling their home, and in December of that year the bathroom suffered water damage.
107. In December 1997, KA's home experienced additional water damage during a storm.

108. A professional engineering firm found fungal growth in various rooms and *Stachybotrys*, *Aspergillus/Penicillium*, and *Cladosporium* fungi growing in the house.
109. In December 2000, Dr. Campbell examined KA and conducted an EEG test, spirometry, and ordered laboratory and neurological testing; the amount charged for this first visit was \$11,459.00.
110. The laboratory testing ordered by Dr. Campbell from ISL included: Anti-Nuclear AB by Hep-2, Anti-Native DNA, Anti-SSA, Anti-SSB, Anti-SM, Anti-RNP, Anti-Centromere, Anti-Striated Muscle, Anti-Smooth Muscle, and Rheumatoid Factor.
111. In February 2001, Dr. Campbell prescribed IVIg once a week for twelve weeks.
112. KA had an adverse reaction to the IVIg and went to a hospital emergency room.
113. In July 2001, Dr. Campbell ordered a series of neurological tests for KA and in August 2001 ordered additional serological studies.
114. Dr. Campbell's identification of KA's symptoms and conditions included alopecia, chest pain, dysuria, hypogammaglobulinemia, and multiple, opportunistic mycoses.
115. Nothing in KA's medical history or physical examination supported a conclusion that KA was suffering from mycosis, any other mold-related disorders, or hypogammaglobulinemia.
116. Nothing in Dr. Campbell's medical records for KA connected the mold in the home to a mold-mediated problem with her health.
117. The ISL tests for antibodies were inappropriate.
118. Nothing in KA's medical records supported the need for antibody testing, the prescription for IVIg, or the neurological tests.

Patient TA:

119. TA was a nine-year-old boy when his mother, KA, first made contact with Dr. Campbell in December 2000.
120. TA had a history of frequent sinus problems, colds, and asthma since birth.
121. TA had been seen by his pediatrician forty times in the 39 months between September 1991 and December 1994.
122. TA had positive skin test results for some allergies.

123. In January 2001, Dr. Campbell examined TA in his office.
124. TA's reported symptoms and conditions at the time of the initial consultation included: fatigue, attention deficit disorder, frequently saying the wrong word, personality changes, mood swings, sleep disturbance, frequent unusual nightmares, headaches, severe nasal and other allergies, cough, easily getting out of breath, symptoms worsened by extremes in temperature, and multiple sensitivities to medicine, food, and other substances.
125. Dr. Campbell ordered neurometry at 14 nerve sites, a PFT with interpretation, a urinalysis, and a battery of neurological and blood tests, including Campbell's Fungal Panels 1 and 2 and other antibody testing; the charge for fees and laboratory tests was \$13,264.00.
126. Dr. Campbell diagnosed TA's condition as immune mechanism disorder, mycosis, and polyneuropathy due to toxic agent.
127. In February 2001, Dr. Campbell recommended an MRI of TA's brain, IVIg infusions once a week for twelve weeks, and further office visits.
128. In May 2001, Dr. Campbell ordered an EEG and a PFT.
129. In August 2001, Dr. Campbell again diagnosed TA with mycosis, for which he prescribed Sporanox for six weeks.
130. Nothing connected the mold infestation in TA's home and TA's health problems.
131. Dr. Campbell should not have ordered the ISL testing because TA's neurological examinations were essentially normal.
132. TA's conditions did not warrant the ordering of an EEG to diagnose a neurological deficit.
133. Dr. Campbell should not have ordered neurological testing on TA.
134. TA did not have a neuropathic or polyneuropathic condition.

Patient MT:

135. MT, a 48-year-old white female, was the mother of MT2, age 21, and AT, age 16.
136. In February 2002, Dr. Campbell examined MT for allergies, stomach problems, gastritis, ulcers, a sore nose, and a sleep disorder.
137. An environmental study of MT's home in December 2001 showed elevated concentrations of many different types of spores, including *Aspergillus/Pencillium*,

Cladosporium, *Amerospores*, and *Stachybotrys*; MT and her family had moved out of the home, and a remediation program was initiated.

138. Dr. Campbell concluded that MT's mold exposure included exposure to toxigenic molds.
139. For MT2, Dr. Campbell ordered the following tests: blood chemistry, a complete blood count; T3 and TSH with reflex; urinalysis; EEG; antibody testing for IgA, IgM, IgG, and IgE; an Immuno Tox Fungal panel; NK Cell Function; IgG, IgM, and IgA immune complexes; C3/C4 complements; and a PFT; and an EEG, BAER, VEP, and NCV for all four quadrants. The charge for these services was \$9,632.00.
140. A few days after the office visit, MT cancelled the tests and filed complaints against Dr. Campbell about the amount of his bill for services.
141. Nothing in MT's records substantiated a toxigenic mold exposure.
142. The environmental assessment of MT's home did not support a conclusion that a toxigenic mold exposure had occurred.
143. Of the multiple ISL tests ordered, only the IgE test might have been useful as to determine allergies.
144. MT had no need for the neurological examinations.

Patient MT2:

145. MT2 was the 21-year-old daughter of MT.
146. MT2 reported she had a sore throat every morning upon waking, drainage every day, feeling as though she had the flu, wheezing with exercise, difficulty urinating, fatigue, and emotional highs and lows.
147. An environmental study of MT2's home in December 2001 showed elevated concentrations of many different types of spores, including *Aspergillus/Pencillium*, *Cladosporium*, *Amerospores*, and *Stachybotrys*; MT and her family had moved out of the home, and a remediation program was initiated.
148. Dr. Campbell concluded that MT2's mold exposure included exposure to toxigenic molds.
149. Dr. Campbell ordered the Immuno Tox Fungal panel, a comprehensive bioscan, antibody testing, urinalysis, and a PFT; the charge for these services was \$9,632.00.
150. MT2's symptoms were typical of a person suffering from asthmatic and allergic conditions.

151. Nothing in MT2's medical history or examination supported Dr. Campbell's ordering of the Immuno Tox Fungal panel or the antibody testing.

Patient AT:

152. AT was the 16-year-old daughter of MT and sister of MT2.

153. AT's first and only office visit with Dr. Campbell was in February 2001.

154. AT suffered from daily headaches that were unrelieved by over-the-counter medications, was tired and found difficulty in concentrating, complained of pain in her wrists and knees, and complained of chronic sore throats, wheezing, and shortness of breath.

155. An environmental study of AT's home in December 2001 showed elevated concentrations of many different types of spores, including *Aspergillus/Pencillium*, *Cladosporium*, *Amerospores*, and *Stachybotrys*; AT and her family had moved out of the home, and a remediation program was initiated.

156. Dr. Campbell concluded that AT's mold exposure included exposure to toxigenic molds.

157. Dr. Campbell ordered an EEG and testing for mold and mycotoxin antibodies; T and B cell functions; lymphocyte subpopulation; NK cell function; IgA, IgG, and IgM immune complexes; C3/C4 complements; a PFT; metabolic panel; CBC; serum immunoglobulins; and a thyroid panel. No out-of-range values were identified other than triglycerides, chloride, and carbon dioxide levels; the charge for these services was \$9,632.00.

158. Nothing in AT's medical record supported Dr. Campbell's conclusion that AT had been affected by a toxic mold exposure.

159. Nothing in AT's medical history or examination supported Dr. Campbell's ordering of the Immuno Tox Fungal panel or the antibody testing.

Consultation Codes:

160. The common procedure terminology (CPT) system is one of the American Medical Association's (AMA's) coding systems used for electronic medical billing.

161. CPT codes are five-digit numerical values developed and copyrighted by the AMA to describe medical procedures and tests.

162. Most CPT codes have a relative value unit to represent the amount of work and other expenses incurred by a physician, and the relative value unit is typically multiplied by a conversion factor to determine the actual payment for each of the CPT codes.
163. When a patient is referred by another physician or another appropriate source, such as an attorney, and the consultant sends a report to the referring source, the office visit may qualify as a consultation and be billed using one of the consultation codes.
164. Dr. Campbell billed consultation codes 99245 for each of the initial office visits for the nine patients considered in this proceeding and billed consultation codes 99244 and 99243 for a number of the follow-up office visits for those patients.
165. The nine patient files included neither a referral from an appropriate source nor a consultant's report from Dr. Campbell to the referring source.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
166. In 1993, Dr. Campbell wrote a detailed consultation report for GF's attorney.
167. Dr. Campbell knew what should be included in a consultation report.

Prolonged Office Visits:

168. A physician should, in his own handwriting, document the time he spends with a patient.
169. Dr. Campbell did not record how long he actually spent with any patient.
170. In order to support a bill for CPT code 99245, most physicians typically spend 80 minutes face-to-face with the patient and/or family.
171. CPT code 99354 may be billed for the first additional hour of a prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.
172. On February 8, 2002, Dr. Campbell charged MT and her daughters for the highest consultation code, 99245, for which he billed \$318 per person.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]

173. That same day, Dr. Campbell gave the T family a “discount” and did not charge for them a prolonged office visit CPT code.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011s]
174. After MT cancelled the tests, she and her daughters were charged \$192 per person for prolonged office visits, CPT code 99354.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
175. MT and her daughters’ appointments were scheduled at 7:30 a.m., 8:00 a.m., and 8:30 a.m. Someone on Dr. Campbell’s staff indicated that both daughters’ appointments ended at 11:00 a.m., and the mother’s appointment ended at 11:15 a.m.
176. Dr. Campbell admitted he was with MT and her daughters for about two-and-a-half hours.
177. By charging CPT code 99245 to each of the T family members, Dr. Campbell billed for 240 minutes, or four hours, of time.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
178. Dr. Campbell knew he did not spend more than four hours of time with the T family.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]

Unbundling:

179. On May 30, 2001, Dr. Campbell billed the following for services provided to TA:

\$135- CPT code 94010, spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), and/or maximal voluntary ventilation

\$160- CPT code 94375, respiratory flow volume loop

\$175- CPT code 99375, physician supervision of patients under care of home health agencies, hospice, or nursing facility patients (patient not present) requiring complex or multi-disciplinary care modalities involving regular physician development and/or revision of care plans

\$278- CPT code 95819, EEG

\$265- CPT code 95812, EEG extended monitoring (41-60 minutes)

\$356- CPT code 92585, auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

\$42- CPT code 99211, level I office or other outpatient visit

\$1,411 Total for May 30, 2001

[The Board does not adopt this Finding of Fact consistent with the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]

Sanctions:

180. A spirometry (94010) and flow volume curve test (94375) are the same test.
[The Board does not adopt this Finding of Fact consistent with Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
181. The charge for 99211 should have been included as part of the spirometry charge.
[The Board does not adopt this Finding of Fact consistent with the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
182. The harm caused to patients by Dr. Campbell's actions included KA's allergic pneumonic reaction to IVIg, CB's adverse reaction to Sporanox, and the lack of an accurate diagnosis for several of Dr. Campbell's patients' neurologic and allergic conditions.
183. Dr. Campbell's patients and their insurers incurred economic harm in paying for the many unwarranted laboratory and neurologic tests; the severity of the harm is measured in the tens of thousands of dollars paid.
184. Dr. Campbell has demonstrated a lifetime of public service including his work as a volunteer, community leader, and public educator.
185. Dr. Campbell conducted his practice to bring relief to his patients.
186. Dr. Campbell practices medicine by attempting to incorporate scientific values as part of a medical ethic.
187. The sanction for Dr. Campbell's violations should include: (1) continuing medical education about the legal obligations that accompany the physician-patient relationship; (2) a brief period of suspension; (3) a practice monitor to whom Dr. Campbell should demonstrate his understanding of the need to comply with the types of patient notification and medical practice revisions required by the Board; (4) an administrative penalty to reflect the fees charged for unnecessary services to patients; and (5) a public reprimand

The Board does not adopt, and deletes Finding of Fact 187, because it is not a proper finding of fact. Board Rule 190.2 states, "The appropriate sanction is not a proper

finding of fact or conclusion of law.” Tex. Occ. Code Section 151.003(2) states, ‘the board should remain the primary means of licensing, regulating and disciplining physicians.’ Tex. Occ. Code 164.007(a) states, “. . . After receiving the administrative law judge’s findings of fact and conclusions of law, the board shall determine the charges on the merits.” Board Rule 190.2 states, “. . . The Board shall render the final decision in a contested case and has the responsibility to assess sanctions against licensees who are found to have violated the Act.” Therefore, this finding of fact of is not proper and is deleted from the PFD. The Board, as delineated below, has determined the appropriate sanction in this case, consistent with its statutory authority.

Jurisdiction and Notice:

188. On May 17, 2004, the Board’s Staff filed its notice of hearing, including a statement of the time, place, and nature of the hearing, a statement of the legal authority and jurisdiction under which the hearing was to be held, a reference to the particular sections of the statutes and rules involved, and a short, plain statement of the matters asserted.
189. The hearing on the merits was convened on April 18, 2006, and was adjourned on April 28, 2006.
190. Staff attorneys Scott Freshour and Mark Martyn represented the Board’s Staff, and attorney Ace Pickens represented Dr. Campbell.
191. The administrative record was closed on August 11, 2006.

CONCLUSIONS OF LAW

1. The Board has jurisdiction to discipline its licensees pursuant to the Texas Medical Practices Act (Act), TEX. OCC. CODE ANN. chs. 151-165.
2. The State Office of Administrative Hearings has jurisdiction to hear this matter and issue a proposal for decision, including findings of fact and conclusions of law, pursuant to TEX. GOV’T CODE ANN. ch. 2003.
3. Dr. Campbell received adequate and timely notice of hearing in this matter and appeared at the hearing. TEX. GOV’T CODE ANN. §§ 2001.051 and 2001.052.
[The Board is adopting this conclusion of law as it relates to notice of all issues other than those related to informed consent and consultation visits as specified in the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
4. Dr. Campbell is subject to disciplinary action by the Board. Act § 164.052(a)(1).

5. The Board has adopted a set of aggravating and mitigating factors to guide its determination of an appropriate sanction if it finds that a sanction should be imposed. 22 TEX. ADMIN. CODE (TAC) §§ 190.14 and 190.15.
6. Dr. Campbell is subject to disciplinary action by failing to practice medicine in an acceptable professional manner consistent with public health and welfare. Act § 164.051(a)(6).
7. Dr. Campbell's 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. 22 TAC §190.8(1)(a).
8. Dr. Campbell engaged in 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 was nontherapeutic in the manner the drug or treatment was administered or prescribed.
9. Dr. Campbell engaged in a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act in engaging in unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.
[The Board is adopting this Conclusion of Law as it relates to all issues other than those related to informed consent and consultation visits as specified in the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
10. Dr. Campbell committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(1) of the Act by the commission of an act that violates any law of this state if the act is connected with Respondent's practice of medicine.
[The Board is adopting this Conclusion of Law as it relates all issues other than those related to informed consent and consultation visits as specified in the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
11. Dr. Campbell 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 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.
[The Board is adopting this Conclusion of Law as it relates to providing unnecessary treatment of patients with Sporanox and IVIG. This Conclusion of Law is supported by Findings of Fact Nos. 83; 103; 118; 129; and 130]
12. Dr. Campbell committed a prohibited act or practice and is subject to discipline pursuant to Section 101.203 of the Act, which provides that a health care professional may not violate Section 311.0025 of the Health Care and Safety Code.

[The Board adopts this Conclusion of Law as it relates to providing unnecessary treatment of patients with Sporanox and IVIG. This Conclusion of Law is supported by Findings of Fact Nos. 83; 103; 118; 129; and 130]

13. The Board is authorized to take disciplinary action if a physician commits unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public. Act § 164.052(a)(5).
[The Board is adopting this Conclusion of Law as it relates all issues other than those related to informed consent and consultation visits as specified in the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
14. Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action based on a physician's failure to practice medicine in an acceptable professional manner consistent with public health and welfare.
15. Reliance upon antibody testing—at its substantial cost to the patient and insurers—in the absence of testing first for other, more probable causes of illness and without established ranges of values, is not within the standard of care.
16. The use of a diagnostic test on a trial basis without prior disclosure to the patient of the unaccepted status of the test is not within the standard of care.
[The Board does not adopt this Conclusion of Law consistent with the Final Order of the 126th Judicial District Court of Travis County, Texas, dated July 2, 2009, and re-affirmed on March 4, 2011]
17. Quantitative electroencephalographic tests may be of investigational value for scientific purposes but are not within the standard of medical care absent a showing of a particular need, coupled with the skill of the physicians involved in the administration and interpretation of the test's results.
18. The use of the neurometer is not within the standard of care for the diagnosis of peripheral neuropathy.
19. Evoked potential, evoked response, and somatosensory studies are not within the standard of care unless the patient is unable to cooperate in the diagnostic process.
20. The use of IVIg by Respondent in four patients was not appropriate because Respondent failed to do adequate clinical examinations and electro-diagnostic testing to determine if the patients had neuropathy or polyneuropathy, which made the use of IVIg medically unnecessary and unreasonable, and was not within the standard of medical care.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, and pursuant to the statutory authority and Board rules, and consistent with the rulings of the Travis County District Court, the Board enters the following Order:

The entry of this Order shall constitute a PUBLIC REPRIMAND by the Board, and Respondent is hereby REPRIMANDED.

1. Respondent's Texas license is hereby SUSPENDED for a period of eight months from the date of the entry of the order.

[This period of suspension is consistent with the period of suspension in the original Final Order, which was affirmed by the Final Order of the 126th Judicial District Court of Travis County, Texas, and was subsequently re-affirmed by the District Court's Final Judgment dated March 4, 2011]

The suspension is supported by the following Findings of Fact and Conclusions of Law demonstrate aggravating factors consistent with:

- 22 Tex. Admin. Code 190.15(1)- harm to one or more patients- Finding Nos. 94, 98 (patient CB); 112 (patient KA); 182 (summation of patient harm); and Conclusion of Law 20;
- 22 Tex. Admin. Code 190.15(2)- the severity of the patient harm Finding Nos. 112 (KA hospitalized); 182 (summation of patient harm); and Conclusion of Law 20;
- 22 Tex. Admin. Code 190.15(3)- one or more violations that involve more than one patient- Conclusion of Law 8, 9, and 20;
- 22 Tex. Admin. Code 190.15(4)- economic harm to any individual or entity and the severity of that harm- Finding Nos. 70-72 (patient GF); 79 (patient JS); 87-90 (patient MS); 101-103 (patient CB); 109-118 (patient KA); 125-134 (patient TA); 139 (patient MT); 149-151 (patient MT2); 157-159 (patient AT); 183 (summary of economic harm); and Conclusions of Law Nos. 7-15, and 20.

2. Within one year of the date of the entry of this order, Respondent shall enroll in and successfully complete one or more continuing medical educational ("CME") courses totaling at least twenty-five hours in duration in the legal obligations of a physician that accompany the physician-patient relationship. The courses must be approved in writing in advance by the

Executive Director of the Board and must be in-person classroom training. To obtain approval for the course, Respondent shall submit in writing to the Director of Enforcement for the Board information on the course, to include at least a reasonably detailed description of the course content and faculty, as well as the course location and dates of instruction. Respondent shall submit documentation of attendance and successful completion of this requirement to the Director of Enforcement for the Board. This course is addition to the minimum CME required to maintain licensure.

3. Within one year of the date of the entry of this order, Respondent shall enroll in and successfully complete one or more CME courses totaling at least twenty-five hours in the standard of care for a physician to use newly available techniques or medications or use existing techniques and medications in new ways. The courses must be approved in writing in advance by the Executive Director of the Board and must be in-person classroom training. To obtain approval for the course, Respondent shall submit in writing to the Director of Enforcement for the Board information on the course, to include at least a reasonably detailed description of the course content and faculty, as well as the course location and dates of instruction. Respondent shall submit documentation of attendance and successful completion of this requirement to the Director of Enforcement. This course is addition to the requirement of Ordering Paragraph No.2 and the minimum CME required to maintain licensure.

4. Respondent shall pay an administrative penalty in the amount of \$64,000.00. The administrative penalty is calculated as itemized in Appendix "A" attached hereto. The administrative penalty shall be paid in 36 monthly payments by cashier's check or money order payable to the Texas Medical Board and shall be submitted to the Director of Enforcement for the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund as follows:

The first payment of \$1777.78 is due on or before 15 days after the termination of the eight-month suspension in Ordering Paragraph No. 1;

The following 34 payments shall due or before the 15th day of each month thereafter; and shall be in the amount of \$1777.78; the 36th and final monthly payment shall be in the amount of \$1777.70.

Respondent's failure to pay the administrative penalty as ordered shall constitute grounds for further disciplinary action by the Board, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

5. Following the termination of the period of suspension specified in Ordering Paragraph No. 1, Respondent's practice shall be monitored by a physician ("monitor"), in accordance with §164.001(b)(7) of the Act for a period of five years. The Compliance Division of the Board shall designate the monitor and may change the monitor at any time for any reason. The monitor shall have expertise in a similar specialty area as Respondent. The Compliance Division shall provide a copy of this Order to the monitor, together with other information necessary to assist the monitor.

- (a) As requested by the Compliance Division, Respondent shall prepare and provide complete legible copies of selected patient medical and billing records ("selected records"). The Compliance Division shall select records for at least 30 patients seen by Respondent during each three-month period following the last day of the month of entry of this Order ("reporting period"). The Compliance Division may select records for more than 30 patients, up to 10 percent of the patients seen during a reporting period. If Respondent fails to see at least 30 patients during any three-month period, the term of this Order shall be extended until Respondent can submit a sufficient number of records for a monitor to review.
- (b) The monitor shall perform the following duties:
 - 1) Personally review the selected records;
 - 2) Prepare written reports documenting any perceived deficiencies and any recommendations to improve Respondent's practice of medicine or assist in the ongoing monitoring process. Reports shall be submitted as requested by the Compliance Division; and
 - 3) Perform any other duty that the Compliance Division determines will assist the effective monitoring of Respondent's practice.
- (c) The Compliance Division shall provide to Respondent a copy of any deficiencies or recommendations submitted by the monitor. Respondent shall implement the recommendations as directed by the Compliance Division.

(d) The monitor shall be the agent of the Board, but shall be compensated by the Respondent through the Board. Such compensation and any costs incurred by the monitor shall be paid by Respondent to the Board and remitted by the Board to the monitor. Respondent shall not charge the compensation and costs paid to the monitor to any patients.

6. Respondent shall fully cooperate with the Board and the Board staff, including Board attorneys, investigators, compliance officers, consultants, and other employees or agents of the Board in any way involved in investigation, review, or monitoring associated with Respondent's compliance with this Order. Failure to fully cooperate shall constitute a violation of this order and a basis for disciplinary action against Respondent pursuant to the Act.

7. Respondent shall not serve as a supervisor for a physician assistant or advanced nurse practitioner.

8. The time period of this Order shall be extended for any period of time that: (a) Respondent subsequently practices exclusively outside the State of Texas; (b) Respondent's license is subsequently cancelled for nonpayment of licensure fees; (c) this Order is stayed or enjoined by Court Order; or (d) for any period of time longer than 60 consecutive days that Respondent does not actively practice medicine. If Respondent leaves Texas to practice elsewhere or ceases active practice for more than 60 consecutive days, Respondent shall immediately notify the Compliance Division of the Board in writing. Upon Respondent's return to active practice or return to practice in Texas, Respondent shall notify the Compliance Division of the Board in writing. When the period of extension ends, Respondent shall be required to comply with the terms of this Order for the period of time remaining on the Order. Respondent shall pay all fees for reinstatement or renewal of a license covering the period of extension or tolling.

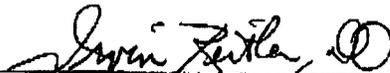
9. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

10. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within 10 days after the address change. This information shall be submitted to the Registration Department and the Compliance Department of the Board. Failure to provide such information in a timely manner shall constitute a violation of this Order and a basis for disciplinary action by the Board against Respondent pursuant to the Act.

11. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public or injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

12. The above-referenced conditions shall continue in full force and effect, without opportunity for amendment except for error in drafting, for one year following the date of entry of this Order. If, after the passage of one-year period, Respondent wishes to seek amendment or termination of these conditions, Respondent may petition the Board in writing. The Board may inquire into the request and may, in its sole discretion, grant or deny the petition without further appeal or review. Petitions for modifying or terminating may be filed only once a year thereafter.

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 3rd day of June, 2011.


Irvin E. Zeitler, Jr., D.O., President
Texas Medical Board

Appendix "A"

Administrative Penalty Assessment by Patient:

G.F.- unnecessary antibody serology testing- Fof F No. 72, 183, and C of L No. 15

1 violation x 3,000= \$3000 TOTAL \$3,000

J.S.- unnecessary antibody serology testing- Fof F No. 83, 183, and C of L No. 15

1 violation x 3,000= \$3000

unnecessary prescription of IVIg- Fof F No. 83, 182, and C of L Nos. 8, and 20

1 violation x 3,000= \$3000 TOTAL \$6,000

M.S.- unnecessary antibody serology testing- Fof F No. 89, 90, 183, and C of L No. 15

1 violation x 3,000= \$3000 TOTAL \$3,000

C.B.- unnecessary antibody serology testing- Fof F No. 93, 96, 97, 101, 102, 103, 183, and C of L No. 15

5 violations x 3,000= \$15,000

unnecessary prescription of IVIg- Fof F No. 97, 103, and C of L Nos. 7, 8, 11, and 20

1 violation x 5,000= \$5000 (increased penalty based on Fof F 98) TOTAL \$20,000

K.A.- unnecessary antibody serology testing- Fof F No. 109,117, 118, 183 and C of L No. 15

3 violations x 3,000= \$9,000

unnecessary prescription of IVIg- Fof F No. 111, 115, 116, 118, and C of L Nos. 7, 8, 11, and 20

1 violation x 5,000= \$5000 (increased penalty based on F of F 112, 182) TOTAL \$14,000

T.A.- unnecessary antibody serology testing- Fof F No. 125, 131, 183 and C of L No. 15

1 violation x 3,000= \$1,000

unnecessary prescription of Sporanox- Fof F No. 55, 129, 130, and C of L No. 7, 8, 11

1 violation x 3,000= \$3,000

unnecessary prescription of IVIg- Fof F No. 127, 130, 134, and C of L Nos. 7, 8, 11, and 20

1 violation x 3,000= \$3,000 TOTAL \$9,000

M.T.- unnecessary antibody serology testing- Fof F No. 139, 143, and C of L No. 15

1 violation x 3,000= \$3,000

TOTAL \$3,000

M.T.2.- unnecessary antibody serology testing- Fof F No. 149, 151, and C of L No. 15

1 violation x 3,000= \$3,000

TOTAL \$3,000

A.T.- unnecessary antibody serology testing- Fof F No. 157, 159, and C of L No. 15

1 violation x 3,000= \$3,000

TOTAL \$3,000

TOTAL ADMIN. PENALTY \$64,000