OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

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In the Matter of Charges and Complaint Against: **MICHAEL SCOTT ZIMMERMAN, M.D., Respondent.**	**Case No. 25-10981-1**

FILED

APR 03 2025

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 Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Scott Zimmerman, 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 physician holding an active license to practice medicine in the State of Nevada (License No. 7539). Respondent was originally licensed by the Board on August 31, 1995.

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

3. Respondent first saw Patient A in 2018 and performed a colonoscopy for a previous diagnosis of metastatic colon cancer and found diverticulitis. Respondent then removed a large tubular adenoma. Additionally, Patient A had developed end stage renal disease in 2018.

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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 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 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 June 13, 2022, Respondent saw Patient A for a renal transplant evaluation, and it was noted that Patient A was requiring hemodialysis and that based on surveillance guidelines Patient A did not need a colonoscopy for another two and a half (2.5) years.

5. On October 11, 2022, Patient A was seen by Respondent to assess his liver with a FibroScan[3] with elastography.

6. On October 27, 2022, the results of the test revealed that Patient A had clinically significant portal hypertension suggestive of compensated advanced chronic liver disease. As a result of this finding, Respondent recommended a screening esophagogastroduodenoscopy (EGD).

7. On February 6, 2023, Patient A had a follow-up appointment with Respondent to review labs and imaging. In Respondent's assessment, Patient A had chronic liver disease, end-stage renal disease, as well as possible low cardiac ejection fraction. Respondent's plan for Patient A was to proceed with an EGD utilizing monitored anesthesia care (MAC) sedation.

8. Patient A's clinical course took a marked decremental shift over the next three (3) months. Specifically, he developed large volume ascites and required repeat ultrasound guided therapeutic paracenteses. Paracenteses were performed on April 24, 2023, March 6, 2023, and March 26, 2023. This amounted to 5.9 L, 5.9 L, and 5.1 L removed, respectively, all of which were ordered by Respondent, for a total of 17 L of fluid removed in five (5) weeks. All the while Patient A continued receiving dialysis.

9. During this period, Patient A shifted from a compensated form of chronic liver disease to a decompensated form. Despite this, the safety of proceeding with an endoscopy in an ambulatory surgical center (ASC) for screening purposes with the complications of decompensated liver disease, dialysis dependent renal disease, and a possible cardiac condition were not questioned by Respondent. Thus, Respondent proceeded with an EGD on June 7, 2023, at an ASC.

10. On June 7, 2023, Patient A had clinical compromise during the EGD that required life-saving interventions and an emergent transfer to Mountain View Hospital, where Patient A would remain, and ultimately expire three (3) days after the EGD procedure on June 10, 2023.

[3] FibroScan is a non-invasive ultrasound test that measures liver's stiffness.

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11. Even though an EGD was performed on June 7, 2023, there is no documentation of pre-procedural labs nor is there a pre-procedural history or physical examination. As a result, Respondent failed to discover that Patient A did not have his regular dialysis treatment the day before the EGD due to hypotension.

COUNT I

NRS 630.301(4) - Malpractice

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

13. NRS 63.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

14. 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."

15. 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, when he failed to perform a proper history and physical examination prior to performing an endoscopy on Patient A who had active comorbid medical conditions. Additionally, Respondent failed to check Patient A's electrolyte levels the day before proceeding with the EGD despite Patient A having end-stage renal disease.

16. 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

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

18. 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.

19. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by, among other things, failing to correctly document any pre-procedural labs, Patient A's pre-procedural history, nor a physical examination when he treated Patient A. Additionally, Respondent failed to correctly document any discussion with Patient A regarding the safety of proceeding with an endoscopy in the ambulatory surgical center with the comorbidities of decompensated liver disease, dialysis dependent renal disease, and in the setting of a possible cardiac condition. Thus, the medical records were not timely, legible, accurate, nor complete.

20. 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

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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 3rd day of April, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Alexander J. Hinman

ALEXANDER J. HINMAN
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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 3rd day of April, 2025.

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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