

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**
2 **OF THE STATE OF NEVADA**

3 * * * * *

4
5 **In the Matter of Charges and Complaint**

Case No. 26-8148-1

6 **Against:**

FILED

7 **STEVEN VICTOR KOZMARY, M.D.,**

FEB 11 2026

8 **Respondent.**

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: 

9
10 **COMPLAINT**

11 The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners
12 (Board), by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC,
13 having a reasonable basis to believe that Steven Victor Kozmary, M.D. (Respondent) violated the
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC)
15 Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's
16 charges and allegations as follows:

17 1. Respondent was at all times relative to this Complaint a medical doctor holding an
18 active license to practice medicine in the State of Nevada (License No. 5695). Respondent was
19 originally licensed by the Board on July 1, 1988.

20 2. Patient A² was a fifty-nine (59) year-old male at the time of the events at issue.

21 3. Patient A had a relevant medical history of obesity following a gastric sleeve
22 procedure, hypertension, diabetes mellitus, obstructive sleep apnea, spinal fusion, and chronic lower
23 back pain.

24 4. On May 17, 2023, Patient A presented to Respondent for the surgical implantation
25 of an intrathecal spinal infusion pump with the intrathecal reservoir placed on the patient's left flank.

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27 ¹ The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal
28 Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Col. Eric D. Wade, USAF
(Ret.), and Hugh L. Bassewitz, M.D., FAAOS.

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.

1 5. Between May 17, 2023, and September 7, 2023, a nurse practitioner (APRN)
2 working with Respondent saw Patient A at eleven (11) office visits.

3 6. On September 7, 2023, Patient A presented to Respondent's practice for medical
4 care. The APRN noted that there was wound dehiscence at the site of the intrathecal pain pump and
5 aspirated a large amount of dark red blood from the surgical site created by Respondent. Patient A
6 was prescribed antibiotics, and Respondent was notified of Patient A's condition.

7 7. On September 17, 2023, Patient A underwent a revision procedure performed by
8 Respondent due to the wound dehiscence. Respondent opened the surgical site and debrided the
9 wound, however left the original pump and catheter in place in their original locations, despite their
10 exposure to possible infection.

11 8. On September 29, 2023, Patient A was seen again at Respondent's office again
12 showing signs of infection but with swelling over the intrathecal pump location, and slight erythema.

13 9. On October 10, 2023, Patient A was again noted to again have wound dehiscence
14 and was prescribed a 10-day course of antibiotics.

15 10. On October 18, P extend the catheter to a new pocket where the replacement
16 intrathecal pump was placed.

17 11. On October 21, 2023, Patient A was admitted to the hospital with a fever and
18 shortness of breath. A computed tomography (CT) scan showed subcutaneous gas adjacent to the
19 pain pump and catheter, indicative of infection. Patient A was admitted and treated inpatient with
20 IV antibiotics and subsequently released.

21 12. On February 22, 2024, Patient A reported to Respondent's practice and stated that
22 he was having brownish discharge from the left flank incision from the first surgery. Patient A was
23 not evaluated in the office but was prescribed a 10-day course of antibiotics.

24 13. On March 13, 2024, Patient A was seen again at the Respondent's practice and was
25 noted to have muddy brown discharge oozing from his left flank incision.

26 14. Patient A was again hospitalized on March 24, 2024, for a fever and drainage from
27 the left flank incision site. An additional CT scan indicated inflammatory changes along the course
28 of the original catheter, with a shallow abscess in the lower left abdomen, where the original

1 intrathecal pump was located. Subsequently, Patient A was discharged against medical advice.

2 15. On March 27, 2024, Respondent took Patient A back for an additional procedure and
3 performed an intrathecal pain pump explant, catheter explant, and drainage of the three (3) separate
4 surgical areas but left the catheter in the intrathecal space from the initial procedure performed on
5 March 17, 2023.

6 16. On March 29, 2024, Patient A was again admitted to the hospital due to a fever and
7 concern for infection. Another CT scan was performed and demonstrated a 9.6 x 1.9 centimeter air
8 fluid collection in Patent A’s left abdomen. On March 30, 2024, Patient A underwent additional
9 surgery at the hospital for an incision and drainage of the left abdominal wall incisions, and removal
10 of the retained catheter and sutures. The surgical report indicates that chronically infected tissue
11 was found in Patient A’s left flank pocket.

12 **COUNT I**

13 **NRS 630.301(4) - Malpractice**

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

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

18 19. NAC 630.040 defines malpractice as “the failure of a physician, in treating a patient,
19 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

20 20. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
21 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
22 rendering medical services to Patient A by failing to remove the intrathecal pain pump following
23 the September 7, 2023, wound dehiscence and port access, which exposed the surgical site to outside
24 contaminants.

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

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1 **COUNT II**

2 **NRS 630.301(4) - Malpractice**

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

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

7 24. NAC 630.040 defines malpractice as “the failure of a physician, in treating a patient,
8 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

9 25. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
10 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
11 rendering medical services to Patient A by failing to remove the intrathecal pain pump and catheter
12 following on October 18, 2023, revision after Patient A developed a second wound dehiscence.
13 Respondent left a known nidus of infection in Patient A by leaving the original catheter in Patient
14 A’s left flank.

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

17 **COUNT III**

18 **NRS 630.301(4) - Malpractice**

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

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

23 29. NAC 630.040 defines malpractice as “the failure of a physician, in treating a patient,
24 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.”

25 30. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
26 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
27 rendering medical services to Patient A by failing to remove the catheter in Patient A’s left flank
28 following the March 27, 2024, revision surgery.

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

3 **COUNT IV**

4 **NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation –**
5 **Failure to Consult**

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

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

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

13 35. Respondent failed to timely seek consultation with regard to Patient A’s medical
14 condition beginning March 27, 2024. Respondent should have consulted with an appropriate care
15 provider to address the doubtfulness of the diagnosis of Patient A’s medical condition, and such a
16 timely consultation would have confirmed or denied such a diagnosis and may have enhanced the
17 quality of medical care provided to Patient A with regard to the continued infection and wound
18 dehiscence. Respondent opted instead to open subcutaneous abscesses, despite not being a properly
19 trained general or neurosurgeon.

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

22 **COUNT V**

23 **NRS 630.306(1)(g) - Continual Failure to Exercise Skill or Diligence**

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

26 38. Continual failure by the Respondent to exercise the skill or diligence or use the
27 methods ordinarily exercised under the same circumstances by physicians in good standing

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1 practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant
2 to NRS 630.306(1)(g)

3 39. Respondent continually failed to exercise skill or diligence as demonstrated by his
4 repeated failure to appropriately address the continued infection and wound dehiscence in Patient
5 A's left flank, and Respondent's repeated failure to completely remove the intrathecal pain pump
6 on two (2) occasions, and failure to remove the intrathecal catheter on three (3) occasions.

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

9 **WHEREFORE**, the IC prays:

10 1. That the Board give Respondent notice of the charges herein against him and give
11 him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within
12 twenty (20) days of service of the Complaint;

13 2. That the Board set a time and place for a formal hearing after holding an Early Case
14 Conference pursuant to NRS 630.339(3);

15 3. That the Board determine what sanctions to impose if it determines there has been a
16 violation or violations of the Medical Practice Act committed by Respondent;

17 4. That the Board award fees and costs for the investigation and prosecution of this case
18 as outlined in NRS 622.400;

19 5. That the Board make, issue and serve on Respondent its findings of fact, conclusions
20 of law and order, in writing, that includes the sanctions imposed; and

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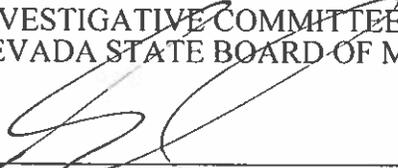
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6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 11th day of February, 2026.

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 11th day of February, 2026.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

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