BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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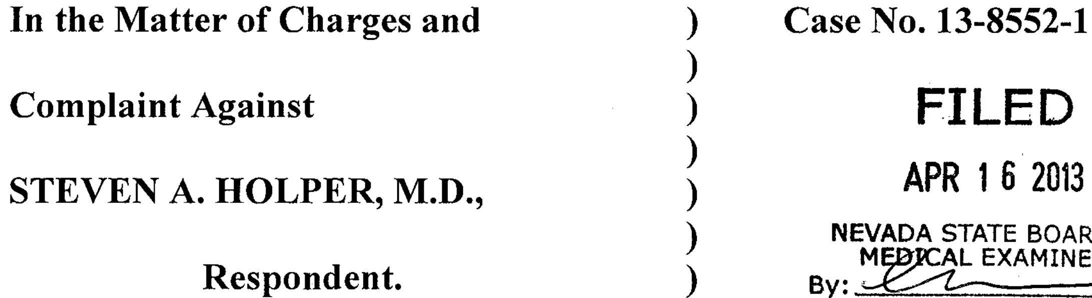

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), composed at the time of filing of Theodore B. Berndt, M.D., Chairman, Valerie J. Clark, BSN, RHU, LUTCF, Member, and Michael J. Fischer, M.D., Member, by and through Erin L. Albright, Esq., Deputy General Counsel for the Board and attorney for the IC, having a reasonable basis to believe that Steven A. Holper, M.D. (Respondent), violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively the Medical Practice Act), hereby issues its formal Complaint, stating the IC's charges and allegations as follows:

FACTUAL ALLEGATIONS

The following facts are pertinent for a determination in this matter.

A. Respondent's Licensure Status

1. Respondent is currently licensed in active status (License No. 6061), and has been licensed by the Board since July 1, 1990, pursuant to the provisions of the Medical Practice Act.

B. Patient A

2. At the time of the incidents alleged herein, Patient A was being treated by Respondent for pain management. His true identity is not disclosed in this Complaint to protect

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his identity, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A first presented to Respondent on or about October 2005, following a motor vehicle accident. Patient A treated with Respondent until February 10, 2009.

4. While treating Patient A, Respondent increased the patient's medications from ten (10) milligrams of Hydrocodone once per day to ten (10) milligrams of Hydrocodone six (6) times per day plus ten (10) milligrams of Methadone ten (10) times per day plus four (4) tablets of Soma per day plus three (3) tablets of Xanax per day. Despite the increased dosages in medication, Respondent repeatedly failed to counsel the patient on addiction and drug-seeking behavior.

5. Respondent failed to keep a log of the medications prescribed to Patient A, to have Patient A submit to urine screens, and failed to run prescription profiles on Patient A.

6. Respondent also repeatedly prescribed Patient A Methadone without requiring Patient A first obtain an EKG.

7. Further, Patient A's medical records are also inaccurate, illegible and/or incomplete.

C. Patient B

8. At the time of the incidents alleged herein, Patient B was being treated by Respondent for pain management. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

9. On or about October 5, 2009, Respondent wrote Patient B a twenty-one (21)-day prescription for one thousand seven hundred twenty-two (1,722) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted eighty-two (82) tablets of Roxicodone per day.

10. On or about October 24, 2009, Respondent wrote Patient B a twenty-(20) day prescription for one thousand eight hundred forty-eight (1,848) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted approximately ninety-two (92) tablets of Roxicodone per day.

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11. On or about November 14, 2009, Respondent wrote Patient B a twenty (20)-day prescription for one thousand eight hundred forty-eight (1,848) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted approximately ninety-two (92) tablets of Roxicodone per day.

12. On or about December 3, 2009, Respondent wrote Patient B a twenty (20)-day prescription for one thousand eight hundred forty-eight (1,848) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted approximately ninety-two (92) tablets of Roxicodone per day.

13. On or about December 17, 2009, Respondent wrote Patient B a twenty (20)-day prescription for one thousand eight hundred forty-eight (1,848) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted approximately ninety-two (92) tablets of Roxicodone per day.

14. On or about December 30, 2009, Respondent wrote Patient B a two (2)-day prescription for four hundred (400) thirty (30)-milligram tablets of Roxicodone. Pursuant to this prescription, Patient B was allotted two hundred (200) tablets of Roxicodone per day.

15. Respondent's medical records for Patient B lack drug profiles and urine toxicology screens. The medical records are also inaccurate, illegible and/or incomplete.

D. Patient C

16. At the time of the incidents alleged herein, Patient C was being treated by Respondent for pain management. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

17. Respondent wrote Patient C three (3) prescriptions for Oxycodone. These prescriptions were written on April 7, 2011, June 2, 2011 and August 8, 2011. Patient C's medical records are lacking any corresponding documentation for said prescriptions.

E. Patient D

18. At the time of the incidents alleged herein, Patient D was being treated by Respondent for pain management. His true identity is not disclosed in this Complaint to protect

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his identity, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

19. From July 2011 through April 2012, Respondent wrote Patient D seven (7) prescriptions for Hydrocodone BIT/Acetaminophen. Respondent also wrote Patient D seven (7) prescriptions for Alprazolam. Patient D's medical records are lacking any corresponding documentation for said prescriptions.

F. Patient E

20. At the time of the incidents alleged herein, Patient E was being treated by Respondent for pain management. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

21. Respondent's medical records for Patient E lack drug profiles and urine toxicology screen. The medical records are also inaccurate, illegible and/or incomplete.

COUNT I

(Malpractice – Two Counts)

22. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

23. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

24. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

25. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill and/or knowledge ordinarily used under similar circumstances when treating both Patients A and B.

26. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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COUNT II

(Medical Records Violation – Five Counts)

27. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

28. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

29. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through E when he failed to maintain timely, legible, accurate and/or complete medical records for said patients.

30. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the IC prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine the sanctions it will impose if it finds Respondent violated the Medical Practice Act;

4. That the Board make, issue and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

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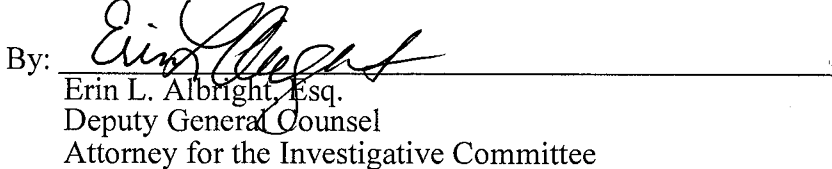
5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 16th day of April, 2013.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

Erin L. Albright, Esq.
Deputy General Counsel
Attorney for the Investigative Committee

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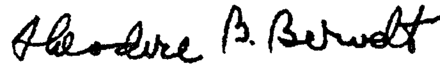
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Theodore B. Berndt, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, that he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 16th day of April, 2013.



Theodore B. Berndt, M.D.

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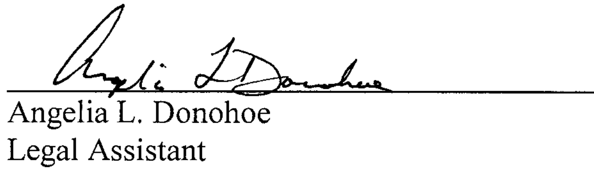
CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 16th day of April 2013; I served a filed copy of the COMPLAINT, PATIENT DESIGNATION & FINGERPRINT INFORMATION, via USPS certified return receipt mail to the following:

L. Kristopher Rath, Esq.
Hutchison & Steffen
10080 West Alta Drive, Ste. 200
Las Vegas, NV 89145

Dated this 16th day of April, 2013.



Angelia L. Donohoe
Legal Assistant