

**EFFECTIVE AS A FINAL ORDER**

DATE: 6/27/17

FILED 

**JUN 16 2017**

**BEFORE THE BOARD OF HEALING ARTS  
OF THE STATE OF KANSAS**

KS State Board of Healing Arts

In the Matter of )  
JAY G. OWENS, D.O. )

Docket No. 17-HA00049

Kansas License No. 05-34086 )  
\_\_\_\_\_ )

**PROPOSED DEFAULT ORDER REVOKING LICENSURE**

NOW on this 9th day of June, 2017, comes on for conference hearing before the Kansas State Board of Healing Arts ("Board") the Petition for discipline filed against the license of Jay G. Owens, D.O. ("Licensee") by the Board. Petitioner appears by and through Susan Gering, Deputy Litigation Counsel. Applicant fails to appear.

Pursuant to the authority granted to the Board, K.S.A. 65-2801 *et seq.*, and in accordance with the provisions of the Kansas Administrative Procedure Act, K.S.A. 77-501 *et seq.*, the Board hereby enters this Proposed Default Order in the above-captioned matter.

Having the agency record before it, the Board finds, concludes and orders as follows:

1. Licensee is or has been entitled to engage in the practice of osteopathic medicine the State of Kansas, having been originally issued License No. 05-34086 to practice osteopathic medicine on or about November 3, 2009. On or about September 1, 2015, Licensee changed his license status from active to inactive. On or about October 30, 2015, Licensee renewed his inactive license. On or about October 31, 2016, Licensee's license was cancelled for failure to renew.

2. A Petition requesting disciplinary action against Licensee's osteopathic medicine license was filed with the Board on or about March 30, 2017.

3. A conference hearing on the Petition for discipline was noticed for June 9, 2017 at the offices of the Kansas State Board of Healing Arts.

4. On or about April 4, 2017, pursuant to K.S.A. 2016 Supp. 77-531, Licensee was served with a Notice of Conference Hearing (“Notice”) to Licensee’s last known mailing address provided to the Board pursuant to K.S.A. 65-28,126. This notice was not returned to the Board.

5. On or about May 8, 2017, a second Notice of Conference Hearing was served on Licensee at his last known address. This notice was returned to the Board on approximately May 11, 2017. Thus, an address search for Licensee was conducted. A new address which had not been provided to the Board was found. The second Notice of Conference Hearing was served on this address on or about May 11, 2017. This notice was not returned to the Board.

6. Pursuant to K.S.A. 2016 Supp. 77-518, both the first and second Notice informed Licensee that any party who fails to attend or participate in the Conference Hearing or other state of a proceeding may be held in default.

7. Licensee failed to appear at the Conference Hearing held on June 9, 2017. Pursuant to K.S.A. 2016 Supp. 77-518 and K.S.A. 2016 Supp. 77-520, Licensee is in default for his failure to appear at the Conference Hearing on June 9, 2017.

8. Petitioner requested that Licensee be held in default pursuant to K.S.A. 77-520. Petitioner requested that the allegations contained in the Petition be found true and correct. Additionally, Petitioner moved to admit all exhibits attached to the Petition in support of her request that the allegations contained in the Petition be found true and correct.

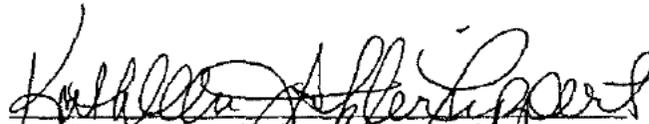
9. Upon review of the agency record and after being fully advised in the premises, the Board finds and concludes that the facts and allegations set forth in the Petition are undisputed and incorporated herein by reference.

**IT IS THEREFORE ORDERED, BY THE KANSAS STATE BOARD OF HEALING ARTS** that Licensee is hereby held in **DEFAULT** pursuant to K.S.A. 2016 Supp. 77-520.

**IT IS FURTHER ORDERED, BY THE KANSAS STATE BOARD OF HEALING ARTS** that upon this Proposed Default Order becoming effective as a Final Order, Licensee's license to practice osteopathic medicine in the State of Kansas is hereby **REVOKED**.

**IT IS SO ORDERED THIS 17 DAY OF JUNE, 2017, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.**

**KANSAS STATE BOARD OF HEALING ARTS**

  
Kathleen Selzler Lipper, Executive Director  
Kansas State Board of Healing Arts

## **FINAL ORDER NOTICE OF RIGHTS**

**PLEASE TAKE NOTICE** that this is a Final Order. A Final Order is effective upon service. A party to an agency proceeding may seek judicial review of a Final Order by filing a petition in the District Court as authorized by K.S.A. 77-601, *et seq.* Reconsideration of a Final Order is not a prerequisite to judicial review. A petition for judicial review is not timely unless filed within 30 days following service of the Final Order. A copy of any petition for judicial review must be served upon Kathleen Selzler Lippert, Executive Director, Kansas Board of Healing Arts, 800 SW Jackson, Lower Level-Suite A, Topeka, KS 66612.

**CERTIFICATE OF SERVICE**

I, the undersigned, hereby certify that a true copy of the foregoing **FINAL ORDER** was served this 21<sup>th</sup> day of June, 2017 by depositing the same in the United States Mail, first-class, postage prepaid, and addressed to:

Jay G. Owens, DO  
[REDACTED]  
Overland Park, KS 66212

Jay G. Owens, DO  
[REDACTED]  
Overland Park, KS 66223

And a copy was hand-delivered to:

Susan Gering, Deputy Litigation Counsel  
Kansas State Board of Healing Arts  
800 SW Jackson, Lower Level-Suite A  
Topeka, Kansas 66612

John Nichols, Licensing Administrator  
Kansas State Board of Healing Arts  
800 SW Jackson, Lower Level-Suite A  
Topeka, Kansas 66612

Office of the General Counsel  
Kansas State Board of Healing Arts  
800 SW Jackson, Lower Level-Suite A  
Topeka, Kansas 66612

And the original was filed with the office of the Executive Director.

  
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Cathy Brown, Executive Assistant

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MAR 30 2017

BEFORE THE BOARD OF HEALING ARTS OF THE STATE OF KANSAS

KS State Board of Healing Arts

In the Matter of )
Jay G. Owens, D.O. )
Kansas License No. 05-34086 )

KSBHA Docket No. 17-HA 00049

PETITION

COMES NOW the Petitioner, the Kansas State Board of Healing Arts ("Board"), by and through Susan R. Gering, Associate Litigation Counsel, ("Petitioner") and initiates these proceedings pursuant to the provisions of K.S.A. 65-2836, K.S.A. 65-2851a, and K.S.A. 77-501 et seq. For its cause of action, Petitioner alleges and states:

FACTS COMMON TO ALL COUNTS

- 1. The Board is the sole and exclusive administrative agency in the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of osteopathic medicine and surgery. K.S.A. 65-2801 et seq.
2. Jay G. Owens, D.O.'s ("Licensee") last known mailing address to the Board is: [redacted] Overland Park, Kansas 66212.
3. At all times relevant to the allegations set forth in the Petition, the Board has maintained jurisdiction over Licensee's license to practice osteopathic medicine and surgery in the State of Kansas because he was practicing medicine under the authority of a current and active license issued by the Board when he committed the misconduct alleged below. See Friedman v. Kansas State Bd. of Healing Arts, 292 Kan. 636, 294 P.3d 287 (2013).
4. Licensee was originally issued license number 05-33439 to practice osteopathic medicine and surgery in the State of Kansas on November 3, 2009.

5. On or about September 1, 2015, Licensee changed his license status from Active to Inactive.

6. On or about October 30, 2015, Licensee renewed his Inactive license.

7. On or about October 31, 2016, Licensee's license was Cancelled for Failure to Renew. Licensee has not attempted to reinstate his license at this time.

8. From at least on or around May 2014, until Licensee changed his license status to Inactive, he owned and provided care as a solo practitioner at Owens Medical Health and Wellness, P.A. located at 15545 W. 87<sup>th</sup> Street, Lenexa, Kansas 66219. Owens Medical Health and Wellness, P.A. was a "Direct Primary Care type practice focusing on evidence based medicine, coupled with complementary and alternative medicine in order to promote wellness and vitality in [his] patient population." See Exhibit 1: Email string between Licensee, Board Investigator, and Licensee's Attorney; see also Exhibit 2: Licensee's LinkedIn Page.

9. From on or around September 2014 to on or around August 2015, Licensee was the Medical Director for Midwest Restorative Health, LLC located at 7201 W 110<sup>th</sup> St, Suite 120, Overland Park, Kansas 66210. See Exhibit 1.

10. Since issuance of licensure in a regulated profession as a medical doctor in the State of Kansas, pursuant to K.S.A. 65-2836, *et seq.*, Licensee did commit the following acts:

### COUNT I

11. Petitioner incorporates herein, by reference, paragraphs one (1) through ten (10) as fully restated and re-alleged herein.

12. On or about June 5, 2015, at approximately 4:00 p.m. the on-duty pharmacist at Target Pharmacy received a phone call from a blocked number from a male individual who identified himself as Dr. Marc Enyart, M.D. See Exhibit 3: Complaint received June 10, 2015.

13. The individual on the phone provided the on-duty pharmacist the name and date of birth of patient, Jay Owens (Licensee), and stated he wanted to authorize prescriptions for Soma 350mg #120, Ambien 10mg #60, Klonopin 2mg #90, and with each prescription allowing for five (5) refills. The individual was asked for Dr. Enyart's DEA number and the individual gave a number. The on-duty pharmacist told the caller that the prescriptions would be available for pick-up after 6 p.m. at which time the caller told the pharmacist that the patient (Licensee) would be bringing C2 prescriptions in as well. The phone call ended at this point in time. *Id.*

14. Prior to receiving the second phone call, the on-duty pharmacist had verified Dr. Enyart's DEA number online and saw that he was an emergency medicine physician in Fort Scott, Kansas. *Id.*

15. Later, the on-duty pharmacist received a second call from a male individual identifying himself as Dr. Enyart. This time the caller wanted to check the pharmacy's stock of hydromorphone 8mg, 4mg, Oxycodone 15mg, MS Contin 30mg and other Schedule 2 narcotics for the patient (Licensee). The caller further asked questions regarding morphine equivalents and hydrocodone. The pharmacist found the questions asked in the phone calls with a person identifying himself as emergency medicine physician Dr. Enyart strange. *Id.*

16. Shortly after the on-duty pharmacist's second phone call with the caller, he received a third phone call from the male individual identifying himself again as Dr. Enyart. The caller began asking the on-duty pharmacist questions about writing C2 prescriptions and how many medications could be included on one prescription blank. *Id.*

17. During the third phone call, the on-duty pharmacist found it strange that an emergency room ("ER") physician would be asking questions about writing C2 prescriptions. The pharmacist

told the male individual that he would need to call the facility Dr. Enyart's DEA number was associated with to verify the prescriptions. *Id.*

18. At this point in time, the individual began asking the pharmacist "when this policy took effect", "why [the pharmacist] needed to verify the prescriptions", and "how many missed phone calls from pharmacies he should anticipate". The pharmacist responded that the pharmacy calls to verify controlled substance prescriptions to protect pharmacist licenses and the doctor's license. The pharmacist again stated that he would attempt to have the prescriptions ready that evening, but again needed to verify them first with the facility associated with Dr. Enyart's DEA number. The conversation then ended. *Id.*

19. At approximately 5:30 p.m. on that same day, June 5, 2015, the on-duty pharmacist from Target contacted Mercy Hospital in Fort Scott, Kansas, asked to have his call transferred to the ER, and asked to speak with Dr. Enyart. An ER nurse indicated that Dr. Enyart was in with a patient and asked if he could call back. The pharmacist requested Dr. Enyart call him back as soon as possible because an individual had just called the pharmacy identifying himself Dr. Enyart. *Id.*

20. Approximately fifteen (15) minutes later, Dr. Enyart returned the pharmacist's phone call. During the conversation, the following occurred:

- a. The pharmacist asked if Dr. Enyart knew patient Jay Owens (Licensee), which Dr. Enyart indicated he had written prescriptions for him in the past.
- b. The pharmacist inquired if Dr. Enyart had contacted the pharmacy that day and Dr. Enyart stated no.
- c. The pharmacist explained that an individual identifying himself as Dr. Enyart had authorized refills for three controlled substances for Licensee, provided the pharmacist Dr. Enyart's DEA number, and asked questions about writing C2 prescriptions.

d. The pharmacist asked if Dr. Enyart wanted to void the prescriptions and any active refills under his name and DEA number. Dr. Enyart said yes.

e. The pharmacist asked if Dr. Enyart had authorized a prescription for hydromorphone 8mg #180 on February 10, 2015, for Licensee, and Dr. Enyart said yes.

f. The pharmacist asked Dr. Enyart if he wanted to press charges, and Dr. Enyart said he did not know at that time.

g. Dr. Enyart indicated to the pharmacist he was going to contact the patient (Licensee) and follow-up with the pharmacist if he wanted to press charges.

*Id.*

21. Licensee was the caller that contacted the Target Pharmacy and impersonated Dr. Enyart.

22.

[REDACTED]

23.

[REDACTED]

24. Dr. Enyart did not give Licensee permission to impersonate Dr. Enyart in obtaining medications from Target Pharmacy on June 5, 2015. Further, he had “never told him it would be

ok to just call in prescriptions and tell them he was me in order to get refills or new medications.”

See Exhibit 4.

25. In a response to the Board on or about July 15, 2015, Licensee states in part, the following:

[REDACTED]

I called Target pharmacy to make sure that they had the medication in stock. While on the phone, I made a poor decision in an attempt to conveniently refill my other prescriptions since I was already talking to the pharmacist. During the discussion with pharmacy staff, I identified myself as Marc Enyart, M.D.

See Exhibit 6: Licensee Response dated July 15, 2015.

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

a. [REDACTED]

b. [REDACTED]

c. [REDACTED]  
[REDACTED]

d. [REDACTED]  
[REDACTED]  
[REDACTED]

e. [REDACTED]  
[REDACTED]

f. [REDACTED]  
[REDACTED]

29. [REDACTED]  
[REDACTED]

a. [REDACTED]  
b. [REDACTED]  
c. [REDACTED]

[REDACTED]

30. [REDACTED]

a. [REDACTED]  
b. [REDACTED]

[REDACTED]

c. [REDACTED]  
[REDACTED]

d. [REDACTED]

e. [REDACTED]

[REDACTED]

[REDACTED]

31.

[REDACTED]

[REDACTED]

[REDACTED]

32.

[REDACTED]

[REDACTED]

[REDACTED]

33.

[REDACTED]

[REDACTED]

[REDACTED]

34.

[REDACTED]

[REDACTED]

[REDACTED]

35.

[REDACTED]

[REDACTED]

[Redacted]

36. [Redacted]

[Redacted]

- a. [Redacted]
- b. [Redacted]
- c. [Redacted]
- d. [Redacted]
- e. [Redacted]

[Redacted]

37. [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

38. [Redacted]

[Redacted]

[Redacted]

39. [Redacted]

[Redacted]

[Redacted]

a. [Redacted]

[Redacted]

[Redacted]

b. [Redacted]

c. [Redacted]

d. [Redacted]

e. [Redacted]

[Redacted]

40. [Redacted]

[Redacted]

41.

[REDACTED]

[REDACTED]

[REDACTED]

42. On or about December 2, 2015, Licensee voluntarily surrendered his DEA controlled substances privileges. Licensee signed a form stating that he had surrendered his privileges:

In view of my alleged failure to comply with Federal requirements pertaining to controlled substances, and as an indication of my good faith in desiring to remedy any incorrect or unlawful practices on my part . . .

See Exhibit 17: DEA surrender form for Licensee received March 31, 2016.

43.

[REDACTED]

[REDACTED]

a.

[REDACTED]

[REDACTED]

b.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

44. [REDACTED]

[REDACTED]

[REDACTED]

45. [REDACTED]

[REDACTED]

[REDACTED]

46. Licensee's acts and conduct constitute violations of the Kansas Healing Arts Act as follows:

- a. K.S.A. 65-2836(b), in that Licensee has committed an act or acts of unprofessional and/or dishonorable conduct;
- b. K.S.A. 65-2836(f), in that Licensee has willfully violated the Healing Arts Act; the Pharmacy Act of the State of Kansas or the Uniform Controlled Substances Act by attempting to prescribe medications, including controlled substances, under a false or assumed name, or the impersonation of another practitioner when he identified himself as Dr. Enyart, gave Dr. Enyart's DEA number, and attempted to refill prescription medications;

- c. K.S.A. 65-2836(h), in that Licensee has engaged in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner when he identified himself as Dr. Enyart, gave Dr. Enyart's DEA number, and attempted to refill prescription medications;
- d. K.S.A. 65-2836(i), in that Licensee's ability to practice the healing arts with reasonable skill and safety to patients is impaired by reason of physical or mental illness, or condition or use of alcohol, drugs or controlled substances;
- e. K.S.A. 65-2836(q), in that Licensee has violated a federal law or regulation relating to controlled substances when he identified himself as Dr. Enyart, gave Dr. Enyart's DEA number, and attempted to refill prescription medications;
- f. K.S.A. 65-2836(u) in that Licensee has surrendered the authority to utilize controlled substances issued by any state or federal agency while under investigation for acts or conduct similar to acts or conduct which would constitute grounds for disciplinary action under this section;
- g. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(12), in that Licensee committed conduct likely to deceive, defraud or harm the public; and/or
- h. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(23), in that Licensee attempted to prescribe a prescription drug or substance, including a controlled substance, in an improper or inappropriate manner, or for other than a valid medical purpose, or not in the course of the licensee's professional practice when he engaged in the practice of the healing arts under a false or assumed name, or the impersonation of another practitioner when he identified himself as Dr. Enyart, gave Dr. Enyart's DEA number, and attempted to refill prescription medications.

47. Pursuant to K.S.A. 65-2836 *et. seq.*, the Board has grounds to revoke, suspend, censure, place on probation, fine or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

### COUNT II

48. Petitioner incorporates herein, by reference, paragraphs one (1) through forty-seven (47) as fully restated and re-alleged herein.

49. On or about July 7, 2014, Patient 1 a thirty-five (35) year old female presented to Licensee for an initial appointment. Patient 1 desired "to have her hormone levels checked in an effort to see if they might be contributing to her fatigue and other symptoms which could be related to early peri-menopause." See Exhibit 19: Licensee's Medical Records for Patient 1, Bates Stamp p. 10.

50. On or about July 9, 2014, Patient 1 went for labs. *Id.* at Bates Stamp pgs. 11-13

51. On or about July 12, 2014, a Saturday, Patient 1 received a call from Licensee regarding her labs, even though not all the lab results were back yet and the ones with results were not "out of range". See Exhibit 19: Bates Stamp pgs. 11-13 and Exhibit 20: Investigative Report dated June 11, 2015.

52. On or about either July 12, 2014 or July 13, 2014, Licensee documented a progress note that he reviewed labs with Patient 1 over the phone and discussed the "pros and cons of hormone therapy in her specific situation. [Patient 1] will think about it some more and get back [with] a decision." No other notations about the pros and cons discussed with Patient 1 are listed in Licensee's progress notes. See Exhibit 19 at Bates Stamp p. 14.

53. On or about July 13, 2014, Patient 1 received a text from Licensee stating "BTW...this is kind of a silly thing to say, but I am really glad that you decided to become my patient. I really

enjoy and appreciate having smart, educated, and fun to talk to patients like yourself ☺.” See Exhibit 21: Email from Patient 1 dated June 11, 2015.

54. On or about July 14, 2014, Licensee called Patient 1 and left a voicemail around 9:00 p.m. requesting Patient 1 return his phone call. See Exhibit 20 and Exhibit 22: Patient 1 Complaint received May 11, 2015.

55. On or about that same day, July 14, Patient 1 returned Licensee’s phone call at approximately 9:40 p.m. The phone call lasted over an hour and during that conversation Licensee discussed the following with Patient 1:

- a. His sexual exploits with co-workers while working in the Emergency Room;
- b. His use of “lewd language” during description of his sexual exploits including “blow job”, “fuck”, and “describing the women’s appearances and bodies in detail.”
- c. He described some of his “‘crazy’ girlfriends and how they were ‘just so hot, I couldn’t help but fuck them.’”
- d. He mentioned that several of his girlfriends snorted cocaine and/or had been in rehab for cocaine use;
- e. He described a “wedding where a man asked him of being ‘gay’” and Licensee was offended so “he yelled across the reception to his girlfriend, ‘hey honey, will you tell this man who I fuck every night?!’”

See Exhibits 20 and 22.

56. Patient 1 ended the conversation stating she really needed to let him go. Licensee responded to Patient 1 by laughing and indicating to Patient 1 that he “‘probably should not have said those things.’” See Exhibit 22.

57. On or about July 15, 2014, Licensee documented Patient 1 “decided against BHRT at that time.” See Exhibit 19 at Bates Stamp p. 14.

58. On or about that same day, July 15, Patient 1 stated that she called Licensee to confront the situation from the night before and “tell him she did not want him to be her doctor anymore.” In that conversation, Patient 1 stated that “[Licensee] blamed his behavior by saying ‘he had a couple of beers.’” Patient 1 was also to decide whether she wanted the pellets Licensee had ordered. During Patient 1’s discussion of the pellets, Licensee indicated that “‘it will not be a problem’” and “‘he could find someone else to use them.’” Licensee also offered to have a beer with her husband and stated he could understand why he would be upset. See Exhibit 20, 22, and Exhibit 23: Patient 1/Licensee texts received May 2, 2016.

59. In a text message to Patient 1 later that same day at approximately 11:02 a.m., Licensee stated again that he understood the way Patient 1 and her husband felt. Licensee further offered to sit down with Patient 1 and her husband to apologize. See Exhibit 23.

60. On or about July 15, 2014, Licensee billed Patient 1’s husband’s health savings plan for medication she did not receive. See Exhibit 24: Supplemental Investigative Report dated May 2, 2016.

61. On July 17, 2014, Patient 1 texted Licensee at approximately 6:29 p.m. that Licensee’s practice was “not a good fit for [her] family” and that \$350 for the pellets had been charged. She requested Licensee reimburse the money for the pellets and that the bill for the labs performed be sent to her address. See Exhibit 23.

62. On July 21, 2014, Patient 1 left a voicemail for Licensee at approximately 7:49 p.m. Licensee responded via text message to Patient 1 stating he would give her a call when he got a chance tomorrow. *Id.*

63. On or about July 22, 2014, Patient 1 again called Licensee and left a voicemail at approximately 12:38 p.m. *Id.*

64. On or about August 15, 2014, Patient 1 and her husband filed a report of unauthorized transactions with the health savings account and ultimately received her money back. The charge was reversed by Licensee after inquiry into the matter was initiated on or about August 19, 2014. See Exhibit 25: Notice of Unauthorized POS Transactions on Health Savings Account and Exhibit 23.

65. Patient 1 initially did not plan to submit a complaint after severing the physician-patient relationship with Licensee, but approximately a year later she went to get a massage at Lenexa Healing Arts Center and was alarmed when she noticed a sign on the door welcoming Licensee to the practice. See Exhibits 20 and 24.

66. On or about May 11, 2015, Patient 1 submitted a complaint in this matter after seeing Licensee's name at Lenexa Healing Arts Center. Exhibits 20, 22 and 24.

67. Licensee responded to the current complaint in a letter dated December 30, 2015, denying Patient 1's allegations as untrue, based on her "poor recall" or a "blatant attempt to put [him] at odds with the Board". He further stated that he contacted Patient 1 on July 14, 2014, to discuss "lab results that had been reported late that day." Licensee indicates that when Patient 1 returned his call that night he had taken a sleeping medication, Zolpidem, shortly prior to her return phone call. Licensee stated that he relayed Patient 1's lab results and answered any questions that she had in regard to the results, but "cannot say with great certainty how the conversation transitioned from a discussion of [Patient 1's] lab results to talking about other matters." See Exhibit 26: Licensee Response dated December 30, 2015.

68. Based on Licensee use of Zolpidem that night he stated that “he can not describe with absolute certainty the ebb and flow of the conversation, or even the some of the specifics of the conversation.” Licensee however, states that “there are several aspects of the conversation that I still remember plainly even after the time that has elapsed since the conversation took place.” *Id.*

69. Licensee’s acts and conduct constitute violations of the Kansas Healing Arts Act as follows:

- a. K.S.A. 65-2836(b), in that Licensee has committed an act or acts of unprofessional and/or dishonorable conduct;
- b. K.S.A. 65-2836(f), in that Licensee has willfully violated the Healing Arts Act;
- c. K.S.A. 65-2836(i), in that Licensee’s ability to practice the healing arts with reasonable skill and safety to patients is impaired by reason of physical or mental illness, or condition or use of alcohol, drugs or controlled substances [REDACTED]  
[REDACTED]
- d. K.S.A. 65-2836(aa), in that Licensee knowingly submitted a misleading, deceptive, untrue or fraudulent representation on a claim form, bill or statement when he attempted to charge her HSA for pellets she never received.
- e. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(12) in that Licensee’s conduct is likely to deceive, defraud or harm the public;
- f. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(16), in that Licensee has committed an act or acts of misconduct which exploited the licensee-patient relationship, with Patient 1;
- g. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837 (b)(25), in that Licensee failed to keep written medical records which accurately describe the services rendered to

the patient, including patient histories, pertinent findings, examination results and test results when Licensee failed to create adequate medical record documentation associated with Patient 1; and/or

h. K.S.A. 65-2836(k), in that Licensee has violated a lawful regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record associated with Patient 1.

70. Pursuant to K.S.A. 65-2836 *et. seq.*, the Board has grounds to revoke, suspend, censure, place on probation, fine or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

### COUNT III

71. Petitioner incorporates herein, by reference, paragraphs one (1) through seventy (70) as fully restated and re-alleged herein.

72. From approximately on or about January 9, 2014 to on or about August 17, 2015, Patient 2, a fifty-four (54) year old female, received care and treatment at Midwest Restorative Health, LLC ("Midwest Restorative"). See Exhibit 27: Medical Records for Patient 2.

73. During her time and treatment at Midwest Restorative Health, Patient 2 was an Advanced Registered Nurse Practitioner at Midwest Restorative. *Id.*

74. On or about October 3, 2014, Licensee documented a New Patient History and Physical form for Patient 2. Patient 2's documented current complaint was hormone deficiency. Licensee prescribed thirty (30) 37.5mg caps of Phentermine one (1) per day with no documented refills, thirty (30) 100mg pills of Spironolactone one (1) as needed per day with refills documented as one (1) year, and ninety (90) 112mcg of Synthroid (no generic) one per day in the morning with refills documented as one (1) year. *Id.* at Bates Stamp pgs. 24, 43-45.

75. On or about November 13, 2014, Licensee documented an appointment for Patient 2 occurred. No vital signs were documented during the encounter. Licensee documented a History of Present Illness (“HPI”) that stated “Pt reports, ‘Can tell time for implant. Want to go down a dose on E2 and T2.’ Pt ARNP at MRH.” In the documented assessment, Patient 2 was diagnosed with menopause, symptomatic and B12 deficiency. The plan was documented to include the following: “1. Procedure as noted above 6mg E2 . . . 70mg T . . . Procedure Code 11980[;] 2. B12 given . . . Encouraged daily B complex[;] 3. Pt seen and treated by A.Blume RN.” Licensee electronically signed the record for Patient 2 on or about December 23, 2014. *Id.*

76. On or about January 2, 2015, Licensee documented an appointment for Patient 2 occurred. Licensee documented a HPI that included “Pt reports, ‘Doing well. Can tell time. Thumbs start hurting.’ Pt NP at MRH.” In the documented assessment, Patient 2 was diagnosed with menopause symptomatic, B12 deficiency and thumb pain. The plan was documented to include the following: “1. Procedure noted above 12.5mg E2 . . . 37.5mg T . . . 100mg T . . . Procedure Code 11980[;] 2. B12 given . . . Encouraged daily B complex[;] 3. ‘Implants take care of[;]’ 4. Fu appointments made. Encourage pt to call with any questions or concerns. Pt see and treated by A.Blume RN. Licensee electronically signed the record for Patient 2 on or about April 14, 2015. *Id.*

77. On or about January 13, 2015, Patient 2 wrote her own prescription for Libido cream-Sildenafil 2%, Testosterone 0.1%, Arginine 6%, Aminophylline 3%, Vaginal Cream with a quantity of three (3) dispensed with refills documented as one (1). *Id.* at Bates Stamp p. 48.

78. On or about January 28, 2015, Patient 2 again wrote her own prescription this time for thirty (30) 200mg C-Progesterone Troche with refills documented as eleven (11). *Id.* at Bates Stamp p. 49.

79. On or about February 4, 2015, Licensee documented an appointment for Patient 2 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included Patient 2 presented for platelet rich plasma (“PRP”) facelift procedure to reduce appearance of fine line and restore her cheeks fullness. Patient 2 was documented as reviewing the “‘Vampire Facelift’ procedure consent form, questions were answered and consent was signed”; however, no signed consent appears in Patient 2’s record. Licensee’s documentation further states that “[p]rocedure was performed during in-house training with Dr. Charles Runnels, MD. Patient was aware of training. Training was group training. While I was present during procedure, procedure was not necessarily performed by me.” Licensee was the only individual to sign the record. *Id.*

80. On or about February 10, 2015, a prescription for thirty (30) 37.5mg pills Phentermine one (1) pill every morning with no documented refills. No corresponding record appears in Patient 2’s chart. *Id.* at Bates Stamp p. 50.

81. On or about March 19, 2015, Licensee documented an appointment for Patient 2 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included “Pt reports, ‘Doing well this cycle.’ Pt NP at MRH.” In the documented assessment, Patient 2 was diagnosed with menopause symptomatic and B12 deficiency. The plan was documented to include the following: “1. Procedure as noted above 12.5mg E2 . . . 37.5mg T . . . 100mg T . . . Procedure Code 11980[;] 2. B12 given . . . Encouraged daily B complex[;] 3. Fu appointments made. Encouraged pt to call with any questions or concerns. Pt seen and treated by A.Blume RN.” Licensee electronically signed the record for Patient 2 on or about April 14, 2015. *Id.*

82. On or about May 26, 2015, Licensee documented an appointment for Patient 2 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included “Pt reports, ‘Doing well. Cant tell time to come in.’” In the documented assessment, Patient 2

was diagnosed with menopause symptomatic and B12 deficiency. The plan was documented to include the following: “1. Procedure as noted above 10mg E2 . . . 50mg T . . . 100mg T . . . Procedure Code 11980[;] 2. B12 given . . . Encouraged daily B complex[;] 3. Insurance forms given to pt and fu appointments made. Encouraged pt to call with any questions or concerns. Pt seen and treated by A.Blume RN.” Licensee electronically signed the record for Patient 2 on or about July 28, 2015. *Id.*

83. On or about August 17, 2015, Licensee documented an appointment for Patient 2 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included “Pt reports, ‘Can tell it is time.’” In the documented assessment, Patient 2 was diagnosed with menopause, symptomatic and B12 insufficiency/ stable. The plan was documented to include the following: “1. Procedure as noted above 12.5mg E2 . . . 37.5mg T . . . 100mg T . . . Procedure Code 11980[;] 2. B12 given . . . [;] 3. Pt NP at MRH. PT seen and treated by A.Blume RN.” Licensee electronically signed the record for Patient 2 on or about August 25, 2015. *Id.*

84. Between on or about October 3, 2014, and on or about December 26, 2014, Licensee wrote multiple prescriptions for Phentermine, Spironolactone, Zithromax and changed dosage of Synthroid with no specific documented reason or description noted in Patient 2’s chart. *Id.*

85. With regard to Licensee’s prescribing of Phentermine to Patient 2, Licensee failed to provide a description or information as to the medical need or plan recorded for the prescriptions. *Id.*

86. Throughout Patient 2’s chart there is no discussion or documentation of the risk or side effects of testosterone replacement in Licensee’s chart. Further, there were no informed consents for the testosterone implantation procedures performed by Licensee. *Id.*

87. During Licensee's care and treatment of Patient 2, Licensee had a collaborating agreement with Patient 2.

88. Licensee's acts and conduct during the course of treating Patient 2 constitute violations of the Kansas Healing Arts Act as follows:

a. Licensee has violated K.S.A. 65-2836(b), in that Licensee committed an act or acts of unprofessional and/or dishonorable conduct;

b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to deceive, defraud and/or harm the public;

c. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe the services rendered to Patient 2, including patient histories, pertinent findings, examination results and test results;

d. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(30), in that Licensee failed to properly supervise, direct or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation or practice protocols when he allowed Patient 2 to prescribe to herself during the time Licensee was treating her.

e. Licensee has violated K.S.A. 65-2836(f), in that Licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substance act, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts; and/or

f. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated any lawful rule and regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record associated with the care and treatment provided to Patient 2.

89. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Healing Arts Act.

#### COUNT IV

90. Petitioner incorporates herein, by reference, paragraphs one (1) through eighty-nine (89) as fully restated and re-alleged herein.

91. From approximately on or about March 12, 2014 to on or about August 6, 2015, Patient 3, a forty-two (42) year old female, received care and treatment at Midwest Restorative Health. See Exhibit 28: Medical Records for Patient 3.

92. On or about December 16, 2014, Licensee documented an appointment for Patient 3 occurred. Licensee documented a HPI that included "Pt here for implant-reviewed pts current s/s sheet as well as her lab levels. Pt states 'I feel good! . . . I had no more acne or facial hair than normal.' Pt currently takes P4 150mg every noc." In the documented assessment and plan, Patient 3 was diagnosed with perimenopause, B12 deficiency, irritability, insomnia, and anxiety. The physical exam documented that Patient 3 would continue P4 150mg every night, "[d]iscussed s/e of E2 and T2 and pt signed consent form. All questions were answered, no insurance forms were given and F/U appts were scheduled. Pt WCB w/ any concerns or problems. Pt was seen and implanted by B. Klausner RN." Licensee electronically signed the record for Patient 3 on December 23, 2014. *Id.*

93. On or about February 4, 2015, Licensee documented an appointment for Patient 3 occurred. Patient 3 underwent three procedures including PRP “Vampire Facelift” procedure, PRP “Vampire Breastlift” procedure, and PRP injection “the O-Shot.” No vital signs were documented during the encounters with Patient 3. Patient 3 was documented as reviewing and signing the consent forms for the documented procedures; however, no signed consent forms appears in Patient 3’s record. Additionally, Licensee’s notes for the “Vampire Facelift” and “Vampire Breastlift” refer to diagrams for specific injection amounts and locations, but no diagrams appear in Patient 3’s record. Licensee’s documentation for all three procedures further states that “procedure was performed during in-house training with Dr. Charles Runnels, MD. Patient was aware of training. Training was group training. While I was present during procedure, procedure was not necessarily performed by me.” Licensee was the only individual to sign the record. Licensee did not date when the record was signed. *Id.*

94. On or about March 12, 2015, Licensee documented an appointment for Patient 3 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included “Pt here for implant . . . Pt states ‘I feel pretty good but I can tell it is time. I have been taking my P4 really well because my PMS s/s are lasting a solid 2 weeks. I take 150mg. I don’t have acne but I do have a little beard. . . .’” In the documented assessment and plan, Patient 3 was diagnosed with perimenopause, B12 deficiency, insomnia and irritability. The physical exam documented plan to suggest continuing P4 150mg to increase to 200mg around “PMS s/s time.” It was further documented that “Pt wondered about dividing dose at that time period and taking 100mg in the am and 100mg at HS stating it does not make her sleepy, just relaxes her. Told pt she could try this bt suggested that pt do it on a day when she does not have to be somewhere or drive anywhere. Also discussed possibly adding low dose E2 at next visit . . .Discussed s/e of E2 and T2 and pt

signed consent form . . . .” B. Klausner, RN, BSN is the nurse listed in the section titled Nurse Signature and Date/Time. Licensee electronically signed the record for Patient 3 on March 17, 2015. *Id.*

95. On or about May 29, 2015, Licensee documented an appointment for Patient 3 occurred. No vital signs were documented during the encounter. Licensee documented a HPI that included “Pt here for implant . . . Pt states ‘I have felt pretty good but I did notice that I was a bit more irritable and aggressive and had more hair so maybe we could dial the T2 back a little bit his time.’ Pt takes P4 150mg every noc.” In the documented assessment and plan, Patient 3 was diagnosed with peri-menopause, irritability, and anxiety. The physical exam documented the “plan to continue P4 150mg every noc. Discussed the nice balance pt has b/w her E2 and P4. Discussed s/e of E2 and T2 and pt signed the consent form.” B. Klausner, RN, BSN is the nurse listed in the section titled Nurse Signature and Date/Time. Licensee electronically signed the record for Patient 3 on June 2, 2015. *Id.*

96. During Licensee’s care and treatment of Patient 3, Licensee failed to document:
- a. a record of discussion of target testosterone with Patient 3;
  - b. discussion or documentation informing Patient 3 that well controlled long term studies of testosterone treatments in women have not been performed;
  - c. Licensee’s thought processes, reason, and justification for the actions and decisions relating to his care and treatment of Patient 3 with unorthodox or non-FDA approved procedures;
  - d. there is no informed consent documentation relating to Patient 3’s “Vampire Facelift”, “Vampire Breastlift” and the “O” Shot procedures performed on February 4, 2015; and/or

- e. there are no face diagram(s) or breast diagram(s) in Patient 3's records as referred to in Licensee's procedures notes for Patient 3's "Vampire Facelift" and "Vampire Breastlift."

97. Licensee's acts and conduct during the course of treating Patient 3 constitute violations of the Kansas Healing Arts Act as follows:

- a. Licensee has violated K.S.A. 65-2836(b), in that Licensee committed an act or acts of unprofessional and/or dishonorable conduct;
- b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to deceive, defraud and/or harm the public;
- c. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe the services rendered to Patient 3, including patient histories, pertinent findings, examination results and test results;
- d. Licensee has violated K.S.A. 65-2836(f), in that Licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substance act, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts; and/or
- e. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated any lawful rule and regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record associated with the care and treatment provided to Patient 3.

98. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Healing Arts Act.

### COUNT V

99. Petitioner incorporates herein, by reference, paragraphs one (1) through ninety-eight (98) as fully restated and re-alleged herein.

100. From approximately on or about March 21, 2014 to on or about August 13, 2015, Patient 4, a thirty-five (35) year old male, received care and treatment from Licensee. See Exhibit 29: Medical Records for Patient 4.

101. On or about March 21, 2014, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included "seeing pt for refills on medications. He has been doing well [with] current dosing. BP controlled, pain controlled. [no] early refills of controlled meds." In the documented assessment, Patient 4 was diagnosed with chronic neck pain "2° DJD and DDD" hypertension, and insomnia. The plan was documented to include Patient 4 "continue with his current medications and chiropractic care." Patient 4 was to have a follow-up in three months or as needed. *Id.*

102. On or about May 13, 2014, Licensee documented a progress note that states "Pt called requesting refills on his Soma. Refills x2 called into CVS. [No] change in Dosing." *Id.*

103. On or about June 3, of some unknown year, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included "Pt [with history] of chronic neck pain 2° . . . DJD [and] DDD after . . . [motor vehicle crash] in 2007 Continuing medical mgmt. [and] conservative care (cervical decompression in order to put off surgery for as long as possible. Pt's neurosurgeon is in agreement [with] this plan of care." In the documented assessment, Licensee listed neck pain "2° DJD and DDD", "hypertension – on Lisinopril (stable), and insomnia

– zolpidem prn.” The plan was documented to include Patient 4 continue with his current medications. Patient 4 was to have a follow-up in two (2) to three (3) months or as needed. *Id.*

104. On or about August 25, 2014, Licensee documented an appointment for Patient 4 occurred. Patient 4 presented to Licensee for a physical exam and annual labs. Licensee documented assessment and plan included “1) HTN – continue lisinopril. Check routine labs. 2) Chronic neck pain . . . Continuing conservative care with chiropractic care and cervical decompression . . . Pain is controlled with current meds, and he has been stable on these medications for several years. . . 3) Insomnia - continue zolpidem 4) Seasonal allergies – controlled on current meds 5) ADHD – stable on current meds. Current dosing per psychiatrist – will refill Adderall at his current dose (30 mg BID #60) 6) Fatigue – Will check appropriate labs.” *Id.*

105. On or about September 29, 2014, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included “Pt presents for refills on medications. He has been stable on the same dose of meds for several years. Will refill meds listed.” In the assessment, Licensee documented “chronic neck pain – DJD [and] DDD – Has been evaluated by neurosurgery”, insomnia, hypertension and ADHD. The plan was documented to include Patient 4 continue his current meds and follow-up after obtaining labs. *Id.*

106. On or about October 30, 2014, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included “Pt has had labs drawn [and] so refills will be provided for his Norco [and] Adderall while results are pending.” In the assessment, Licensee documented chronic neck pain and ADHD diagnosed “by psychiatrist.” The plan was documented to include Patient 4 continue current medications. Licensee was to call once Patient 4’s lab results were available. There is no documentation in the Licensee’s record for Patient 4 regarding Licensee having a discussion with Patient 4 regarding his lab results. *Id.*

107. On or about December 27, 2014, Licensee documented a progress note stating “Pt called requesting Abx for a sinus infection.” Licensee further documented calling Patient 4 a prescription for Augmentin and was to follow-up if symptoms failed to improve. *Id.*

108. On or about February 2, 2015, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included “Pt requesting medication refills [and] to review labs in person that were reviewed by phone previously.” In the assessment, Licensee documented “chronic neck pain 2° DJD [and] DDD”, insomnia, hypertension, and hypogonadism. The plan was documented to include refills of meds as listed in Patient 4’s record and Patient 4 was presented with options for testosterone replacement. Patient 4 is documented as wanting to think about testosterone replacement options and to call once he had decided. There is no documentation by Licensee that Patient 4 ever called regarding testosterone replacement. *Id.*

109. On or about February 12, 2015, Licensee documented a progress note stating “Pt called stating that he was experiencing another sinus infection. Will repeat Augmentin course. Also discussed supportive care [with] pt – of which he is quite familiar.” *Id.*

110. On or about February 26, 2015, an Operative Report for Male Testosterone Pellet Insertion is in Licensee’s record for Patient 4. Patient 4 had nine (9) 200mg pellets inserted. No informed consent for the procedure appears in Licensee’s record. Additionally, the record is not signed by Licensee. *Id.*

111. On or about April 27, 2015, an Operative Report for Male Testosterone Pellet Insertion is in Licensee’s record for Patient 4. Patient 4 had two (2) 100mg pellets and seven (7) 87.5mg pellets inserted. Licensee documented that a total dosage of 800mg were received; however, it appears that the total dosage would be 812.5mg. No informed consent for the procedure appears in Licensee’s record. Licensee did not date when he signed the Operative Report. *Id.*

112. On or about May 4, 2015, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included “BHRT insertion site is closed [and] healing well. Pt Req. Refills of his regular medications. He is without any new complaints. Pt reports that he is feeling much better after starting Testosterone therapy. Fatigue has resolved. He reports that he has [decreased] his Adderall use because he feels so much better.” In the assessment, Licensee documented chronic neck pain, hypogonadism and ADHD. The plan was documented as “meds . . . listed above” and testosterone pellet implants - will monitor labs. *Id.*

113. On or about July 6, 2015, Licensee documented an appointment for Patient 4 occurred. Licensee documented a HPI that included “Pt here for medication refills. He reports that he has been feeling better after starting Testosterone therapy. He reports [decrease] musculoskeletal pain [and] improved energy levels (less fatigue).” In the assessment, Licensee documented chronic neck pain – DJD [and] DDD, ADHD, insomnia and hypogonadism. The plan was documented for Patient 4 to continue current medications and labs would be monitored regarding hormone therapy. Follow-up was to occur after Patient 4’s next set of labs (as indicated). *Id.*

114. On or about August 13, 2015, an Operative Report for Male Testosterone Pellet Insertion is in Licensee’s record for Patient 4. Patient 4 had seven (7) 200mg pellets inserted. Licensee documented that a total dosage of 1400mg were received. No informed consent for the procedure appears in Licensee’s record. Additionally, the record is not signed by Licensee.

115. During Licensee’s care and treatment of Patient 3, Licensee failed to document/maintain documentation of the following:

- a. informed consent surrounding testosterone pellet insertion on three separate occasions;
- b. how many pills Patient 4 was consuming on a daily basis;

- c. the reasons for extra refills given to Patient 4; and/or
- d. appropriate reasons for the way that prescriptions for Patient 4 were written.

116. Licensee's acts and conduct during the course of treating Patient 4 constitute violations of the Kansas Healing Arts Act as follows:

- a. Licensee has violated K.S.A. 65-2836(b), in that Licensee committed an act or acts of unprofessional and/or dishonorable conduct;
- b. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(12), in that Licensee engaged in conduct likely to deceive, defraud and/or harm the public;
- c. Licensee has violated K.S.A. 65-2836(b), as further defined in K.S.A. 65-2837(b)(25), in that Licensee failed to keep written medical records which accurately describe the services rendered to Patient 4, including patient histories, pertinent findings, examination results and test results;
- d. Licensee has violated K.S.A. 65-2836(f), in that Licensee has willfully or repeatedly violated this act, the pharmacy act of the state of Kansas or the uniform controlled substance act, or any rules and regulations of the secretary of health and environment which are relevant to the practice of the healing arts; and/or
- e. Licensee has violated K.S.A. 65-2836(k), in that Licensee has violated any lawful rule and regulation promulgated by the Board, specifically, K.A.R. 100-24-1, by failing to meet the minimum requirements for an adequate patient record associated with the care and treatment provided to Patient 4.

117. Pursuant to K.S.A. 65-2836, the Board has grounds to revoke, suspend, censure, fine or otherwise limit Licensee's license for violation of the Kansas Healing Arts Act.

## COUNT VI

118. Petitioner incorporates herein, by reference, paragraphs one (1) through one hundred seventeen (117) as fully restated and re-alleged herein.

119. As of September 2015, Licensee's Kansas license status was changed to Inactive and Licensee possessed no other licenses under which he could practice the Healing Arts in the State of Kansas.

120. On or about April 8, 2016, Board staff discovered the following **active** website: [www.drjayowens.com](http://www.drjayowens.com). The website listed Licensee's information including: his name, telephone number and photograph of Licensee. The website also indicated that there was a "10 minute average wait time" notification. See Exhibit 30: Investigative Report dated April 11, 2016; see also Exhibit 31: Screenshots of "Meet Dr. Owens" and "Home" tabs of website drjayowens.com dated received April 8, 2016.

121. In addition the website stated the following information:

Fewer Patients = More Time for You

[Licensee] has on average, 500 patients. If that seems like a lot, compare it to the typical 2,000 or so of a traditional primary care physician. Because he limits the number of patients he sees, that opens ups[sic] his schedule to be available when you need him – no matter what time of the day, or part of the week.

Insurance-Free = Hassle-Free

[Licensee] doesn't accept insurance. But don't let that scare you, because most of his patients actually save money as Owens Medical Center members. We can help you find the combination of healthcare, and health insurance that saves you money and results in better quality service. We even have someone in-house specifically for that!

Doctoring the way it used to be[.]

Are you looking for a relaxed, personal experience with your physician?

Do you miss the days where your Doctor actually spent time with you, listened to you and was directly involved in your health? Guess what....that's exactly what we do. We put the "care" back in healthcare.

An innovative approach to health care[.]

Unlimited access to your doctor. Literally. After hours, weekends, holidays- there's no bad time to receive excellent medical care. Full access via technology. You'll be able to reach our team and other medical information via webcam, e-mail, text and more. The sky is the limit.

You will receive text notifications or emails with copies of your lab orders, instructions and prescriptions. No more fumbling around trying to find a prescription or waiting on the pharmacy to find your insurance information.

Your monthly membership to Owens Medical Center ensures a consistent and comfortable billing process for you as the patient.

See Exhibit 32: Website drjayowens.com after it was taken down on April 8, 2016.

122. On April 18, 2016, Board staff discovered that Licensee had a LinkedIn profile. See Exhibit 2.

123. Licensee's LinkedIn profile available to the public at <https://www.linkedin.com/in/drjayowens> indicates Licensee is employed at Owens Medical Health and Wellness, PA Restorative Health from May 2014 to Present. Specifically, it states that Owens Health and Wellness, PA is "Direct Primary Care type practice focusing on evidence based medicine, coupled with complementary and alternative medicine in order to promote wellness and vitality in my patient population." *Id.*

124. Licensee's LinkedIn profile also indicates Licensee is employed as an ER Physician with Docs Who Care from June 2014 to Present. *Id.*

125. Licensee's acts and conduct constitute violations of the Kansas Healing Arts Act as follows:

a. K.S.A. 65-2836(b), in that Licensee has committed an act or acts of unprofessional and/or dishonorable conduct; when he held himself out to the public as being professionally engaged in the practice of the Healing Arts while holding a license in Inactive status.

K.S.A. 65-2809(g), allows the board "to issue an inactive license only to a person who is not regularly engaged in the practice of the healing arts in Kansas, who does not hold oneself out to the public as being professionally engaged in such practice and who meets the definition of inactive health care provider as defined in K.S.A. 40-3401, and amendments thereto. An inactive license shall not entitle the holder to practice the healing arts in this state."

b. K.S.A. 65-2836(d) in that Licensee used fraudulent or false advertisements when he continued to advertise his practice after his changing his license to Inactive status in the state of Kansas on or about September 1, 2015;

c. K.S.A.(g) in that Licensee has unlawfully invaded the field of practice of the healing arts by soliciting professional patronage even though he was not licensed to practice the healing arts with a license in Inactive status.

d. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(1) solicitation of professional patronage through the use of fraudulent or false advertisements; and/or

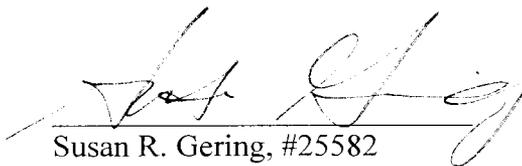
e. K.S.A. 65-2836(b) as further defined by K.S.A. 65-2837(b)(12), in that Licensee committed conduct likely to deceive, defraud or harm the public.

126. Pursuant to K.S.A. 65-2836 *et. seq.*, the Board has grounds to revoke, suspend, censure, place on probation, fine or otherwise limit Licensee's license for violations of the Kansas Healing Arts Act.

**WHEREFORE**, Petitioner prays that the Board make findings of fact and conclusions of law that Licensee committed these acts in violation of the Kansas Healing Arts Act, that Licensee's license to practice medicine and surgery in the State of Kansas be revoked, suspended, placed on probation, censured, or otherwise limited, and that the Board assess such administrative fines and impose such costs against Licensee as it shall deem just and proper and as authorized by law.

**WHEREFORE**, Petitioner further requests this matter be set for a conference hearing pursuant to K.S.A. 77-533. It would be appropriate to set this matter for a hearing at the next available Board meeting. Alternatively, Petitioner further requests that upon Licensee's request this matter have a Presiding Officer appointed and be set for a Formal Hearing pursuant to K.S.A. 77-513.

Respectfully submitted,



Susan R. Gering, #25582  
Associate Litigation Counsel  
800 SW Jackson Street  
Lower Level Suite A  
Topeka, KS 66606  
(785) 368-8212  
(785) 368-8210 – facsimile  
[susan.gering@ks.gov](mailto:susan.gering@ks.gov)

**CERTIFICATE OF SERVICE**

I, the undersigned, hereby certify that the foregoing Petition was served this 30<sup>th</sup> day of March, 2017, by depositing the same in the United States Mail, first-class postage prepaid, and addressed to:

Jay G. Owens, D.O.

*Licensee*

[REDACTED]

Overland Park, KS 66212

Tom Rottinghaus

*Attorney for Licensee*

Wagstaff & Cartmell, LLP

4740 Grand Avenue

Kansas City, MO 64112

and the original was filed with the office of the Executive Director:

Kathleen Selzler Lippert

Executive Director

Kansas State Board of Healing Arts

800 SW Jackson Lower Level, Suite A

Topeka, KS 66612

