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

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **MICHAEL SCOTT MALL, M.D., Respondent.**	**Case No. 23-8666-1**

FILED

AUG 11 2023

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Scott Mall, 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. 6074). Respondent was originally licensed by the Board on July 1, 1990.

2. Patient A[2] was a forty-nine (49) year-old female at the time of the events at issue.

3. Patient A presented for consultation for laser treatment of a scar on her chest on or about August 21, 2019, and was given a consent form.

4. Respondent's notes and records for this visit show that Respondent did not document Patient A's history, nor did he document that he had reviewed her history or any intake forms.

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[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 Bret W. Frey, M.D., Carl N. Williams, Jr., M.D., FACS and Col. Eric D. Wade, USAF (Ret.).

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

5. Respondent did document at this visit that Patient A had a raised scar on her upper chest, however some of the handwritten notes are illegible and it appears Respondent failed to acknowledge whether the scarring was hypertrophic, keloid or another type of scarring. Both hypertrophic and keloid scarring are contraindicated for aggressive CO2 resurfacing, which Respondent also failed to document or take into consideration prior to treating Patient A.

6. On or about August 28, 2019, Patient A received treatment with the use of an Accupulse CO2 fractional resurfacing laser. During the procedure, Patient A felt more pain than she expected to and believed the area being treated was larger than the area that she had consented to be treated. Later that same day, Patient A developed blisters on her skin at the treated area and texted Respondent about the blisters. Respondent replied the blisters were normal and part of healing.

7. In review of the medical records for the August 28, 2019 treatment, Respondent failed to document the amount of time of the treatment, the intensity of the laser setting, and the number of passes for each area treated. Additionally, and according to Respondent, he would routinely use the same intensity settings on the laser during the entirety of the treatment, regardless of different body parts.

8. Respondent did not follow-up with Patient A after two (2) weeks post-treatment, so Patient A called Respondent's office to schedule a follow-up appointment.

9. On or about September 16, 2019, Patient A presented for her follow-up appointment at Respondent's office concerned that she was not healing properly and had a grid pattern on her chest. Respondent assured Patient A that her experience and healing were normal, eighteen (18) days post-procedure.

10. Patient A did not agree with Respondent and did not return for care from Respondent. On October 1, 2019, Patient A noticed elevated scarring at the treatment site and chose to see another medical provider for her aftercare.

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COUNT I

NRS 630.301(4) - Malpractice

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

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

13. 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."

14. 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 when he failed to document Patient A's history of previous scarring or document that he discussed risk factors, such as possible scarring from CO2 treatment; when he unnecessarily treated a larger area than what Patient A consented to; when he failed to document the amount of time he used the laser during treatment; the intensity of the laser setting, and the number of passes for each area treated; when he was unable to recognize the severe side effects of the laser treatment, such as Patient A's blistering, and failed to refer her to a dermatologist in a timely manner; and according to Respondent, routinely used the same intensity for all body parts.

15. 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

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

17. 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.

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18. Respondent failed to maintain legible, accurate, and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document Patient A's history and risk factors; by his lack of review of any intake forms; by failing to document the amount of time the laser was used during treatment or intensity of the laser setting, as well as the number of passes for each area treated; and by failing to document Patient A's severe side effects from the laser treatment, such as blistering. Further, Respondent's consent form was incomplete, as it did not outline the three (3) of the most common side effects of CO2 laser treatment, including but not limited to scarring, infection, and pigmentation changes.

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

COUNT III

NRS 630.306(1)(p) - Unsafe or Unprofessional Conduct

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

21. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

22. NAC 630.615 provides in pertinent part:

> Before offering advice about the means or instrumentality of treatment, the licensee shall undertake an assessment of the patient. The assessment must be documented in the medical chart of the patient and should include, without limitation, the conventional methods of diagnosis ordinarily utilized by physicians in good standing practicing in the same specialty or field. The assessment may include nonconventional methods of diagnosis. The assessment must include the following:
> 1. An adequate medical record.
> 2. Documentation as to whether conventional treatment options, including, without limitation, referral options for conventional treatment, ordinarily utilized by physicians in good standing practicing in the same specialty or field have been:
> (a) Discussed with the patient;
> (b) Offered to the patient;
> (c) Refused by the patient; or
> (d) Undertaken with the patient and, if so, the outcome of the treatment.

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23. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to document Patient A's previous history of scarring or document that he discussed risk factors, such as possible scarring from CO2 laser treatment. Moreover, Respondent's consent form was incomplete, as it did not outline the three (3) most common side effects of CO2 laser treatment, including, but not limited to, scarring, infection, and pigmentation changes. Respondent's conduct was unsafe and unprofessional.

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

COUNT IV

NRS 630.306(1)(e) - Practice Beyond Scope of License

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

26. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform, or which are beyond the scope of his or her training, constitutes grounds for initiating disciplinary action.

27. Accupulse CO2 fractional resurfacing requires training and experience to gain competence to provide adequate medical care and ensure the safety of patients. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to document Patient A's history of previous scarring or document that he discussed risk factors, such as possible additional scarring from CO2 laser treatment. Due to Respondent's lack of training and experience in the area of dermatology and skin treatments, he unnecessarily treated a larger area than what Patient A consented to; failed to document the amount of time, the intensity of the laser setting, and the number of passes for each area treated. Further, he was unable to recognize the severe side effects of the laser treatment in the patient's follow-up appointment including Patient A's blistering, and therefore failed to refer her to an experienced dermatologist in a timely manner; and, according to Respondent, routinely used the same intensity for all body parts, thereby underscoring that he was practicing beyond the scope of his license.

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

WHEREFORE, the Investigative Committee 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 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 11th day of August, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
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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 11th day of August, 2023.

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 11th day of August, 2023, I served a file-stamped copy of the foregoing **COMPLAINT** and **PATIENT DESIGNATION** with required fingerprinting materials to:

MICHAEL SCOTT MALL, M.D.
7455 W. Washington Ave., Ste. 400
Las Vegas, NV 89128

Tracking No.: 9171 9690 0935 0255 6834 37

DATED this 11th day of August, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners