1	BEFORE THE BOARD O	F MEDICAL EXAMINERS	
2	OF THE STATE OF NEVADA		
3	* * * * *		
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5	In the Matter of Charges and Complaint	Case No. 24-8629-1	
6	Against:	FILED	
7	DAVID MICHAEL ROSS, M.D.,	JUL 1 1 2024	
8	Respondent.	NEVADA STATE BOARD OF MEDICAL-EXAMINERS	
9		Ву:	

COMPLAINT

The Investigative Committee¹ (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 David Michael Ross, 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:

Respondent was at all times relative to this Complaint a physician holding an active 17 1. license to practice medicine in the State of Nevada (License No. 6082). Respondent was originally 18 licensed by the Board on June 9, 1990, and has a specialty in anesthesiology. 19

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Patient A^2 was a sixty-two (62) year-old female at the time of the events at issue. 2.

On August 30, 2019, Patient A presented to Smoke Ranch Surgery Center for a T6-21 3. 7, and T7-8 TESI (transforaminal epidural steroid injections), a procedure that does not cure back 22 pain, but can provide pain relief. For the procedure, Respondent provided deep sedation 23 anesthesia to Patient A while another doctor performed the injections. 24

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¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal 27 Complaint was authorized for filing, was composed of Board members Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, Irwin B. Simon M.D., FACS. 28

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.

4. The American Society of Anesthesiology (ASA) has published a position statement on "Anesthetic Care During Interventional Pain Procedures for Adults"³ and the concomitant risk of procedural sedation not only includes the general risks of anesthesia but also the additional risk of nerve damage, as these procedures are in close proximity to neural and vital structures. The standard of care requires that a patient be able to give feedback regarding needle placement and pain and monitoring of level consciousness. During high dose propofol anesthesia or deep sedation, patient feedback cannot be solicited.

8 5. Respondent failed to document any medical rationale or necessity for using deep
9 sedation anesthesia during the procedure.

6. On August 30, 2019, at 11:16 a.m., Patient A was taken to the operating room and placed on the procedure table. Respondent, without any documented discussion with the doctor performing the TESI injections, then began administering deep sedation anesthesia. Patient A ultimately received three (3) successive doses of IV Propofol (100mg each), while the other doctor performed the TESI procedures on Patient A's right T6-7 and T7-8 vertebrae.⁴

The procedure ended at 11:31 a.m., and the anesthesia time noted by Respondent
was fifteen (15) minutes from anesthesia start to finish. Respondent opines that Patient A "must
have awakened to some degree at least twice during the procedure..." otherwise there would have
been no reason to have administered an additional two (2) doses of IV Propofol (100mg).

8. After the procedure, when Patient A regained consciousness, she complained of
 pain, numbness, and tingling. The physician that performed the TESI's, then took Patient A back
 to the OR and, for reasons not documented, performed an SI joint injection using conscious
 sedation, and then ordered an MRI.

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- 25 ³ "Anesthetic Care During Interventional Pain Procedures for Adults," states "[e]xamples of procedures that typically do not require sedation but are not limited to epidural steroid injections, epidural blood patch, trigger point injections, injections into the shoulder, hip, knee, facet, and sacroiliac joints, and occipital nerve blocks." (Emphasis added.)
- ⁴ Medicare (CMS) guidelines for performing TESI confirms the avoidance of deep sedation or general anesthesia, stating "[u]se of Moderate or Deep Sedation, General Anesthesia, and Monitored Anesthesia (MAC) is usually unnecessary, or rarely indicated for these procedures and therefore, not considered medically reasonably and necessary." "Even in patients with a needle phobia and anxiety, typically oral anxiolytics suffice. In exceptional and unique cases, documentation must clearly establish the need for such sedation in the specific patient."

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9. After examining the MRI, Patient A was transferred to Southern Hills Hospital via
 ambulance. Patient A was hospitalized for seven (7) days following the procedure and was not
 discharged from Southern Hills Hospital until September 5, 2019. From there she was transported
 to a rehabilitation hospital.
 10. On January 20, 2020, Patient A was seen at the Cleveland Clinic and was

diagnosed with iatrogenic cervicothoracic syrinx formation, which was caused by the August 30, 2019, procedure. Further providers at the Cleavland Clinic diagnosed Patient A with Central Pain Syndrome that included leg and arm weakness and difficulty walking.

<u>COUNT I</u>

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.

15 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."

18 14. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed 19 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when 20 rendering medical services to Patient A, when Respondent used deep sedation and/or general 21 anesthesia for the thoracic transforaminal injections performed on August 30, 2019, thus 22 prohibiting Patient A from providing real-time feedback in regard to needle placement, and pain.

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 Complete Medical Records

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

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NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate 1 17. and complete medical records relating to the diagnosis, treatment and care of a patient" constitute 2 3 grounds for initiating discipline against a licensee.

Respondent failed to maintain complete medical records relating to the diagnosis, 18. 4 treatment and care of Patient A, by failing to correctly document his actions when he treated 5 Patient A, by, among other things, not documenting any medical rationale or medical necessity for 6 using anesthesia during the procedure. Thus, Respondent's medical records were not timely, 7 8 legible, accurate, and complete.

By reason of the foregoing, Respondent is subject to discipline by the Board as 9 19. provided in NRS 630.352. 10

WHEREFORE, the Investigative Committee prays:

That the Board give Respondent notice of the charges herein against him and give 1. 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;

That the Board set a time and place for a formal hearing after holding an Early 2. 15 Case Conference pursuant to NRS 630.339(3); 16

That the Board determine what sanctions to impose if it determines there has been 17 3. a violation or violations of the Medical Practice Act committed by Respondent; 18

That the Board award fees and costs for the investigation and prosecution of this 4. 19 case as outlined in NRS 622.400; 20

That the Board make, issue and serve on Respondent its findings of fact, 5. 21 conclusions of law and order, in writing, that includes the sanctions imposed; and 22

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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	 6. That the Board take such other and further action as may be just and proper in these premises. DATED this <u>11</u>¹² day of July, 2024. INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS By: <u>Warder Market Board of MEDICAL EXAMINERS</u> By: <u>ALEXANDER J. HINMAN</u> Deputy General Counsel 9600 Gateway Drive Reno, NV 89521 Tel: (775) 688-2559 Email: <u>ahinman@medboard.nv.gov</u> Attorney for the Investigative Committee
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1	VERIFICATION	
2	STATE OF NEVADA)	
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 11th day of July, 2024.	
12	INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS	
13	MEVADA STATE BOARD OF MEDICINE EXHIBITIERS	
14	By: HAWEN AND DUD FACE	
15	CHOWDHURY H. AHSAN, M. , PH.D., FACC Chairman of the Investigative Committee	
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OFFICE OF THE GENERAL COUNSEL Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

1	CERTIFICATE OF SERVICE		
2	I hereby certify that I am employed by the Nevada State Board of Medical Examiners and		
3	that on the 15th day of July, 2024, I served a file-stamped copy of the foregoing COMPLAINT		
4	and a true and correct copy of the PATIENT DESIGNATION , via USPS Certified Mail, postage		
5	pre-paid, to the following parties:		
6	P O Box 80906		
7 8	Las Vegas, NV 89180 Respondent		
° 9	9171 9690 0935 0254 6113 49		
10	Tracking No.:		
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13	DATED this		
14	A		
15	MEDGEDEG NUENTER		
16	MERCEDES PUENTES Legal Assistant		
17	Nevada State Board of Medical Examiners		
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