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: **MUSTAFA ISMAIL AHMED, M.D., Respondent.**	**Case No. 25-43488-1**

FILED
DEC - 5 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 Mustafa Ismail Ahmed, 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. 15815). Respondent was originally licensed by the Board on April 13, 2015, with a specialty in internal medicine and subsequently as a general surgeon.

2. Information submitted to the Board by Respondent, and included on the Board's website, shows Respondent's specialties as Internal Medicine and General Surgery, with a subspeciality in Surgical Critical Care. Plastic and cosmetic surgery are not specialties nor subspecialties of Internal Medicine, Surgery, and Surgical Critical Care.

3. Respondent was at all times relative to this Complaint the Managing Member at Las Vegas Body Sculpting and Aesthetics, LLC as well as Southern Nevada Bariatrics, LLC.

[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, M.D., FACS, and Col. Eric D. Wade, USAF (Ret.).

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4. At all times relative to this Complaint, Respondent was performing elective cosmetic procedures, that are not medically necessary, including but not limited to regularly performing liposuction on patients at two (2) businesses he is the owner of: Las Vegas Body Sculpting and Aesthetics and Southern Nevada Bariatrics.

5. Respondent was, at all times relative to this Complaint, certified by the American Board of Medical Specialties (ABMS). Respondent is also a member of the American Board of Internal Medicine and the American Board of Surgery which are members of ABMS. Respondent is not certified by any other ABMS Board.

6. Respondent has only received training in liposuction surgery by way of an array of short (1-2 day), unaccredited mini-courses in aesthetic procedures; however, Respondent does not have a certification with the ABMS for plastic surgery.

7. Respondent used Renuvion, a controversial device for label use in aesthetic surgery, as the device does not allow for temperature control that other skin tightening technologies have, and leads to higher risk of burns as seen in cases addressed below.

PATIENT A

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

9. Patient A[2] was a twenty-seven (27) year-old female at the time of the events at issue.

10. On August 11, 2021, Patient A first presented to Respondent's practice, at Las Vegas Body Sculpting and Aesthetics, for a consultation regarding an abdominoplasty procedure, (colloquially known as a "tummy tuck").

11. Patient A saw Respondent an additional two (2) times for consultations in August and September of 2021.

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[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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12. Respondent's lack of ABMS accreditation and having only taken short unaccredited courses on aesthetic procedures is not satisfactory training to perform plastic or cosmetic surgical procedures such as ultrasonic liposuction and abdominoplasties.

13. On October 22, 2021, Respondent performed a lipoabdominoplasty on Patient A, where, during the procedure, it was discovered that Patient A had four (4) small hernias centrally located. Respondent closed these defects before plication of the rectus muscle, as the procedure would not have been able to be completed without first repairing the hernias.

14. Patient A's medical history and physical examination prior to the procedure failed to indicate that Patient A previously had multiple hernia repairs as well as other abdominal surgeries (i.e., a c-section).

15. Respondent failed to document that he provided any clinical assessment regarding Patient A's putative umbilical hernia, despite there being obvious umbilical abnormalities appearing in the preoperative pictures.

16. Patient A's medical history including her prior surgical procedures and abnormalities are relevant to the candidacy and safety of an abdominoplasty patient. Respondent should have: (1) taken the umbilical abnormalities into account when forming his medical plan, and (2) disclosed and discussed the potential risks and complications with Patient A associated with performing the lipoabdominoplasty given her history of multiple abdominal surgeries, and the use of Renuvion and VASER in conjunction.

17. Following the October 22, 2021, procedure, Patient A went on to experience the known complications of a malpositioned or necrotic umbilicus.

PATIENT B

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

19. Patient B[3] was a forty-four (44) year-old female at the time of the events at issue.

20. On November 20, 2021, Respondent performed 360 ultrasound vibration amplification of sound energy at resonance (VASER) liposuction on Patient B, a body contouring

[3] 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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procedure that uses ultrasound energy to liquefy fat cells for removal. In addition to utilizing VASER on Patient B, Renuvion (also known as J-Plasma) was used. Renuvion is a cosmetic procedure that uses a combination of helium gas and radiofrequency energy to create plasma, which is then applied under the skin to tighten it.

21. In the medical records for Patient B, it appears that radiofrequency (Renuvion) and ultrasound (VASER) liposuction were both used, however these fundamentally different technologies were used interchangeably, and in tandem. These medical technologies carry their own unique risks/benefits and should have been outlined and documented in the discussions with Patient B during the informed consent process. Respondent failed to provide full informed consent to Patient B regarding the use of these technologies, where temperatures rise to approximately seventy to eighty degrees Celsius (70-80°C).

22. In the days after the procedure, Patient B developed a seroma (a mass caused by the accumulation of serum within a tissue or an organ that can accumulate as a complication of surgery) which was subsequently drained, though there is no documentation that identifies when the drainage was performed and by whom. Moreover, seroma evacuation is a procedure that requires consent and documentation, which is also absent in Patient B's medical records.

23. The use of energy-based technologies such as radiofrequency Renuvion or ultrasound (VASER) with liposuction increases the patients' risk for thermal injury, seromas, and contour irregularities. The use of both technologies together make the likelihood of complications greater.

24. Respondent utilized both technologies in tandem and based on Patient B's medical records, she was not provided adequate informed consent regarding the medical rational and benefits for using both Renuvion and VASER and the increased risk of combining these technologies.

25. Respondent's training and experiences were inadequate to perform the aforementioned treatments.

26. Respondent has only participated in 1-2 day non-accredited observerships which does not equate to meaningful residency training in the specialty of plastic and cosmetic surgery.

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27. Prior to the procedure, Patient B signed a "Preoperative Cosmetic Surgery Procedure Patient Agreement Form," in which Respondent listed that Renuvion would be used, but the form did not mention that VASER would also be used. Given that the combination of these two (2) technologies increases the risk of complications, Patient B should have been informed of this preoperatively. Further, there are deficiencies in the medical records surrounding Patient B's care. Specifically, there are no details in the operative medical records indicating (1) the power used by the VASER, (2) the areas that were treated by which method, or (3) the duration of the treatment for the areas.

28. Using VASER and Renuvion in conjunction increases the risk of burning and scarring; however, there was no discussion of these risks in Patient B's medical documentation, nor was it addressed in the consent forms Respondent presented to Patient B for her signature.

29. Following the November 20, 2021, procedure, Patient B experienced known complications, such as a fluid collection that was subsequently drained and there was a significant increase in the laxity of the skin surrounding the areas Respondent worked on, post-procedure.

PATIENT C

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

31. Patient C[4] was a forty-six (46) year old female at the time of the events at issue.

32. On August 21, 2021, Patient C presented to Las Vegas Body Sculpting for consultation, and she had two (2) additional consultations with Respondent in 2021.

33. On January 10, 2022, Patient C received liposuction with VASER and Renuvion skin tightening to her abdomen, flanks, and back.

34. Postoperatively, Patient C developed thermal burns and a seroma, and it was drained in Respondent's office; however, there is no documentation of the date of this occurrence of the drainage. Moreover, there does not appear to be any medical records regarding the postoperative care of Patient C, and the only documentation of a history and physical exam from the day of the surgery.

[4] 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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35. Further, Patient C's medical history included previous liposuction and other abdominal operations; however, these elements appear to have not been addressed with Patient C; and these considerations are important to not only determine a patient's candidacy for the procedure, but also to assess the patient's overall risk profile.

36. As a result of the procedure and subsequent Renuvion procedure, Patient C sustained burns to her neck, back, and flank areas. These thermal injuries will cause permanent scarring and were a result of a non-plastic surgeon's use of the combination of energy-based devices (VASER and Renuvion / J-Plasma) rather than a compression garment.

37. No protective sleeve was used for Patient C, and the use of protective sleeves at the skin insertion of the device is a standard medical approach to avoid burns at the entry point of the liposuction area.

38. Lastly, there are no details in the medical documentation for Patient C to elucidate the settings utilized on the VASER device, which is a standard expectation in the medical discipline Respondent is currently practicing in, despite having insufficient training.

COUNT I

NRS 630.306(1)(e) - Practice Beyond Scope of License – Patient A

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

40. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training constitutes grounds for initiating disciplinary action.

41. Liposuction requires a complex surgery, preferably at a well-equipped hospital, not an outpatient office visit, where it was performed by Respondent in this case. Further, Respondent is not ABMS certified for Plastic Surgery but rather has training as an internist and as a general surgeon, with an array of short courses on aesthetic procedures. Respondent's participation in these courses are not considered to be satisfactory training to perform major

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plastic or cosmetic surgical procedures, such as the procedures performed on Patient A, consisting of ultrasonic liposuction with an abdominoplasty.

42. 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 – Patient A

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

44. 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.

45. 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, including but not limited to his failure to indicate that Patient A had multiple prior hernia repairs as well as other abdominal surgeries (i.e., a c-section) in her history and physical. Further, Respondent's operative report does not indicate that the ultrasound assisted liposuction (VASER) was performed, however record of the VASER procedure appears only in the operative nursing notes. Lastly, there are no details in Respondent's operative report indicating the power settings of that were used on the VASER device, the areas that were treated, nor the duration of the treatment. As a result, Respondent's medical records for Patient A were not timely, legible, accurate, and complete.

46. 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

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

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

49. 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."

50. 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 clearly define the procedures being performed, such as Renuvion and VASER, and failing to get, clear, informed consent for these procedures. Further, a seroma developed and Respondent performed draining of the seroma, without any evidence of informed consent obtained by Patient B this additional procedure.

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

COUNT IV

NRS 630.306(1)(e) - Practice Beyond Scope of License – Patient B

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

53. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training constitutes grounds for initiating disciplinary action.

54. Liposuction requires a complex surgery, preferably at a well-equipped hospital, not an outpatient office visit, where it was performed by Respondent in this case. Further, Respondent is not ABMS certified for Plastic Surgery nor Cosmetic Surgery but rather has training as an internist and as a general surgeon with an array of short courses on aesthetic procedures. This is not considered satisfactory training to perform major plastic surgery procedures such as those procedures performed on Patient A, which consisted of ultrasonic liposuction (Renuvion) and VASER.

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

COUNT V

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

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

57. 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.

58. 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 B, such as Patient's B medical history in the history and physical portions of her records, indicating that Patient B had multiple prior hernia repairs as well as other abdominal surgeries (i.e., a c-section). Further, Respondent's operative report does not indicate that the ultrasound assisted liposuction (VASER) was performed, however record of the VASER procedure appears only in the operative nursing notes. Lastly, there are no details in Respondent's operative report indicating the power settings of the device, the areas that were treated, nor the duration of the treatment. As a result, Respondent's medical records for Patient A were not timely, legible, accurate, and complete.

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

COUNT VI

NRS 630.301(4) – Malpractice – Patient C

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

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

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62. 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."

63. 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 failing to clearly define the procedures being performed, such as Renuvion and VASER, and failing to get, clear, informed consent for these procedures. Respondent is not a Plastic Surgeon nor a Cosmetic Surgeon, and his lack of satisfactory training in those disciplines may have been a contributing factor to Patient C's thermal injuries.

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

COUNT VII

NRS 630.306(1)(e) - Practice Beyond Scope of License – Patient C

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

66. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training constitutes grounds for initiating disciplinary action.

67. Liposuction requires a complex surgery, preferably at a well-equipped hospital, not an outpatient office visit, where it was performed by Respondent in this case. Further, Respondent is not ABMS certified for Plastic Surgery nor Cosmetic Surgery but rather has training as an internist as and general surgeon with an array of short courses on aesthetic procedures. This is not considered to be satisfactory training to perform major plastic surgery procedures such as the procedures performed on Patient C, which consisted of ultrasonic liposuction (Renuvion) and VASER.

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

COUNT VIII

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

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

70. 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.

71. 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. The only documentation of the history and physical of Patient C was on the day of the surgery, and there is no documentation in Respondent's history and physical note identifying that Patient C had previously had liposuction and other abdominal operations, which are important considerations when determining the candidacy of a patient for the procedures he performed. As a result, Respondent's medical records for Patient A were not timely, legible, accurate, and complete

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

COUNT IX

NRS 630.306(1)(g) - Unsafe or Unprofessional Conduct – For All Patients

73. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

74. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(p).

75. As demonstrated by, but not limited to, the above-outlined facts, Respondent was practicing beyond the scope of his training, and continually failed to exercise the skill or diligence

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or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field. Thus, Respondent's treatment of Patients A, B, and C posed a significant risk to patient safety.

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

WHEREFORE, the IC 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 5th day of December, 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 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 5th day of December, 2025.

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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