# BEFORE THE BOARD OF MEDICAL EXAMINERS
# OF THE STATE OF NEVADA

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| **In the Matter of Charges and Complaint Against:** **MICHAEL IRA SCHNEIER, M.D.,** **Respondent.** | **Case No. 24-40539-1** |

FILED
JUL 30 2024
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 William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Ira Schneier, 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. 14728). Respondent was originally licensed by the Board on March 8, 2013, and has a specialty in spine surgery.

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

3. Patient A was admitted to Sunrise Hospital on December 26, 2019, with complaints of lower back pain, weakness, and inability to walk. Patient A underwent an MRI of the lumbar spine on December 27, 2019, which demonstrated severe canal narrowing at the T11-T12 level. Patient A then underwent an MRI of the thoracic spine on December 30, 2019, which demonstrated severe central stenosis at the T10-T11 level, with abnormal cord signal at this level.

[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 his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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4. On December 31, 2019, Respondent performed a thoracic laminectomy for spinal cord decompression with pedicle screw fixation and onlay lateral transverse fusion (hereinafter referred to as the "laminectomy"), intended to be performed at the T10-T11 level. According to Respondent's preoperative diagnosis, Respondent diagnosed Patient A with thoracic myelomalacia myelopathy with spinal stenosis at the T10-T11 level.

5. Respondent performed the December 31, 2019, laminectomy at the T9-T10 level and failed to perform surgery on Patient A's main pathology at the T10-T11 level.

6. Patient A returned to Sunrise Hospital on January 22, 2020, with complaints of continued severe pain, spasms, and numbness in the bilateral lower extremities. A CT scan performed during Patient A's admission demonstrated that on December 31, 2019, Respondent performed the laminectomy at the T9-T10 level and not the T10-T11 level as originally intended. During Patient A's hospitalization, there was also concern of a medial breach of the left T9 screw.

7. On January 23, 2020, Respondent performed a second surgery on Patient A, by removing the T9 pedicle screws and rods. Although again, Respondent did not address the severe stenosis at the T10-T11 level during the second surgery.

8. There is no documentation that Respondent informed Patient A that the initial laminectomy was performed at the incorrect level, or that Patient A still required operation on the T10-T11 level.

9. On February 4, 2020, Patient A underwent a repeat MRI of the thoracic spine, which demonstrated continued severe stenosis at the T10-T11 level. On February 13, 2020, Respondent reported spasticity in his lower extremities and functional decline. Patient A underwent further MRI testing on February 15, 2020, and May 13, 2020, both of which demonstrated continued severe central stenosis at the T10-T11 level.

10. On May 29, 2020, Patient A presented to another hospital with continued complaints of back pain, lower extremity pain, and spasticity. On or about June 4, 2020, Patient A underwent a T10-T11 laminectomy, which was performed by another surgeon.

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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 treating Patient A, by failing to recognize and address Patient A's continued spinal stenosis at the T10-T11 level, after performing surgery at the incorrect spinal level on December 31, 2019. Respondent's failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances includes, but is not limited to, the failure to address Patient A's T10-T11 spinal stenosis during the second surgery Respondent performed on January 23, 2020.

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**

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.

18. 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, by, among other things, Patient A's continued stenosis at the T10-T11 level after the

December 31, 2019, procedure. Thus, Respondent's medical records were not timely, legible, accurate, and complete.

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)(g) – Continual Failure to Exercise Skill or Diligence**

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

21. Continual failure by the Respondent to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(g).

22. Respondent continually failed to exercise skill or diligence as demonstrated by his repeated failure, after December 31, 2019, to recognize and address Patient A's continued spinal stenosis at the T10-T11 level, despite multiple imaging studies indicating that the spinal stenosis at the T10-T11 level had not resolved.

23. 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;

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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 30th day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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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 30th day of July, 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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| **In the Matter of Charges and Complaint Against:** **IRA MICHAEL SCHNEIER, M.D.** **Respondent.** | **Case No. 24-40539-1** |

FILED
AUG 21 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

## ERRATA TO COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC hereby submit this Errata to its Complaint in Case No. 24-40539-1, filed July 30, 2024, and should be appended thereto. An inadvertent clerical error was discovered on page 1, line 7, in the case caption and on page 1, line 13, in which Respondent's name should read as "Ira Michael Schneier, M.D."

DATED this 21st day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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