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
APR - 4 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

FIRST AMENDED 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

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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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not note 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 to be taken twice daily.

4. Respondent continued to see Patient A from June 2017 through January 2021 for no less than twenty (20) follow-up visits. Respondent failed to regularly screen Patient A for medicinal safety to discuss potential side effects of the medication prescribed by Respondent. On each visit, Respondent documented a templated and 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. Patient A was not being treated with antipsychotic drugs and this example is indicative of his cloned medical records for Patient A.

B. Respondent's Treatment of Patient B

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 attention deficit hyperactivity disorder (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 Patient B. Furthermore, Respondent failed to document a discussion of the risks or benefits of the

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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.

medication, and any alternatives, as would be required in the process of obtaining informed consent.

C. Respondent's Treatment of Patient C

7. Patient C[5] was a thirty-six (36) year-old female at the time of the events at issue.

8. On or about July 12, 2018, Patient C presented to Respondent for psychiatric care. Respondent diagnosed Patient C with bipolar disorder and moderate depression. In the medical record, Respondent noted that Patient C met the criteria for his diagnosis but did not note any history of mania or specific psychiatric signs to support the diagnosis of bipolar disorder, or moderate depression. Respondent prescribed Patient C 2mg of Xanax to be taken once a day before bedtime without noting anxiety or insomnia in the medical record of Patient C.

9. On or about October 22, 2018, Respondent diagnosed Patient C with panic attacks, in addition to her depression, anxiety, and bipolar disorders.

10. On or about May 9, 2019, Respondent added ADHD to Patient C's list of diagnoses and prescribed Adderall to Patient C.

11. On or about September 4, 2020, Patient C's prescription monitoring program (PMP) report demonstrated Patient C was being prescribed narcotics. On September 15, 2020, Respondent continued to prescribe Patient C Xanax and Adderall, despite the PMP data showing Patient C was taking additional sedatives, and stimulants, and had a moderate overdose risk without noting any possibility of drug interactions between the different classes of medication. Respondent additionally failed to either document or discuss altering Patient C's medications nor investigating alternative treatments.

12. Respondent saw Patient C from July 2018 through September 2020 on no less than thirty (30) follow-up visits. Respondent routinely failed to discuss the risks or benefits of alternative treatment for Patient C's psychiatric conditions and failed to regularly screen Patient C for medicinal safety by discussing potential side effects of the medications prescribed by Respondent. On each visit, Respondent documented a templated and generic mental status examination at each visit stating:

[5] Patient C'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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> "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[6] and understands that TD can be permanent, disfiguring disabling and rarely lethal."

Respondent's note regarding TD does not apply to Patient C's treatment. Patient C was not being treated with antipsychotic drugs and this example is indicative of his cloned medical records for Patient C.

D. Respondent's Treatment of Patient D

13. Patient D[7] was a thirty-three (34) year-old female at the time of the events at issue.

14. On or about May 29, 2020, Patient D presented to Respondent for psychiatric care. Respondent had previously diagnosed Patient D with ADHD, panic disorder, bipolar disorder, and depression. Patient D's PMP data demonstrated that Patient D was being prescribed opioid medication. Despite having a moderate overdose score and taking three (3) different controlled substances from differing therapeutic classes, Respondent failed to appropriately screen Patient D for safety and failed to document or discuss alternatives including alternative treatments.

15. Respondent saw Patient D from April 2018 through December 2020 on no less than thirty (30) follow-up visits. Respondent routinely failed to discuss the risks and benefits of alternative treatment for her psychiatric conditions and failed to regularly to screen Patient D for safety and to discuss potential side effects of the medication prescribed by Respondent. On multiple visits, 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 and understands that TD can be permanent, disfiguring disabling and rarely lethal."

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

[7] Patient D'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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Respondent's note regarding Tardive Dyskinesia (TD) does not apply to Patient D's treatment. Patient D was not being treated with antipsychotic drugs and this example is indicative of his cloned medical records for Patient D.

E. Respondent's Treatment of Patient E

16. Patient E[8] was a sixty-two (62) year-old male at the time of the events at issue.

17. On or about August 18, 2021, Patient E presented to Respondent for an initial psychiatric appointment and medication refill. At the time, Patient E was taking diazepam.

18. Respondent's evaluation omitted substantial portions of the psychiatric evaluation, including a lack of social history or violence, risk assessment, and an incomplete psychiatric history including duration and treatment. Additionally, Respondent failed to document a mental status evaluation or provide a diagnosis or treatment plan.

19. Respondent documents contradictory information to Patient E's intake sheet, noting that he, "is not known to have any medical problems or issues," despite Patient E documenting a clinically relevant history of traumatic brain injury which is associated with psychiatric concerns, including panic disorder.

F. Respondent's Improper Utilization of Billing Codes

20. 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.

21. For example, 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.

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[8] Patient E'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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COUNT I

NRS 630.301(4) - Malpractice

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

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

24. 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."

25. 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 failing to document accurate and appropriate mental status examinations.

26. 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 Proper Medical Records

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

28. 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.

29. 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.

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

COUNT III

NRS 630.301(4) - Malpractice

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

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

33. 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."

34. 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.

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

COUNT IV

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

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

37. 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.

38. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient B, 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. Additionally, Respondent's records for Patient B were

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highly templated which proliferated outdated and contained incorrect patient information making Patient B's medical records untimely, illegible, inaccurate, and incomplete.

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

COUNT V

NRS 630.301(4) - Malpractice

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

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

42. 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."

43. 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 C by routinely failing to screen for patient safety, and for prescribing drugs from multiple treatment classes despite PMP data showing Patient C was taking opioid medications and had a moderate overdose risk.

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

COUNT VI

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

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

46. 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.

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47. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient C, by failing to correctly document his actions when he treated Patient C, whose medical records were not timely, legible, accurate, and complete. Patient C's records failed to include pertinent psychiatric signs and symptoms to support their diagnoses and justify treatment. Additionally, Respondent's records were highly templated which proliferated outdated and incorrect patient information making Patient C's medical records untimely, illegible, inaccurate, and incomplete.

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

COUNT VII

NRS 630.301(4) - Malpractice

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

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

51. 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."

52. 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 D by routinely failing to screen for patient safety, and for prescribing drugs from multiple treatment classes despite PMP data showing Patient D was taking opioid medications and had moderate overdose risks.

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

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COUNT VIII

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

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

55. 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.

56. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient D, by failing to correctly document his actions when he treated Patient D. Patient D's medical records failed to include pertinent psychiatric signs and symptoms to support their diagnoses and justify treatment. Additionally, Respondent's records for Patient D were highly templated which proliferated outdated and contained incorrect patient information making Patient D's medical records untimely, illegible, inaccurate, and incomplete.

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

COUNT IX

NRS 630.301(4) - Malpractice

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

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

60. 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."

61. 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 E by failing to correctly evaluate Patient E in his psychiatric

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assessment or providing a diagnosis. Respondent failed to include vital portions of the psychiatric assessment in the record, including psychiatric and social history.

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

COUNT X

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

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

64. 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.

65. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient E, by failing to correctly document his actions when he treated Patient E, whose medical records were not timely, legible, accurate, and complete. Respondent omitted large portions of the psychiatric evaluation and history in Patient E's medical record.

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

COUNT XI

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

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

68. 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.

69. 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 in full according to medical records and

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clinical schedules, but Respondent billed under the code anyway and was compensated for these improper billings as a medical provider.

70. 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;

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 4th day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

IAN J. CUMINGS
Senior Deputy General Counsel
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Attorney for the Investigative Committee

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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 4th day of April, 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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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 4th day of April, 2024, I served a file-stamped copy of the foregoing **FIRST AMENDED COMPLAINT**, via USPS Certified Mail, postage pre-paid, to the following parties:

LYN E. BEGGS
Law Offices of Lyn E. Beggs
316 California Ave., Suite 863
Reno, NV 89509
Attorney for Respondent

Tracking No.: 9171 9690 0935 0241 6249 25

With courtesy copy by email to:

Lyn E. Beggs, at lyn@lbeggslaw.com
Respondent

Paul A. Lipparelli, at paul.lipparelli@gmail.com
Hearing Officer

DATED this 4th day of April, 2024.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners