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

* * * * *

In the Matter of Charges and Complaint Against: ORLANDO LAMAR WELLS, M.D., Respondent.	Case No. 23-28073-2

FILED
NOV 16 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 Orlandis Lamar Wells, 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. 10558). Respondent was originally licensed by the Board on July 7, 2003.

PATIENT A

2. Patient A[2] was a twenty-five (25) year-old female at the time of the events at issue.

3. Respondent treated Patient A from in or about August 2016 to in or about December 2016, at his office, namely Hormone Centers of Nevada.

/ / /

/ / /

[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 Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn and Victor M. Muro, M.D.

[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.

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

4. Although Patient A had earlier encounters with Respondent at another office, it appears that her initial visit to Respondent at Hormone Centers of Nevada was on or about September 12, 2016, wherein she complained of chronic pain.

5. Patient A was already taking 30 mg of oxycodone and 350 mg of carisoprodol for approximately two (2) years. In addition, she was prescribed 5 mg methadone "as needed" and 10 mg methadone "as needed" for over one (1) year.

6. Patient A visited Respondent three (3) more times, on or about October 13, 2016, on or about November 10, 2016, and on or about December 19, 2016.

7. Respondent's documentation for each visit for Patient A was virtually identical and fails to justify the continued prescriptions for high doses of opioids, nor did he create a plan to investigate the cause of Patient A's chronic pain.

8. Respondent's documentation does not reflect that he attempted to obtain Patient A's records from previous providers.

9. Respondent's documentation does not reflect that he utilized imaging studies to determine the cause of Patient A's chronic pain.

10. Respondent's documentation does not reflect that he attempted to utilize alternative treatment (non-opioid) for Patient A's chronic pain.

11. Respondent's documentation indicates, "drug screen appropriate for meds prescribed," but test results are not included in the records for Patient A.

12. Respondent provided inadequate attention to an initial assessment to determine if opioids were clinically indicated and to determine the risks associated with their use in a particular individual with pain with regard to Patient A's medical care.

13. Respondent provided inadequate monitoring of Patient A during the utilization of medications that have the strong potential for misuse.

14. Respondent provided inadequate attention to patient education and informed consent for Patient A's medical care.

15. Respondent failed to justify dose escalation without properly counseling Patient A of the potential risks or alternative treatments.

16. Respondent excessively relied on opioids, particularly high dose opioids for chronic pain management with regard to Patient A.

17. Respondent did not make use of available tools for risk mitigation with regard to Patient A.

COUNT I

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 rendering medical services to Patient A when the records for each of Patient A's visits were nearly identical, when Respondent failed to obtain Patient A's medical records from previous providers, when Respondent failed to utilize imaging studies to determine the cause of Patient A's chronic pain, when Respondent failed to utilize alternative treatment options (non-opioid) for Patient A's chronic pain, and when Respondent failed to utilize drug screening to determine the appropriate prescriptions for Patient A.

22. 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

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

///

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

24. 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.

25. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by documenting for each visit virtually identical records and failing to justify continued prescriptions for high doses of opioids.

26. 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)(b)(2) - Violation of Standards of Practice

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

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

29. The Board adopted by reference the Model Policy in NAC 630.187.

30. 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 standards set forth in the Model Policy.

31. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote prescriptions to Patient A for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy when the records for each of Patient A's visits were nearly identical, when Respondent failed to obtain Patient A's medical records from previous providers, failed to utilize imaging studies to determine the cause of Patient A's chronic pain, failed to utilize alternative treatment (non-opioid) for Patient A's chronic pain, and failed to utilize drug screening to determine the appropriate prescriptions for Patient A.

32. 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

COUNT IV

NRS 630.306(1)(c) – Unlawful Prescribing of Controlled Substance or Dangerous Drug

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

34. NRS 630.306(1)(c) provides that administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law, constitute grounds for initiating disciplinary action.

35. NRS 453.381(1) provides in part that, ... a physician may prescribe controlled substances only for a legitimate medical purpose and in the usual course of his or her professional practice....

36. Respondent did not "prescribe controlled substances only for a legitimate medical purpose," making these prescriptions unlawful pursuant to NRS 630.306(1)(c).

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

PATIENT B

38. Patient B[3] was a forty-one (41) year old male at the time of the events at issue.

39. Respondent treated Patient B from on or about January 2, 2017, to on or about January 30, 2017, at his office, Hormone Centers of Nevada.

40. Patient B's January 2, 2017, progress note does not indicate that this was his first visit with Respondent.

41. The medical records for Patient B's two (2) separate visits are identical and they are strikingly similar to Patient A's medical record.

42. Respondent prescribed Patient B 30 mg oxycodone and 10 mg for diazepam as early as March 14, 2016, but there is no documentation supporting the prescribing of high doses of 180 MME/day of oxycodone in combination with the diazepam.

///

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

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

1 43. Respondent had Patient B's MRI of the lumbar and cervical spine dated September
2 20, 2014, but no other previous records.
3 44. Respondent provided inadequate attention to Patient B's initial assessment in
4 determining if opioids were clinically indicated nor determined the risks associated with their use
5 in a particular individual with pain when he treated Patient B.
6 45. Respondent provided inadequate monitoring of Patient B during the utilization of
7 medications that have the strong potential for misuse.
8 46. Respondent provided inadequate attention to patient education and informed
9 consent for Patient B.
10 47. Respondent failed to justify dose escalation without adequate attention to the risks
11 or alternative treatments with regard to Patient B.
12 48. Respondent excessively relied on opioids, particularly high dose opioids for
13 chronic pain management with regard to Patient B.
14 49. Respondent did not make use of available tools for risk mitigation with regard to
15 Patient B.
16 **COUNT V**
17 **NRS 630.301(4) - Malpractice**
18 50. All of the allegations contained in the above paragraphs are hereby incorporated by
19 reference as though fully set forth herein.
20 51. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating
21 disciplinary action against a licensee.
22 52. NAC 630.040 defines malpractice as "the failure of a physician, in treating a
23 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
24 circumstances."
25 53. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
26 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
27 rendering medical services to Patient B when the records for both of Patient B's visits were
28 identical, when Respondent obtained one (1) previous MRI from Patient B's medical records from

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

previous providers, failed to utilize alternative treatment (non-opioid) for Patient B's chronic pain, and failed to utilize drug screening to determine the appropriate prescriptions for Patient B.

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

COUNT VI

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

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

56. 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," constitutes grounds for initiating discipline against a licensee.

57. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient B, by documenting for both visits identical records and failing to justify continued prescriptions for high doses of opioids.

58. 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

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

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

61. The Board adopted by reference the Model Policy in NAC 630.187.

62. 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 standards set forth in the Model Policy.

63. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote prescriptions for Patient B for opioid analgesics to treat chronic pain in a manner that deviated

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

from the Model Policy. Respondent's deviations include but are not limited to when the records for both of Patient B's visits were identical, when Respondent failed to obtain all but one (an MRI) of Patient B's medical records from previous providers, when Respondent failed to utilize alternative treatment (non-opioid) for Patient B's chronic pain, and when Respondent failed to utilize drug screening to determine the appropriate prescriptions for Patient B.

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

COUNT VIII

NRS 630.306(1)(c) – Unlawful Prescribing of Controlled Substance or Dangerous Drug

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

66. NRS 630.306(1)(c) provides that administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law, constitute grounds for initiating disciplinary action.

67. NRS 453.381(1) provides in part that, … a physician may prescribe controlled substances only for a legitimate medical purpose and in the usual course of his or her professional practice….

68. Respondent did not "prescribe controlled substances only for a legitimate medical purpose," making these prescriptions unlawful pursuant to NRS 630.306(1)(c).

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

PATIENT C

70. Patient C[4] was a forty (40) year-old female at the time of the events at issue.

71. Respondent treated Patient C from on or about September 22, 2016, to on or about February 16, 2017, at his office, Hormone Centers of Nevada.

///

[4] Patient C'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.

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

72. Patient C visited Respondent at Hormone Centers of Nevada three (3) times, on or about December 15, 2016, on or about January 19, 2017, and on or about February 16, 2017.

73. Patient C was prescribed 30 mg oxycodone as early as May 2014.

74. Respondent's documentation for each visit is identical, fail to justify continued prescriptions for high doses of opioids, and they are identical to Patient A's notes.

75. Patient C's physical examination is identical to Patient A's.

76. A urine drug screen dated November 17, 2016, documented negative results for all substances tested including oxycodone, which should have alerted Respondent to potential misuse of oxycodone by Patient C.

77. Respondent's subsequent progress note dated December 15, 2016, failed to mention the negative test results, and in the alternative stated, "drug screen appropriate for meds prescribed." Respondent then prescribed an additional 30 mg oxycodone during this same visit.

78. Respondent's documentation does not reflect that he attempted to obtain Patient C's records from previous providers.

79. Respondent's documentation does not reflect that he utilized imaging studies to determine the cause of Patient C's chronic pain, nor any attempt by Respondent to consider alternate treatments for Patient C's chronic pain.

80. When treating Patient C, Respondent provided inadequate attention to initially assess and determine if opioids were clinically indicated or to determine the risks associated with their use by Patient C.

81. Respondent provided inadequate monitoring of Patient C during the utilization of medications that have the strong potential for misuse.

82. Respondent provided inadequate attention to patient education and informed consent for Patient C.

83. Respondent failed to justify dose escalation without adequate attention to risks or alternative treatments with regard to Patient C.

84. Respondent excessively relied on opioids, particularly high dose opioids for chronic pain management with regard to Patient C.

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

85. Respondent did not make use of available tools for risk mitigation with regard to Patient C when beginning a regimen of strong opioid medication.

COUNT IX

NRS 630.301(4) - Malpractice

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

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

88. 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."

89. 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 when the records for Patient C's visits were identical for each visit and were identical to Patient A's records (including the physical examination); when Respondent failed to obtain Patient C's medical records from previous providers; when Respondent failed to utilize alternative treatment (non-opioid) for Patient C's chronic pain and failed to properly utilize drug screening to determine the appropriate prescriptions for Patient C when placing her on strong opioid medication.

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

COUNT X

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

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

92. 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.

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

93. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient C, by documenting identical records for each visit (and documenting the identical records as he did for Patient A) and failing to justify continued prescriptions for high doses of opioids.

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

COUNT XI

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

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

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

97. The Board adopted by reference the Model Policy in NAC 630.187.

98. 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 standards set forth in the Model Policy.

99. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote prescriptions to Patient C for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy when the records for each of Patient C's visits were identical (and identical to Patient A's records), when Respondent failed to obtain Patient C's medical records from previous providers, when Respondent failed to utilize alternative treatment (non-opioid) for Patient C's chronic pain, and when Respondent failed to properly utilize drug screening to determine the appropriate prescriptions for Patient C.

100. 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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

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

COUNT XII

NRS 630.306(1)(c) – Unlawful Prescribing of Controlled Substance or Dangerous Drug

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

102. NRS 630.306(1)(c) provides that administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law, constitute grounds for initiating disciplinary action.

103. NRS 453.381(1) provides in part that, … a physician may prescribe controlled substances only for a legitimate medical purpose and in the usual course of his or her professional practice….

104. Respondent did not prescribe controlled substances only for a legitimate medical purpose making these prescriptions unlawful pursuant to NRS 630.306(1)(c) when the records for each of Patient C's visits were identical to each other and to Patient A's medical records, when Respondent failed to obtain Patient C's medical records from previous providers, failed to utilize alternative treatment (non-opioid) for Patient C's chronic pain, and failed to properly utilize drug screening to determine the appropriate prescriptions for Patient C.

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

PATIENT D

106. Patient D[5] was a thirty-eight (38) year-old female at the time of the events at issue.

107. Respondent treated Patient D from on or about March 7, 2016, to on or about February 16, 2017, at his office, Hormone Centers of Nevada.

108. On March 7, 2016, Respondent prescribed Patient D 30 mg oxycodone and 350 mg carisoprodol which continued on a monthly basis until December 15, 2016.

109. Respondent also prescribed 10 mg diazepam to Patient D on March 7, 2016.

///

[5] Patient D'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.

110. Patient D's progress notes were nearly identical to the progress notes of Patients A, B, and C.

111. A urine drug screen collected on November 17, 2016, was negative for oxycodone and not addressed in this visit nor subsequent visits. The negative result should have alerted Respondent to potential misuse of oxycodone by Patient D.

112. Instead, Respondent's subsequent progress notes dated December 15, 2016, January 17, 2017, and February 16, 2017, state, "[drug] screen appropriate for meds prescribed."

113. Respondent prescribed 30 mg oxycodone tablets on the same day as the negative result, December 15, 2016.

114. Respondent's documentation does not reflect that he attempted to obtain Patient D's records from previous providers nor did Respondent utilize imaging studies to determine the cause of Patient D's chronic pain.

115. Respondent's documentation does not reflect that he attempted to utilize alternative treatment (non-opioid) for Patient D's chronic pain.

116. Respondent provided inadequate attention to initial assessment to determining if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain with regard to Patient D.

117. Respondent provided inadequate monitoring of Patient D during the utilization of medications that have the strong potential for misuse.

118. Respondent provided inadequate attention to patient education and informed consent for Patient D.

119. Respondent failed to justify dose escalation without adequate attention to risks or alternative treatments with regard to Patient D.

120. Respondent excessively relied on opioids, particularly high dose opioids for chronic pain management with regard to Patient D.

121. Respondent did not make use of available tools for risk mitigation with regard to Patient D.

///

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

COUNT XIII

NRS 630.301(4) - Malpractice

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

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

124. 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."

125. 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 D when the records for Patient D's progress notes were nearly identical to the progress notes of Patients A, B and C, when Respondent failed to obtain Patient D's medical records from previous providers, failed to utilize alternative treatment (non-opioid) for Patient D's chronic pain, and failed to properly utilize drug screening to determine the appropriate prescriptions for Patient D.

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

COUNT XIV

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

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

128. 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.

129. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient D, by documenting progress notes for Patient C that were nearly identical to the progress notes for Patients A, B, and C, failing to justify continued

prescriptions for high doses of opioids, and failing to accurately document the results of Patient D's urine drug screen.

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

COUNT XV

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

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

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

133. The Board adopted by reference the Model Policy in NAC 630.187.

134. 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 standards set forth in the Model Policy.

135. As demonstrated by, but not limited to, the above-outlined facts, Respondent wrote prescriptions to Patient D for opioid analgesics to treat chronic pain in a manner that deviated from the Model Policy.

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

COUNT XVI

NRS 630.306(1)(c) – Unlawful Prescribing of Controlled Substance or Dangerous Drug

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

138. NRS 630.306(1)(c) provides that administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or herself or to others except as authorized by law, constitute grounds for initiating disciplinary action.

///

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

139. NRS 453.381(1) provides in part that, ... a physician may prescribe controlled substances only for a legitimate medical purpose and in the usual course of his or her professional practice....

140. Respondent did not "prescribe controlled substances only for a legitimate medical purpose," making these prescriptions unlawful pursuant to NRS 630.306(1)(c).

141. 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;

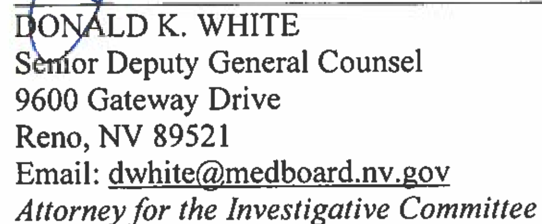
4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

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 16th day of November, 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
Email: dwhite@medboard.nv.gov
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

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 16th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

CHOWDHURY H. AHSAN, M.D., Ph.D., FACC
Chairman of the Investigative Committee

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