

HEARING CONDUCTED BY THE  
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS  
SOAH DOCKET NO. 503-10-3509.MD  
TEXAS MEDICAL LICENSE NO. F-8432

IN THE MATTER OF THE  
COMPLAINT AGAINST

JESUS ANTONIO CAQUIAS, M.D.

BEFORE THE

TEXAS MEDICAL BOARD

**SECOND AMENDED COMPLAINT**

TO THE HONORABLE TEXAS MEDICAL BOARD AND THE HONORABLE  
ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED:

COMES NOW, the Staff of the Texas Medical Board (the "Board"), and files this Second Amended Complaint against Jesus Antonio Caquias, M.D., ("Respondent"), based on Respondent's alleged violations of the Medical Practice Act ("the Act"), Title 3, Subtitle B, Texas Occupations Code, and would show the following:

**I. INTRODUCTION**

The filing of this Second Amended 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**

1. Respondent is a Texas Physician and holds Texas Medical License No. F-8432, that was originally issued on December 3, 1980. Respondent's license was in full force and effect at all times material and relevant to this Complaint.

2. Respondent received notice of the Informal Settlement Conference ("ISC") and appeared at the ISC, which was conducted in accordance with §2001.054(c), GOV'T CODE and §164.004 of the Act. All procedural rules were complied with, including but not limited to, Board Rules 182 and 187, as applicable.

3. No agreement to settle this matter has been reached by the parties.

4. All jurisdictional requirements have been satisfied.

### III. FACTUAL ALLEGATIONS

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

1. Respondent is a physician in the Brownsville, TX area. He worked as a physician for the Center for Autistic Spectrum Disorders and Nutrigenomics ("CASD") in Austin, Texas, on a part-time contract basis to provide and supervise medical diagnosis and treatment for autistic children. Patients would travel from all over the country to see Respondent at the CASD in Austin, because he represented that he had treated autism successfully.

2. Patient A:

a. Respondent saw adult Patient A<sup>1</sup> on January 8, 2007, for severe migraine headaches. The patient reported a history of hyperthyroidism, painful migraine headaches and body aches since a "betrayal by a friend." She also reported chronic fatigue and difficulty sleeping. Respondent did not document any physical examination. Respondent signed an "amino acid supplement schedule" for Patient A.

b. The next visits recorded metal levels and interpretations based on speculative effects of those levels on the patient's symptoms, but no patient history or physical examination was documented. Respondent ordered laboratory tests to diagnose various mineral and vitamin abnormalities in the patient. There is no documentation of assessment, monitoring of headaches, or discussion with the patient. At these visits, the only documentation is a short recommendation such as "no deficiency detected, repeat test" or "vitamin B's IV recommended, Detoxification IV recommended." Respondent failed to document any therapeutic rationale, monitoring or results for his medical treatment of Patient A.

c. Patient A received an intravenous infusion on December 1, 2006, of "Vitamin B complex, McGuff vitamin C, methylcobalamin, heparin, procaine, folic acid, Vitamin B6 and magnesium sulfate 50%." The volume of liquid and the amount of each substance infused was not recorded. On December 2, 16 and 17, 2006, the patient received similar infusions that

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<sup>1</sup> The identity of the Patients will be provided to the Administrative Law Judge under seal in order to protect the Patients' confidentiality rights.

included lithium, and the volumes of liquid and the amount of each substance infused again were not recorded.

d. Respondent failed to appropriately document his supervision of the care, including intravenous infusions, rendered to Patient A.

3. Patient B:

a. Patient B was a 19-year-old woman diagnosed with autism who was brought in by her parents to see the Respondent initially on February 26, 2007. The patient's parents provided Respondent with a developmental history and medical history including: psychotropic medications; difficulty with auditory processing; being distracted easily; and being easily disoriented. Patient B's past medications included: Risperdal, Seroquel, Zyprexa, Cogentin, Paxil, Adderall, Buspar, and Ritalin. Respondent's physical exam of Patient B is documented only by a check-off type of physical examination record, and several items were not marked. The failure to mark items on this check-off form indicates that the particular conditions listed and unmarked were not determined by Respondent or his staff.

b. Respondent recommended that Patient B take a long list of vitamins, probiotics, anti-oxidants, valtrex 500 mg BID, and IV treatments.

c. Over the next two years, Respondent saw the patient one to two times each month, and only provided non-specific documentation such as "symptoms improved" or "tremendous progress in cognitive and social skill." Respondent did not document any physical examinations during this time. The vast majority of the notes deal with assessment of vitamin or mineral deficiency or excess and recommendation for a large number of vitamin or mineral supplements. Respondent failed to document any therapeutic rationale, monitoring or results for his medical treatment of Patient B.

d. The patient received approximately 12 intravenous infusions, initially with the McGuff B complex, lithium, methylcobalamin, and vitamin C combination. In September 2008, Respondent added anti-oxidative IV therapy and phoshatidylcholine phenybutrate IV therapy. Respondent continued to order anti-oxidative IV therapy and phoshatidylcholine phenybutrate IV therapy for this patient. The volumes of the infusions and the amount of each substance infused were not documented. There is no documentation of any assessments, monitoring, observations, or discussion with the patient or family.

e. Respondent failed to appropriately document his supervision of the care, including intravenous infusions, rendered to Patient B.

4. Patient C:

a. Patient C was a four-year-old girl diagnosed with autism that was brought in by her parents to see the Respondent initially on July 28, 2006. The patient's parents provided to Respondent a developmental history and medical history including: aloofness; developmental delay, and decreased eye contact. There is no physical examination documented until 2008. That 2008 physical exam of Patient C is documented only by a check-off type of physical examination record, and several items were not marked. The failure to mark items on this check-off form indicates that the particular conditions listed and unmarked were not determined by Respondent or his staff.

b. Patient C received McGuff vitamin C and B-complex infusion which included methylcobalamin, procaine, Vitamin B6, and magnesium sulfate 50%, and five courses of phosphatidylcholine phenylbutyrate IV therapy during this time. The volumes of the infusions were not documented. There is no documentation of any assessments, monitoring, observations, or discussion with the patient or family. Respondent failed to document any therapeutic rationale, monitoring or results for his medical treatment of Patient C.

c. Respondent failed to appropriately document his supervision of the care, including intravenous infusions, rendered to Patient C.

5. Patient D:

a. In early 2008, the owner of CASD decided to open up a satellite office in Tampa, Florida. Respondent participated in the opening of the Florida CASD clinic by training the doctor and staff who would be providing care in Florida in the protocols for treatment of autism that he had developed at CASD in Texas. CASD planned to implement the protocols and procedures used in the Austin clinic for the same use in the Florida clinic. No one modified the forms and procedures regarding billing to remove all the signatures and authorizations used by the Austin clinic and substitute the appropriate authorizations for use in the Florida clinic.

b. A mother of an autistic child in Florida took her child to the Florida CASD clinic

on June 1, 2008, and met with Jeff Baker, a naturopathic provider who is neither a licensed doctor nor a licensed nurse. Mr. Baker recommended an extremely large battery of diagnostic tests and several prescriptions according to the protocols that Respondent had established for the CASD clinic. These tests and prescriptions were not supported by a physical examination by a licensed care provider or any documented medical condition of the patient. All documentation from the Florida clinic for this patient was made on documents that had the CASD Austin clinic address.

c. At the beginning of June 2008, the personnel in the CASD Florida clinic sent instructions to the Texas clinic to (a) fax a prescription request to a pharmacy in New Jersey that was owned by another doctor who was employed by CASD to provide and supervise medical care for the clinic patients in Florida and (b) fax orders for several laboratories to perform the large battery of tests on specimens provided by the patient in Florida on June 2, 2008. The instructions were for the prescriptions and orders to be authorized by Respondent.

d. The CASD staff used a stamp to provide Respondent's signature for the prescriptions and the laboratory test orders in Respondent's name. The CASD staff did not check with Respondent on June 2, 2008, to receive his permission or instructions to use his signature for this specific purpose.

e. Respondent's failure to take appropriate and adequate measures at the time that the Florida clinic was opened to prevent his signature stamp from being involved in activities of the Florida clinic demonstrated a lack of proper diligence in his professional practice and a failure to adequately supervise staff.

6. Patient E:

a. In November 2007, Respondent began seeing Patient E at the CASD. Patient E complained of sleep apnea, memory loss, confusion, no energy, aching in head, irritability, inability to make decisions, no motivation, and that these factors interfered with his ability to work.

b. Patient E was given an IV challenge with minerals and urine testing. Respondent failed to perform or to document the performance of any physical examination prior to the ordering and administration of chelation therapies at two to four week intervals.

c. During the chelation treatments, Patient E received intravenous: vitamins including amino acids, lithium, vitamin B complex, vitamin C; boron; magnesium sulfate; DMPS (a chelating agent); glutathione; and uridine. Respondent failed to adequately document the amount of these substances ordered or administered.

d. Although Respondent ordered diagnostic lab tests before ordering chelation therapy to begin, he did not document those lab tests and how those results affected his continuing diagnosis and treatment of Patient E. Respondent did not order diagnostic laboratory testing or document lab results while he continued the chelation therapy for Patient E.

e. Patient E was seen and evaluated by other providers after the beginning of October 2008. Those providers noted Patient E to not have had lead poisoning or heavy metal poisoning at that time or at any time, and that his medical complaints were likely neuropsychiatric.

7. Prior Board Orders:

a. The Board entered an Agreed Order on June 22, 2006, ("2006 Order") due to Respondent's failure to maintain adequate medical records in his position as "gatekeeper" for the Cameron County indigent patient program. The 2006 Order required Respondent to: submit charts to a chart monitor quarterly for two years; attend the University of California San Diego Physician Assessment and Clinical Education ("PACE") medical recordkeeping program within one year; and resign from his position as "gatekeeper" for the Cameron County indigent patient program.

b. The Board entered an Agreed Order on April 13, 2007, ("2007 Order") due to Respondent's misleading advertising. The 2007 Order required Respondent to cease the misleading advertising and to pay an administrative penalty of \$5,000.

8. Respondent's actions in this case are below the standard of care due to one or more of the following: inadequate medical recordkeeping; negligence in providing medical services; failure to use proper diligence; poor medical judgment; poor decision making; and non-therapeutic prescribing and/or treatment.

9. The actions of the Respondent as specified above violate one or more of the following provisions of the Medical Practice Act:

- a. 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.
- b. Section 164.051(a)(6) of the Act, failing to practice medicine in an acceptable professional manner consistent with public health and welfare, is further defined by Board Rule 190.8(1)(A), the failure to treat a patient according to the generally accepted standard of care; Board Rule 190.8(1)(B), negligence in performing medical services; Board Rule 190.8(1)(C), failure to use proper diligence in one's practice; Board Rule 190.8(1)(D), failure to safeguard against potential complications; Board Rule 190.8(1)(H) failure to disclose reasonable alternative treatment to the proposed treatment or treatment; and Board Rule 190.8(1)(K) prescription or administration of a drug in a manner that is not in compliance with Board Rule §200 relating to the standards for physicians practicing complementary and alternative medicine.
- c. §164.052(a)(5) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public as provided by Section 164.053 of the Act, or injure the public.
- d. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's committing or attempting to commit a direct violation of a rule adopted under this subtitle. Specifically, Respondent violated of Board Rule 165.1, by failing to maintain adequate medical records and Board Rule 200.3 by failure to follow guidelines for the practice of complementary and alternative medicine.
- e. 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.
- f. Respondent has committed a prohibited act or practice within the meaning of Sections 164.053(a)(8) of the Act by failure to supervise adequately the activities of those acting under the supervision of the physician.

10. Pursuant to Board Rule 190.15, the Board may consider aggravating factors in determining the appropriate sanctions in this case. This case involves the following aggravating factors:

- a. patient harm;
- b. multiple patients;
- c. multiple violations of the Act;
- d. prior similar violations of the Act; and
- e. prior disciplinary actions taken by the Board against Respondent.

#### IV. APPLICABLE STATUTES AND RULES FOR THE CONTESTED CASE PROCEEDING

The following statutes, rules, and agency policy are applicable to the conduct of the contested case:

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, CHAPTER 155 sets forth the rules of procedure adopted by SOAH for contested case proceedings.
4. 1 TEX. ADMIN. CODE, CHAPTER 155.507, requires the issuance of a Proposal for Decision (PFD) containing Findings of Fact and Conclusions of Law.
5. Section 164.007(a) of the Act, Board Rule 187.37(d)(2) and Board Rule 190 et. seq., provides the Board with the sole and exclusive authority to determine the charges on the merits, to impose sanctions for violation of the Act or a Board rule, and to issue a Final Order.

#### V. NOTICE TO RESPONDENT

**IF YOU DO NOT FILE A WRITTEN ANSWER TO THIS COMPLAINT WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS WITHIN 20 DAYS AFTER THE**



**DATE OF RECEIPT, A DEFAULT ORDER 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 ANSWER YOU FILE WITH THE STATE OFFICE OF ADMINISTRATIVE HEARINGS SHALL ALSO BE PROVIDED TO THE HEARINGS COORDINATOR OF THE TEXAS MEDICAL BOARD.**

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, and issue a Proposal for Decision ("PFD") containing Findings of Fact and Conclusions of Law necessary to support a determination that Respondent violated the Act as set forth in this Second Amended Complaint.

Respectfully submitted,

TEXAS MEDICAL BOARD

By: *Lee Bukstein*

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THE STATE OF TEXAS

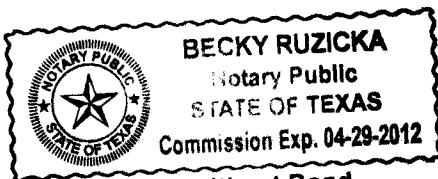
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COUNTY OF TRAVIS

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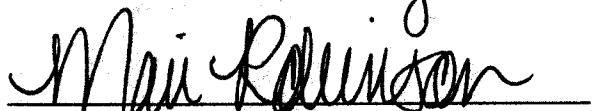
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SUBSCRIBED AND SWORN to before me by the said Lee Bukstein on this 14<sup>th</sup> day of July, 2011.



*Becky Ruzicka*  
Notary Public, State of Texas

Filed with the Texas Medical Board on this 13<sup>th</sup> day of July, 2011.

A handwritten signature in cursive script that reads "Mari Robinson". The signature is written in black ink and is positioned above a horizontal line.

Mari Robinson, J.D.  
Executive Director  
Texas Medical Board

SERVICE LIST

On July 14, 2011, I certify that a true and correct copy of this Complaint has been served on the following individuals at the locations and the manner indicated below:

**BY CERTIFIED MAIL RETURN RECEIPT REQUESTED 7008 2810 0000 1403 9892  
and FIRST CLASS MAIL**

Jesus Antonio Caquias, M.D.  
625 East Price Road  
Brownsville, TX 78521

**VIA FACSIMILE TRANSFER (512) 322-2061:**


Docket Clerk  
State Office of Administrative Hearings  
William P. Clements Bldg.  
300 W. 15th Street, Suite 504  
Austin, Texas 78701-1649

**BY FAX TRANSMISSION TO: (956) 546-0470**

Ron Armstrong, Attorney at Law  
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**BY HAND DELIVERY:**

Sonja Aurelius  
Hearings Coordinator  
Texas Medical Board  
333 Guadalupe, Tower 3, Suite 610  
Austin, Texas 78701

  
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Lee Bukstein