BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against GARY MANLEY, PA-C, Respondent.	**Case No. 20-36618-2**

FILED
AUG 10 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Gary Manley, PA-C (Respondent), a licensed physician assistant in Nevada. After investigating this matter, the IC[1] has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act). The IC alleges the following facts:

1. Respondent was licensed by the Board, pursuant to the provisions of the Medical Practice Act, on March 1, 2010, and is currently licensed in active status (License No. PA1209).

2. On March 29, 2016, Respondent and fellow Board licensee Dr. Ibrahim Fakhouri, M.D. (License #14038), entered into a supervision of physician assistant agreement (PA Supervision Agreement) pursuant to the Medical Practice Act.

A. Respondent's Treatment of Patient A

3. Patient A's true identity is not disclosed herein to protect his or her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

4. Patient A was treated by Respondent from May 31, 2016 through September 28, 2017, and Respondent was supervised in his care of Patient A by Dr. Fakhouri, who reviewed and signed off on all of Respondent's care of Patient A during this aforementioned time.

[1] The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), at the time this formal Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Chairman, Aury Nagy, M.D., and Michael C. Edwards, M.D., FACS.

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

5. Respondent treated Patient A, who presented with a subjective complaint of 20 years of chronic back pain. With only a musculoskeletal examination at the initial visit, and the majority of follow-up visits only documenting a condition of a "normal gait," Patient A was prescribed doses of opioids equivalent to 180 MME (Morphine Milligram Equivalents). From August 2, 2016 through December 1, 2016, Patient A's history of present illness, review of systems, physical examination and the subjective information documented appears to be a series of "cut and pastes" from visit to visit, and the following, "pain meds allow her to work…she is a dealer struggling to do her job" was indicated in the medical records.

6. On July 5, 2016, Patient A received a trigger point injection, but there was no documentation of why such procedure was medically justified, the location of such injection and how it (the injection) was tolerated or if there was an improvement from such treatment. Additionally, the only documentation supporting the aforementioned injection was a physical examination on July 5, 2016, that stated "normal gait, right lumbar area lumbar TTP." This aforementioned examination entry into the medical records was the only musculoskeletal examination documentation throughout Patient A's encounters with the Respondent, but for the constant cut-and-paste entry of "normal gait." On December 1, 2016, Patient A received another trigger point injection despite Patient A's medical records indicating an unremarkable history, negative review of systems and negative physical examination. On March 28, 2017, almost 10 months after receiving treatment from Respondent, Patient A provided a UDS (urine drug screen) test and these test results indicated a "negative" for Temazepam (prescribed), a "positive" for Alprazolam (not prescribed) and a "positive" for Methadone and Oxycodone (both prescribed). Respondent took no subsequent actions or informed Patient A of these UDS results as this specific UDS was the one and only documented within the medical records. Respondent prescribed two benzodiazepines, Temazepam for insomnia and Diazepam for psoriasis. Patient A did not execute an informed consent or patient education discussing the known risks with opioid dosages greater than 90 MME and current use of benzodiazepines. From June 26, 2017 through August 28, 2017, Respondent did not inquire about Patient A's pain condition, yet Respondent continued to write monthly (greater than 90 MME) pain medications at each visit. Medical records note that

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

Respondent prescribed monthly opioids and benzodiazepines without a determination of how much Patient A required from the previous month, and there was minimal evaluation of response or pain level inquiry from month to month. Medical records of Patient A do not contain any clear rationale or medical justification, and do not contain any physical or diagnostic evidence of chronic back pain. Respondent, in his care of Patient A, did not attempt to obtain any previous or current diagnostic evidence of Patient A's physiologic source of pain, did not request previous medical records, copies, or previous imaging, did not order additional imaging, adjuvant therapies, and there was no consideration for a referral to a pain management specialist. Only one Nevada Prescription Monitoring Program (PMP) was obtained for the duration of Patient A's visits, and was not indicated in the medical records.

COUNT I

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

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

8. A physician assistant is subject to discipline for violating of NRS 630.301 through 630.3065 inclusive, pursuant to NAC 630.380(1)(m).

9. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1) (b)(2).

10. Pursuant to NAC 630.187, the Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards of the United States, Inc. (Model Policy).

11. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat chronic pain in a manner that deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* adopted by reference in NAC 630.187.

12. On information and belief, Respondent wrote prescriptions to Patient A for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy. Deviations included but were not limited to the following: 1) prescribing excessively high doses of opioid

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
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therapy over 90 MME in violation of the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013; 2) failing to justify the use of high dosages of opioid medication; 3) failing to review the PMP prior to, during, and after the encounters with Patient A; 4) failing to assess Patient A for alternative non-opioid treatments; 5) failing to assess and discuss with Patient A with the risks versus benefits of opioid therapy; 6) failing to assess Patient A's concurrent medications interactions with the opioid therapy; 7) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 8) failing to assess Patient A for possible drug screens on a consistent basis; and, 9) prescribing a combination of benzodiazepines and opioids without documenting the medical justification.

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

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

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

15. NRS 630.3062(1)(a) 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.

16. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions in complying with the Model Policy, including, but not limited to, failing to document the following: physical examinations before prescribing opioid analgesics; queries of the PMP before prescribing opioid analgesics; urinalysis before and after prescribing opioid analgesics; support for his diagnoses with physical examination findings; treatment objectives to evaluate treatment progress; monitoring and adapting his treatment plan; progress toward discontinuation of opioid therapy.

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

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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Nevada State Board of Medical Examiners
9600 Gateway Drive
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(775) 688-2559

COUNT III

NRS 630.301(4) (Malpractice)

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

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

20. 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.

21. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A. The Respondent's specific acts of malpractice are as follows, but not limited to: 1) prescribing excessively high doses of opioid therapy over 90 MME in violation of the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013; 2) failing to justify the use of high dosages of opioid medication; 3) failing to review the PMP prior to, during, and after the encounters with Patient A; 4) failing to assess Patient A for alternative non-opioid treatments; 5) failing to assess and discuss with Patient A with the risks versus benefits of opioid therapy; 6) failing to assess Patient A's concurrent medications interactions with the opioid therapy; 7) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 8) failing to assess Patient A for possible drug screens on a consistent basis; and, 9) prescribing a combination of benzodiazepines and opioids without documenting the medical justification

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

B. Respondent's Treatment of Patient B

23. Patient B's true identity is not disclosed herein to protect his or her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint. Patient B was treated by Respondent from April 1, 2016 through September 8, 2017 and Respondent was supervised in his care of Patient B by Dr. Fakhouri, who reviewed and signed off

on all of Respondent's care of Patient B during this aforementioned time.

24. Respondent treated Patient B, who at the initial visit stated that her pain was due to a bodily assault and motor vehicle accident, and was found to have "lumbar and gluteal tenderness" based upon Respondent's physical examination. Patient B was prescribed doses of opioids equivalent to 225 MME (Morphine Milligram Equivalents) without physical or diagnostic evidence of Patient B's chronic pain condition. On March 23, 2017, after more than 17 months of treatment under Respondent's care Patient B provided only one UDS, which indicated a toxicity screen consistent with Respondent's prescribed opioids and benzodiazepine, but inconsistent for codeine and cannabinoids. Respondent did not address these UDS results with the Patient B or in the medical records. On April 18, 2017, Patient B complained of headaches not being controlled by pain medications, and this encounter is the first that there is a subjective pain assessment section of her medical records. A review of symptoms from the medical records was for headache, back pain, and anxiety, which were not consistent with the diagnoses and disproportionate opioid medication prescription therapy. From October 26, 2016 through September 8, 2017, according to the medical records, a review of symptoms for Patient B was negative for back pain and anxiety. Patient B's anxiety disorder was treated by Respondent, who prescribed Diazepam (10mg) (3x daily) with no evaluation of her use, function or consideration of a behavioral health referral. The medical records of Patient B do not indicate how or whether she took the medicine as prescribed. Had Respondent reviewed the PMP, then such would have indicated that Patient B was not filling the aforementioned prescription and perhaps this medication was not required, or in the alterative, Respondent should have recognized Patient B's inconsistent filling of excessive benzodiazepines and inquired about her use. Respondent's evaluation of Patient B's anxiety issues were "she presents with a history of depression with anxiety and she has had an official diagnosis of anxiety disorder in the past by a medical professional." From June 2016 to May 2017, Patient B filled the aforementioned quantities of Diazepam monthly. During this aforementioned time, Respondent did not inquire about this of medication, nor further explore her anxiety issues nor attempt to refer her to an appropriate mental health provider. Patient B's hypothyroid disorder was treated by Respondent for at least six (6)

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Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

months without testing for the Thyroid-Stimulating Hormone (TSH). When this thyroid testing was obtained, it indicated exogenous hyperthyroid, which can cause clinical manifestations such as deceased bone density, increased fracture risk, increased incidence of atrial fibrillation, increased heart rate and contractility, insomnia and anxiety. The treatment could have reduced the thyroid medication therapy, but Respondent did not address such with Patient B. From month to month, Respondent added the following assessment and plan to Patient B's medical record: "acquired hypothyroidism, medications with no change to current regimen." One year later, Patient B's TSH results indicated a constant state of hyperthyroidism. This test result was never addressed in the medical records, and there was no change in her thyroid medication dosing, which could have potentially exposed Patient B to risks of osteoporosis, increased anxiety and cardiac arrhythmias. Patient B's medical records do not contain any clear rationale or medical justification, and do not contain any physical or diagnostic evidence of chronic pain. Respondent, in his care of Patient B, did not attempt to obtain any previous or current diagnostic evidence of Patient B's physiologic source of pain, did not request previous medical records, copies, or previous imaging, did not order additional imaging, adjuvant therapies, and there was no consideration for a referral to a Pain Management Specialist. Nominal PMPs were obtained for Patient B's visits, and there was no informed consent or counseling of the risks of opioid drug treatment.

COUNT IV

NRS 630.306(1) (b) (2) (Violation of Standards of Practice)

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

26. A physician assistant is subject to discipline for violating of NRS 630.301 through 630.3065 inclusive, pursuant to NAC 630.380(1) (m).

27. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1) (b)(2).

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28. Pursuant to NAC 630.187, the Board adopted by reference the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013, published by the Federation of State Medical Boards of the United States, Inc. (Model Policy).

29. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat chronic pain in a manner that deviates from the policies set forth in the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain* adopted by reference in NAC 630.187.

30. On information and belief, Respondent wrote prescriptions to Patient B for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy. Deviations included but not limited to the following: 1) prescribing excessively high doses of opioid therapy over 90 MME in violation of the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013; 2) failing to justify the use of high dosages of opioid medication; 3) failing to review the PMP prior to, during, and after the encounters with Patient B; 4) failing to assess Patient B for an alternative for non-opioid treatments; 5) failing to assess and discuss with Patient B with the risks versus benefits of opioid therapy; 6) failing to assess Patient B's concurrent medications interactions with the opioid therapy; 7) failing to assess Patient B for possible drug abuse, drug diversion or any other non-medical related activity; 8) failing to review the PMP data; 9) failing to assess Patient B for possible drug screens on a consistent basis; and, 10) prescribing a combination of benzodiazepines and opioids without documenting the medical justification.

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

COUNT V

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

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

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Nevada State Board of Medical Examiners
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33. NRS 630.3062(1)(a) 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.

34. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient B, by failing to document his actions in complying with the Model Policy, including, but not limited to, failing to document the following: physical examinations before prescribing opioid analgesics; queries of the PMP before prescribing opioid analgesics; urinalysis before and after prescribing opioid analgesics; support for his diagnoses with physical examination findings; treatment objectives to evaluate treatment progress; monitoring and adapting his treatment plan; progress toward discontinuation of opioid therapy.

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

COUNT VI

NRS 630.301(4) (Malpractice)

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

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

38. 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.

39. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient B. The Respondent's specific acts of malpractice are as follows, but not limited to: 1) prescribing excessively high doses of opioid therapy over 90 MME in violation of the *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain,* July 2013; 2) failing to justify the use and increase, decrease, and then increase of dosages of opioid medication; 3) prescribing a combination of benzodiazepines and opioids without documenting the medical justification; 4) failing to review the PMP prior to, during, and after the

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

encounters with Patient B; 5) failing to assess Patient B for alternative, non-opioid treatments; 6) failing to assess and discuss with Patient B with the risks versus benefits of opioid therapy; 7) failing to assess Patient B's concurrent medications interactions with the opioid therapy; 8) failing to assess Patient B for possible drug abuse, drug diversion or any other non-medical related activity; 9) failing to review the PMP data; and, 10) failing to assess Patient B for possible drug screens on a consistent basis.

39. 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 what sanctions to impose if it finds and concludes that there has been a violation or violations of the Medical Practice Act committed by Respondent;

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

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

DATED this 7 day of August, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Robert Kilroy, Esq.
General Counsel
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Mr. M. Neil Duxbury, 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, he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 10th day of August, 2020.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

M. Neil Duxbury

M. Neil Duxbury, M.D., Chairman

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 10th day of August, 2020, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

Gary Manley, PA-C
c/o Todd Weiss, Esq.
John H. Cotton & Associates, LTD.
7900 W. Sahara, Suite 200
Las Vegas, NV 89117
(702) 832-5909
TWeiss@jhcottonlaw.com

Dated this 10th day of August, 2020.

Sheri L. Quigley

Sheri L. Quigley, Legal Assistant

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559