BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **MARIA CORAZON O. REGALADO, M.D., Respondent.**	**Case No. 21-12597-1**

FILED
NOV - 4 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Aaron Bart Fricke, J.D., General Counsel and attorney for the IC, having a reasonable basis to believe that Maria Corazon O. Regalado, 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 Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 8966). Respondent was originally licensed by the Board on April 27, 1999.

A. RESPONDENT'S TREATMENT OF PATIENT A

2. Patient A[2] is an immediate family member of Respondent.

3. Respondent prescribed to Patient A controlled substances on more than twenty (20) occasions between 2008 and 2014, including eighteen (18) separate prescriptions for hydrocodone, an opioid analgesic, totaling one thousand six hundred ninety (1,690) tablets containing hydrocodone. Respondent prescribed Patient A multiple other scheduled medications,

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Wayne Hardwick, M.D., Chair, Theodore Berndt, M.D., and Mr. M. Neil Duxbury.

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

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including codeine cough syrup and muscle relaxants, on numerous occasions without examination, work-up, justification, or a treatment plan, and without any documentation of the same.

4. Respondent saw Patient A as a patient on at least four (4) occasions between June 7, 2012, and May 28, 2014.

5. Respondent maintained some medical records of the four (4) encounters in 2012 through 2014 documenting "low backpain" on all of these visits, and a "foot sprain" during the two (2) visits that occurred in 2014.

6. Respondent did not otherwise document her encounters with Patient A, nor did she order any additional studies, evaluations, consultations, or referrals for Patient A.

COUNT I

NRS 630.301(4) - Malpractice

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

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

9. 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."

10. 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 rendering medical services to Patient A.

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

COUNT II

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

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

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

14. 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).

15. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the Model Policy.

16. Respondent failed to conduct any detailed neurologic or musculoskeletal examinations that would establish medical reasoning for Patient A to receive long-term opioid medication for pain control.

17. Respondent failed to recommend other conservative treatments before or concurrent with long-term opioid therapy including, but not limited to, physical therapy, exercise and movement, or massage therapy, among others, which may have alleviated these findings on physical examination.

18. Pursuant to the Model Policy, a physician's patient evaluation should include, without limitation: a complete medical history and a physical examination targeted to the pain condition, evaluation of the nature and intensity of the pain, and history of current and past treatments, including interventional treatments. Respondent maintained records of only four (4) patient encounters, and otherwise consistently failed to include such information in Respondent's medical records for Patient A.

19. Respondent's records do not contain or show any indication of recent or contemporaneous imaging (e.g. X-rays, MRIs, or CT scans) that would substantiate the need for long-term opioids for pain control.

20. Based on, but not limited to, the foregoing, Respondent wrote prescriptions to Patient A for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy.

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

COUNT III

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

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

23. 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" constitute grounds for initiating discipline against a licensee.

24. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A.

25. 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

26. Patient B[3] is an immediate family member of Respondent.

27. Respondent maintained medical records for only one (1) visit with Patient B on July 24, 2015, at which time Respondent evaluated Patient B for hypertension, "panic attacks," and a history of a stroke with left sided hemiplegia. Respondent wrote numerous prescriptions to Patient B at that visit, including alprazolam (Xanax) for Patient B's "panic attacks."

28. Although Respondent maintained medical records for only one (1) formal office visit, Respondent prescribed numerous medications to Patient B on numerous occasions, including twenty (20) prescriptions for Xanax tablets, sixty (60) count, totaling one thousand two hundred (1,200) tablets, between just January 27, 2014 and October 16, 2015. Respondent did not order additional visits, evaluations, diagnostic tests, consultations or referrals, and no treatment plans were documented.

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

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COUNT IV

NRS 630.301(4) - Malpractice

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

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

31. 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."

32. 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 rendering medical services to Patient B.

33. 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 Complete Medical Records

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

35. 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" constitute grounds for initiating discipline against a licensee.

36. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient B.

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

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C. RESPONDENT'S TREATMENT OF PATIENT C

38. Patient C[4] was a patient of Respondent between March 13, 2013, and December 17, 2014.

39. Patient C died of acute oxycodone and morphine toxicity on January 17, 2015.

40. Patient C had multiple medical conditions, and Respondent saw Patient C approximately once a month between March 2013 and December 2014. Despite Patient C having multiple severe medical conditions, including chronic obstructive pulmonary disease (COPD), an abdominal "mass," severe and chronic renal insufficiency, seizures, and demonstrated opiate dependence and drug seeking behavior; Respondent routinely prescribed to Patient C multiple sedating and dangerous medications, in very large doses, on a monthly basis with minimal or no additional work-ups, referrals, consultation requests, diagnostic tests, treatment plans, or evaluations of Patient C's chronic "pain" or other problems.

41. On at least one (1) visit, Respondent documented a "RLQ MASS – HUGE," yet on subsequent visits the "mass" was not even mentioned. On at least one (1) visit, Respondent documented "back pain," but also documented a normal physical exam (e.g., "Back- normal, no tenderness"). Respondent did refer the patient for an abdominal CT scan on one (1) occasion and to a surgeon on another occasion, however these referrals were not completed, and Respondent did not follow-up on them.

42. In September of 2014, a laboratory evaluation ordered by Respondent revealed severe chronic kidney disease with a serum creatinine of over 6 and a BUN of over 70. These abnormal test results were also documented in a Valley Hospital laboratory result the same month (BUN 81 and creatinine 6.9). Respondent referred Patient C to a nephrologist, but was informed in writing that Patient C never made an appointment.

43. Despite being informed that Patient C did not see the nephrologist as referred, Respondent documented the next month, on a visit on October 22, 2014, that Patient C "was seen by a nephrologist and told her kidneys were ok." By this point in time, Respondent knew or should have known, by lab reports that she possessed, that Patient C was essentially in "end stage"

[4] Patient C's true identity is not disclosed herein to protect his or her identity, but is disclosed in the Patient Designation contemporaneously served upon Respondent along with a copy of this Complaint.

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kidney disease, yet Respondent did nothing more to address Patient C's obvious and serious renal failure.

44. Each and every month that Respondent saw Patient C, almost without exception, Respondent prescribed Patient C very large volumes and high doses of opioids (usually between ninety (90) and one hundred twenty (120) tablets of thirty (30) mg oxycodone) and benzodiazepines (usually ninety (90) tablets of the two (2) mg Xanax). In addition, Respondent often prescribed ninety (90) pills of the muscle relaxant carisoprodol (Soma) concurrently. Patient C's other medical conditions noted herein, including COPD, renal failure, and seizure disorder, were not addressed by Respondent at all or only in a cursory fashion.

45. Respondent documented during a visit on April 15, 2013, that Patient C was "still on methadone," yet, went on to prescribe large doses and volumes of opioids, benzodiazepines and muscle relaxants routinely, every month (alprazolam, clonazepam, and Ativan were all prescribed) for another full year. In such a situation, the standard of care dictates that only the pain management physician should be providing opioid analgesics for Patient C.

46. Patient C, who had COPD and was obese, was at a particularly high risk for morbidity and mortality from respiratory depression from the combination of high-dose sedative medications prescribed by Respondent. In addition, Patient C's severe and chronic kidney disease further increased her risk of morbidity and mortality. Additional necessary evaluations for her pain, anxiety, kidney disease, abdominal "mass," and COPD were not undertaken, and appropriate specialty consultations and referrals were not pursued

COUNT VI

NRS 630.301(4) - Malpractice

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

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

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49. 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."

50. 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 rendering medical services to Patient C.

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

COUNT VII

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

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

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

54. 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).

55. Pursuant to NAC 630.230(1)(k), a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the Model Policy.

56. Respondent failed to conduct any detailed neurologic or musculoskeletal examinations that would establish medical reasoning for Patient C to receive long-term opioid medication for pain control.

57. Respondent failed to recommend other conservative treatments before or concurrent with long-term opioid therapy including, but not limited to, physical therapy, exercise and movement, or massage therapy, among others, which may have alleviated these findings on physical examination.

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58. Pursuant to the Model Policy, a physician's patient evaluation should include, without limitation: a complete medical history and a physical examination targeted to the pain condition, evaluation of the nature and intensity of the pain, and history of current and past treatments, including interventional treatments. Respondent consistently failed to include such information in Respondent's medical records for Patient C.

59. Respondent's records do not contain and show no indication of recent or contemporaneous imaging (e.g. X-rays, MRIs, or CT scans) that would substantiate the need for long-term opioids for pain control.

60. Based on, but not limited to, the foregoing, Respondent wrote prescriptions to Patient C for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy.

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

COUNT VIII

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

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

63. 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" constitute grounds for initiating discipline against a licensee.

64. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient C.

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

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WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against her and give him notice that she 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 determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 4 day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AARON BART FRICKE, J.D.
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Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 4 day of November, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 4th day of November, 2021, I served a file-stamped copy of the foregoing **COMPLAINT** via U.S. Certified Mail, to the following parties:

MARIA CORAZON O. REGALADO, M.D.
1811 S. Rainbow Blvd., Ste. 108
Las Vegas, NV 89146
Tracking No.: 9171 9690 0935 0252 1579 24

DATED this 4th day of November, 2021.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners