BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against:

RICARDO J. VELAZQUEZ-HENRIQUEZ, M.D.,

Respondent.

Case No. 24-30140-1

FILED

AUG 06 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: [signature]

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 Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Ricardo J. Velazquez-Henriquez, 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 physician holding an active license to practice medicine in the State of Nevada (License No. 11680). Respondent was originally licensed by the Board on November 1, 2005, with a specialty in internal medicine.

2. Patient A[2] was a fifty-two (52) year-old female at the time of the events at issue.

3. From April 8, 2019, through February 8, 2021, Patient A saw Respondent on approximately a monthly basis for a variety of medical issues.

4. In the "past medical history" section of Patient A's chart notes, which Respondent filled out at each visit, a history of uterine and ovarian tumors was acknowledged; however, Respondent failed to include any specifics regarding the type of tumor(s).

[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 Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela J. Beal.

[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 prescribed Tylenol #3 (Acetaminophen and Codeine), a controlled substance, at nearly every visit with Patient A without ever referencing any medical basis or reasoning for why it was being prescribed.

6. On August 9, 2019, Respondent noted Patient A had "mild suprapubic discomfort" for the first time. Respondent further noted, as Respondent throughout his care of Patient, that her abdominal exam was normal, and he prescribed Tylenol #3. Respondent did not order a pelvic exam, or a urinalysis (UA) and no pelvic exam was ever documented.

7. All subsequent notes after the August 9, 2019, visit with Respondent documented Patient A as having "mild suprapubic discomfort," with a normal physical exam. No orders were ever given addressing Patient A's complaint of discomfort in her pelvic area.

8. On February 10, 2020, Patient A again complained of pelvic pain, but no pelvic exam was performed, and the physical exam was documented as normal. During this visit, and for the first time in the six (6) months since Patient A began reporting suprapubic pain, Respondent ordered labs for a metabolic panel, complete blood count (CBC), liver function test (LFT), lipid panel, UA, and thyroid stimulating hormone (TSH), as well as a mammogram. However, Respondent failed to order diagnostic imaging of any kind.

9. On November 13, 2020, Respondent prescribed Patient A prednisone and multiple medications for asthma exacerbation despite there being no documented complaints of respiratory issues from Patient A, nor were there any underlying medical diagnoses or medical reasoning noted during the visit.

10. On February 8, 2021, in the "history of present illness" section of the form for Patient A, Respondent documented "abdominal pain periumbilical", but he also noted that Patient A's abdominal exam was normal. Respondent, for the first time since seeing Patient A in April of 2019, ordered abdominal ultrasounds. Respondent again prescribed Patient A Tylenol #3 without any documented medical rationale. The ultrasound was not completed until March 18, 2021, and was the imaging was not read until March 23, 2021.

11. On March 8, 2021, Patient A was seen by Respondent and in the Review of Systems (ROS) portion of the medical notes, Respondent wrote Patient A "denies abdominal pain,

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mild suprapubic discomfort," but Respondent yet again failed to order a pelvic exam. Additionally, there was no discussion of whether the ultrasound had been performed.

12. On April 5, 2021, Patient A "came for follow up to review US (ultrasound)," which showed she had a large, five (5) pound, ovarian tumor. Patient A allegedly claimed that she had no pain in that area, but stated she felt abdominal bloating. In the ROS, Respondent noted, again, "[Patient A] reports mild suprapubic discomfort," and a normal physical exam was noted. Respondent then ordered a CT scan and an OB/GYN follow up. The CT was ordered routine, rather than STAT, and the results of the CT, received April 12, 2021, revealed a "large complex pelvic mass suspicious for malignancy."

13. On May 3, 2021, Respondent noted that Patient A is "[f]eeling well" and he stated, "CT to review and that [Patient A] has a follow up with OG/GYN oncologist." The ROS noted "mild suprapubic discomfort."

14. On July 20, 2021, Patient A underwent extensive surgery for the removal of the large ovarian tumor, which turned out to be benign. As with all of Respondent's notes for Patient A, "mild suprapubic discomfort," was reported. No physical examination was documented.

15. On August 20, 2021, the Respondent's medical notes for Patient A stated, "patient claimed her incision is closed but she is still [experiencing] abdominal discomfort." Patient A was sent back to work beginning September 2021, and an abdominal exam was noted to be "within normal limits."

16. On a September 3, 2021, visit, Respondent noted Patient A was "[s]till complaining of pain and discomfort," and Patient A requested that her leave from work be extended, and an abdominal exam was noted to be normal. ROS "reports mild suprapubic discomfort," and a normal abdominal exam was documented.

COUNT I

NRS 630.301(4) - Malpractice

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

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

19. 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."

20. 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: 1) failed to properly evaluate Patient A's complaints of suprapubic pain by failing to perform a pelvic exam and document or perform a thorough and accurate physical exam, despite eighteen (18) months of consistently seeing Patient A, who complained of suprapubic abdominal pain on multiple visits with Respondent; 2) failed to order any timely diagnostic tests of Patient A's middle to lower abdomen; 3) when he prescribed narcotic pain medications at nearly every visit in 2019 and through the early months of 2020 despite Patient A providing no symptomology to support the continued prescriptions; and 4) when he failed to promptly consult or refer Patient A to an OB/GYN despite Patient A's prior history of uterine and ovarian tumors.

21. 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 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 complete medical records relating to the diagnosis, treatment and care of Patient A, by, among other things, not documenting an accurate physical examination of Patient A. Respondent continued to prescribe narcotic pain medication to

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Patient A without documenting any medical reasoning or diagnosis for it. Thus, Respondent's medical records of Patient A were not timely, legible, accurate, and complete.

25. 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 Established by Regulation

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

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

28. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

29. Respondent failed to timely seek consultation with an OB/GYN, general surgeon or radiologist with regard to Patient A's medical condition from April 8, 2019, through February 8, 2021. Respondent should have consulted with an appropriate care provider to address Patient A's history of uterine and ovarian tumors with complaints of suprapubic pain. A timely consultation with an OB/GYN, general surgeon, or radiologist would have likely located the tumor earlier and the diagnosis would have enhanced the quality of medical care provided to the Patient A.

30. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners 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);

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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 8th day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

ALEXANDER J. HINMAN
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: ahinman@medboard.nv.gov
Attorney for the Investigative Committee

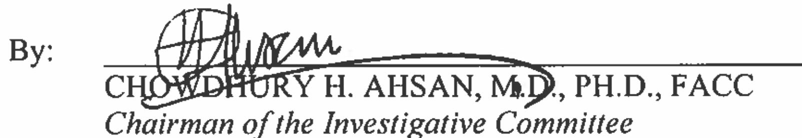
1 **VERIFICATION**

2 STATE OF NEVADA)
: ss.
3 COUNTY OF CLARK)

4 Chowdhury H. Ahsan, M.D., Ph.D., FACC, having been duly sworn, hereby deposes and
5 states under penalty of perjury that he is the Chairman of the Investigative Committee of the
6 Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent
7 herein; that he has read the foregoing Complaint; and that based upon information discovered in
8 the course of the investigation into a complaint against Respondent, he believes that the
9 allegations and charges in the foregoing Complaint against Respondent are true, accurate and
10 correct.

11 DATED this 8 day of August, 2024.

12 INVESTIGATIVE COMMITTEE OF THE
13 NEVADA STATE BOARD OF MEDICAL EXAMINERS

14 By: 
15 CHOWDHURY H. AHSAN, M.D., PH.D., FACC
Chairman of the Investigative Committee

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