BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **ABDOLLAH ASSAD, M.D.,** **Respondent.**	**Case No. 24-28982-2**

FILED

AUG 14 2024

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 Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Abdollah Assad, 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. 10883). Respondent was originally licensed by the Board on April 8, 2004.

2. Patient A[2] was a thirty-three (33) year-old male at the time of the events at issue.

3. On July 3, 2019, Patient A began seeing Respondent to continue medication-assisted treatment following the retirement of a psychiatrist he had been seeing regularly for the issue. Respondent diagnosed Patient A with opioid dependence but did not include a comprehensive assessment, review or records from Patient A's previous provider. Respondent also failed to collect other pertinent information to support a comprehensive diagnosis or

[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 Chowdhury H. Ahsan, M.D., Ph.D, FACC, Ms. Pamela J. Beal and Irwin B. Simon, M.D., FACS.

[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.

treatment plan. Respondent then prescribed Patient A buprenorphine, but did not document any evidence that a discussion about informed consent took place prior to the prescription of controlled substances to Patient A.

4. On August 20, 2019, Respondent prescribed Patient A Risperdal, an antipsychotic medication. Respondent did not include a review of prior records, any documentation, nor any comprehensive examination in his records to support a diagnosis of a psychiatric disorder that would justify prescribing Risperdal. Moreover, Respondent also failed to document whether Patient A received informed consent or alternatives to Risperdal prior to delivery of the prescription.

5. On November 6, 2019, Respondent prescribed Patient A Zoloft, an SSRI antidepressant. Respondent did not include any documentation or examination in his records to support an appropriate diagnosis of depression that justifies the prescription for Zoloft, nor did Respondent document that Patient A received informed consent or alternatives to Zoloft prior to delivery of the prescription.

6. In total, Respondent saw Patient A from July 7, 2019, through January 8, 2020. Throughout Patient A's treatment, Respondent did not include documentation that he checked Patient A's Prescription Monitoring Program (PMP) report prior to prescribing Patient A controlled substances in violation of Nevada law, especially given Patient A's history of medication dependence.

7. Throughout Respondent's treatment of Patient A, Respondent required urine drug screenings which required Patient A to pay out-of-pocket for the tests despite having Medicare. Respondent did not have a valid Clinical Laboratory Improvements Amendment (CLIA) waiver for the point-of-care testing offered in his practice to charge payments to his patients.

8. On January 8, 2020, Patient A was noted by Respondent to be a "no call, no show" whereupon Respondent ceased his medical care of Patient A. Respondent documents no further effort to contact Patient A or refer him to an appropriate clinician to maintain his prescription.

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COUNT I

NRS 630.301(4) - Malpractice

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

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

11. 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."

12. 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 by failing to either document or perform an appropriate psychological examination or perform a review of Patient A's prior medical records to support the diagnosis of opioid dependence, and to provide the prescription of controlled substances.

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 Complete 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" constitute 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 correctly document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete as evidenced by Respondent's handwritten and illegible medical records for Patient A's care which omits standard

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portions of psychological examinations including an appropriate review of symptoms, and informed consent.

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

COUNT III

NRS 630.304(7) - Terminating Medical Care without Adequate Notice to a Patient

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

19. NRS 630.304(7) provides that terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient is grounds for initiating disciplinary action.

20. Respondent terminated the medical care of Patient A without adequate notice to Patient A and without making any arrangements for Patient A's continued care after January 8, 2020, when Respondent failed to appropriately follow-up or refer Patient A to another medical care provider after the termination of his care. Furthermore, Respondent failed to document his termination treatment for Patient A.

21. 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)(b)(2) - Violation of Standards of Practice – Violation of Model Policy

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

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

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

25. 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.

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26. 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 by failing to check Patient A's PMP report at any time during the course of Patient A's treatment.

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

COUNT V

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation – Unreasonable Additional Charges for Laboratory Tests

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

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

30. NAC 630.230(1)(f) provides that a physician shall not, "Make an unreasonable additional charge for tests in a laboratory"

31. Respondent charged cash payments to Patient A for laboratory testing covered by Medicare in violation of Medicare policies without having a valid CLIA Waiver.

32. 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;

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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 14th day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

IAN J. CUMINGS
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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 14th day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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