

1 4. During this visit, Patient A agreed to proceed with the EP study and the ablation
2 procedure to be performed by Respondent.

3 5. Respondent, or an employee acting on his behalf, ordered a computed tomography
4 angiogram (CTA) scan of Patient A's chest.

5 5. On September 1, 2022, Patient A underwent the CTA scan. According to the
6 radiologist's report, the CTA demonstrated a right paratracheal mass measuring 5.04 x 4.69 x 3.03
7 cm, which was worrisome for lung carcinoma, and a 1.52 cm spiculated mass in the right middle
8 lobe, which may have represented a satellite tumor.

9 6. According to the radiologist's report, the radiologist notified Respondent of the
10 results of the CTA on September 1, 2022, at 10:27 a.m.

11 7. On September 12, 2022, Patient A underwent the EP study. Respondent documented
12 that the result of the study was negative, and no ablation procedure was performed.

13 8. There is no documentation from September 12, 2022, or any other date, that
14 Respondent, or anyone acting on his behalf, informed Patient A of his CTA scan results from
15 September 1, 2022. Respondent's notes from September 12, 2022, further do not document that
16 Patient A underwent the CTA scan or that the radiologist informed Respondent of the results.

17 9. On April 28, 2023, Patient A presented to a physician at the VA Sierra Nevada
18 Health Care System Medical Center. The VA physician noted that Patient A had a CTA chest
19 ordered by Respondent, which was worrisome for lung carcinoma, and informed Patient A of the
20 CTA results. Per the VA physician's notes, Patient A "stated that he has not followed for his lung
21 mass until he reported to me in office visit on 4/28/23."

22 10. On May 5, 2023, Patient A presented to a pulmonologist. Pulmonology obtained the
23 September 1, 2022, CTA results, revealing the right paratracheal mass and the right middle lobe
24 mass, and informed Patient A of the results.

25 11. On May 9, 2023, Patient A underwent an updated chest CT. The results of this CT
26 demonstrated an increased size of the right upper lobe mass and right middle lobe nodule, as well
27 as right axillary adenopathy. On May 16, 2023, Patient A underwent further CT scans, which
28 confirmed the masses.

COUNT III

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

22. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

23. NAC 630.210 requires a physician to “seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services.”

24. Respondent failed to timely seek consultation with another provider of health care, such as an oncologist or pulmonologist, after Patient A’s September 1, 2022, CTA results demonstrated possible lung carcinoma. Such a timely consultation, including, but not limited to, a referral to an oncologist or pulmonologist for further evaluation, may have enhanced the quality of medical services and care provided to Patient A.

25. 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

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
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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 10th day of March, 2026.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



WILLIAM P. SHOGREN, ESQ.

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Attorney for 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 11th day of March, 2026, I served a file-stamped copy of the foregoing **COMPLAINT** via USPS Certified Mail, postage pre-paid, to the following parties:

JUAN FELIPE RODRIGUEZ REYES, M.D.
3671 Pinot Grigio Drive
Reno, NV 89509

Tracking No.: 9489 0178 9820 3045 5232 87

DATED this 11th day of March, 2026.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners