BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **YARON ZEDEK, M.D.,** **Respondent.**	**Case No. 24-10652-1**

FILED
FEB 12 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 Yaron Zedek, 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. 7310). Respondent was originally licensed by the Board on December 15, 1994.

A. Respondent's Treatment of Patient A

2. Patient A[2] was a forty-three (43) year-old female at the time of the events at issue.

3. On or about June 17, 2017, Patient A presented to Respondent for psychiatric care and Respondent diagnosed Patient A with bipolar disorder and moderate depression. In Patient A's medical record, Respondent noted that she met the criteria for his diagnosis but did not denote

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[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 Bret W. Frey, M.D., Carl N. Williams, Jr., M.D., and Col. Eric D. Wade (USAF) Ret.

[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.

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any symptomology to meet the criteria for a diagnosis of bipolar disorder or moderate depression. Respondent prescribed Patient A Xanax in the amount of 1mg twice daily.

4. Respondent continued to see Patient A from June 2017 through January 2021 on no less than twenty (20) follow-up visits. Respondent failed to regularly to screen Patient A for safety to discuss potential side effects of the medication prescribed by Respondent. On each visit, Respondent documented a templated generic mental status examination at each visit stating:

> "No suicidal or homicidal ideation. Patient is seen to have well-delineated futuristic thoughts and plans. The patient/or legal guardian gave informed consent for the proposed medical treatment after careful evaluation of the risk/benefit analysis involved, as well as alternative treatment options. The patient and/or legal guardian was informed of potential side effects and what to do should they arise. The patient and/or legal guardian is aware of developing TD[3] and understands that TD can be permanent, disfiguring disabling and rarely lethal."

Respondent's note regarding Tardive Dyskinesia (TD) does not apply to Patient A's treatment, as she was not being treated with antipsychotic drugs and is indicative of his cloned medical records for Patient A.

B. <u>Respondent's Treatment of Patient B</u>

5. Patient B[4] was a forty-three (43) year-old female at the time of the events at issue.

6. On or about April 4, 2019, Patient B presented to Respondent for psychiatric care. On her intake form, Patient B noted a relevant medical history of depression, anxiety, and an eating disorder. Respondent diagnosed Patient B with ADHD, and prescribed Vyvanse which can be contraindicated in patients with an eating disorder. Respondent failed to include essential components of a psychiatric evaluation in the medical record omitting the patient's medical history, any evaluation of mental status, no screening for homicidal ideation, and no diagnosis or treatment plan for the patient. Furthermore, Respondent failed to document a discussion of the risks or benefits of the medication, and any alternatives, as would be required in the process of obtaining informed consent.

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[3] Tardive Dyskinesia is a side effect caused by antipsychotic medication.

[4] Patient B'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.

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C. **Respondent's Improper Utilization of Billing Codes**

7. Between the dates of January 4, 2021, and February 12, 2021, Respondent documented seeing as many as forty (40) patients per day despite utilizing the medical billing time code "99214" which denotes a forty-five (45) minute patient visit.

8. On January 4, 2021, Respondent was scheduled to see patients between 9:30 a.m. and 4:00 p.m. for a total time of six and a half (6.5) hours of clinical time. Despite the limited clinical time, Respondent was scheduled to see a total of sixty-seven (67) patients including three (3) new patient evaluations and sixty-four (64) follow-ups. Patient records demonstrate Respondent's improper use of code 99214 for forty-five (45) minute visits which is impossible given his clinical schedule with double-booked patients throughout January 4, 2021.

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 appropriately screen for medication safety and document accurate and appropriate mental status examinations.

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

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COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Proper 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 appropriate psychiatric examinations and safety screenings when treating Patient A, whose medical records were not timely, legible, accurate, and complete.

COUNT III

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.

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 B by failing to appropriately screen for medication safety and or failing to address or document proper informed consent when prescribing Vyvanse to Patient B despite her comorbidities.

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

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COUNT IV

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 failing to correctly document appropriate psychiatric examinations and safety screenings when treating Patient B, whose medical records 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 V

NRS 630.305(1)(d) – Charging for Services Not Rendered

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

2. NRS 630.305(1)(d) provides that, "charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient," is grounds for initiating discipline against a licensee.

3. Respondent charged for services that were not rendered but were billed according to patient medical records. Services billed under the CPT code of 99214 for forty-five (45) minutes of patient care were not actually performed according to medical records and clinical schedules, but the Respondent billed under the code anyway and was compensated for such improper billings as a medical provider.

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

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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 12th day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., 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 12th day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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