BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **YEVGENIY ANATOLIY KHAVKIN, M.D., Respondent.**	**Case No. 22-35041-2**

FILED
OCT 24 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

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COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Brandee Mooneyhan, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Yevgeniy Anatoliy Khavkin, 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. 13271). Respondent was originally licensed by the Board on August 26, 2009, and specializes in neurological surgery.

PATIENT A

Patient A's First Surgery by Respondent

2. Patient A[2] was a fifty (50) year-old male with a history of low back pain when the events described below began.

3. On December 30, 2015, which was approximately three (3) months before he met Respondent, Patient A had magnetic resonance imaging (MRI) of his lumbar spine. In pertinent

[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., (Chair), Col. Eric D. Wade, USAF (Ret.) (Public Member), and Carl N. Williams, Jr., 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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part, the radiologist who performed the MRI found that the lumbar segments between Patient A's L2 and L3 vertebrae (L2-3)[3] and between his L3 and L4 vertebrae (L3-4) were essentially normal:

> L2-3: No significant spinal canal or foraminal[4] narrowing.
> L3-4: Mild annular[5] bulge not resulting in significant spinal canal nor significant foraminal narrowing.

The radiologist found mild-to-moderate issues with the vertebral segments between Patient A's L4 and L5 vertebrae (L4-5) and at the lumbosacral joint between the L5 and the sacrum (L5-S1):

> L4-5: Mild broad-based annular bulge with a left central to paracentral tiny annular fissure. No significant spinal canal narrowing. No significant foraminal narrowing.
> L5-S1: Mild broad-based annular bulge not resulting in significant spinal canal narrowing. Mild-to-moderate right and mild left foraminal narrowing.

The radiologist recorded his overall impression regarding Patient A's spine as:

> 1. Degenerative changes of the lumbar spine not resulting in significant spinal canal narrowing. Foraminal narrowing is most notable on the right at L5-S1 (mild to moderate).
> 2. No abnormal enhancement within the spinal canal.

4. Patient A was referred to Respondent for consultation regarding his back pain, and Patient A first presented to Respondent's clinic on April 14, 2016.

5. On his intake paperwork at Respondent's clinic, Patient A indicated that he had not tried epidural steroid injections, trigger point injections, chiropractic therapy, or physical therapy for his back pain; the paperwork also asked whether he had tried pain management, but this question was unanswered on the paperwork.

6. Respondent's record of the April 14, 2016, encounter indicated that Patient A had "been through extensive conservative treatment, including physical therapy and pain management

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[3] "There are three main groups of vertebrae—the cervical vertebrae atop the spinal column, of which there are seven; the thoracic vertebrae, situated below the cervical vertebrae, of which there are twelve; and the lumbar vertebrae situated below the thoracic vertebrae, of which there are five. The letters 'C,' 'T,' and 'L' are used respectively to designate cervical, thoracic and lumbar vertebrae. The sacrum is located at the base of the spinal column and below it, the coccyx or 'tailbone.' The five sacral and four coccygeal vertebrae are fused and together are considered one bone." *Mousseau v. Schwartz*, 756 N.W.2d 345, 347 n.2 (S.D. 2008).

[4] A foramen is the opening in the spine where nerve roots leave the spinal canal; narrowing of the foramen is called foraminal stenosis. *See "foraminotomy,"* https://medlineplus.gov/ency/article/007390.htm (last visited October 24, 2022).

[5] "Annular" is defined as "of, relating to, or forming a ring." *Annular*, https://www.merriam-webster.com/dictionary/annular (last visited October 24, 2022).

which unfortunately did not improve his condition." Respondent did not explain the discrepancy between these statements and Patient A's intake paperwork.

7. Respondent further stated that his own interpretation of the MRI done on December 30, 2015, along with his "[d]irect visualization . . . demonstrate[d] severe degenerative changes at the L4-L5 and L5-S1 level, a loss of disc height as well as the bilateral foraminal stenosis,[6] causing compression of the nerve roots." Respondent indicated that he planned to perform "Transforaminal Lumbar Interbody Fusion w/Wide Decompression[7] [at] L45 L5S1"[8] on Patient A.

8. Patient A had a second visit with Respondent on May 26, 2016, for a preoperative consultation. Respondent's record of that encounter reiterated that Patient A was "scheduled to undergo transforaminal lumbar interbody fusion with decompression at L4-5 L5-S1 on 6/3/2016."

9. Respondent's records of his two (2) preoperative meetings with Patient A discussed only the L4-5 and L5-S1 segments of Patient A's spine; the L3-4 segment was never mentioned.

10. On the "Surgery & Procedure Scheduling Form" filed with the hospital regarding the June 3, 2016, procedure, which was signed by Respondent, in the space for "Procedure as it is to appear on the Consent," was entered: "TRANFORAMINAL LUMBAR INTERBODY FUSION FOUR TO SACRAL ONE."[9]

11. On the morning of June 3, 2016, Patient A presented to Spring Valley Hospital Medical Center for the planned transforaminal lumber interbody fusion with decompression at his L4-5 and L5-S1 vertebral segments.

12. Although Patient A's preoperative MRI report indicated that Patient A's L3-4 segment had no "significant spinal canal nor significant foraminal narrowing," and the L3-4

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[6] Stenosis refers to narrowing of the spinal canal or foramina; such "narrowing puts pressure on [the] nerves and spinal cord and can cause pain." *See "Spinal Stenosis,"* https://medlineplus.gov/spinalstenosis.html (last visited October 24, 2022).

[7] In the context of spinal surgery, decompression refers to the surgical relief of pressure on the spinal cord or nerves.

[8] "To accomplish the fusion during [transforaminal lumbar interbody fusion] surgery, two rods are placed lengthwise on either side of the spine and attached with screws into the pedicle bones of the spine. This bracing provides stability, while a small metal cage with bone-growth material is placed between the vertebra to facilitate new bone growth and fusion of the spine." *Knight v. Clark*, 283 So. 3d 1111, 1124 (Miss. Ct. App. 2019) (Westbrooks, J., dissenting) (internal footnotes omitted).

[9] This is consistent with the plan recorded in Respondent's records of Patient A's preoperative encounters, as lumbar "four to sacral one" encompasses the L4-5 and L5-S1 vertebral segments.

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vertebral segment was not mentioned in Respondent's preoperative records, Respondent evidently calculated that the L3-4 segment was a prospect for surgery, as he arranged for the addition of that level to Patient A's relevant surgical consent paperwork prior to actually performing the surgery.

13. The hospital's record of medical orders related to Patient A's admission shows that on the morning of June 3, 2016, Respondent directed hospital personnel to "add to surgical consent: possible lumbar 3 to 4."

14. Consequently, on the relevant "Consent to Surgery or Special Diagnostic, Invasive or Therapeutic Procedures," on the blank lines following the typewritten statement "Your surgeons/physicians have recommended the following operation or procedure:" was handwritten "Transforaminal lumber Interbody Fusion lumbar four to sacral one"; appended thereto was a second handwritten phrase "possible lumber three to four," with Patient A's initials next to the apparent addition of L3-4 (Patient A's full signature appeared at the bottom of the form in the space labeled "Signature of Consenting Party").

15. Additionally, the "Pre-Procedure Site Verification Note" signed and dated on the morning of June 3, 2016, which contains a drawing of a human body to allow marking of where a surgery is to be performed, contains a handwritten phrase to the right of the drawing which reads: "Transforaminal Lumber Interbody Fusion Four to Sacral One"; added below is a second handwritten phrase: "possible lumbar three to lumbar four," which also appears to be initialed by Patient A (Patient A's full signature was at the bottom of the form in the space labeled "Patient or Legal Representative Signature").

16. During the June 3, 2016, surgery, in addition to performing the planned procedures at the L4-5 and L5-S1 segments, Respondent operated on the L3-4 segment of Patient A's spine.

17. In his operative report of the June 3, 2016, surgery, Respondent stated that he made an intraoperative decision to extend the surgery to the L3-4 segment based on the segment's appearance:

> The L3-L4 segment was examined and appeared to be grossly abnormal showing significant amount of instability present. Per my previous discussion with the patient and to accomplish better clinical postoperative outcome, it was decided to incorporate the L3-L4 segment in a construct . . . .

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18. Respondent failed to explain in his operative report why the L3-4 segment was "examined" in the midst of the June 3, 2016, surgery when the preoperative MRI showed it was essentially normal, with no significant canal or foraminal narrowing, and thus not a reasonable candidate for surgery.

19. Neither did Respondent explain how Patient A's L3-4 segment was "examined" in the midst of the June 3, 2016, surgery, when mere appearance of the segment would be insufficient to demonstrate instability and physical manipulation of the segment would be unwarranted.

20. Nor did Respondent explain what criteria he used to determine the L3-4 segment was "grossly abnormal" or provide any objective measurement of its alleged instability.

21. Finally, Respondent did not reconcile that prior to the surgery, he procured Patient A's consent to possibly operate on the L3-4 level, while in his operative report he states that he decided to operate on that level intraoperatively.

22. A neurosurgeon would not ordinarily "examine" the stability of a spinal segment during a surgery being performed on other spinal segments, and the "appearance" of a spinal segment is not sufficient to support a clinical determination regarding its stability.

23. Respondent's statement in his operative report that Patient A's L3-4 segment was "examined" in the midst of surgery and "appeared to be grossly abnormal showing significant amounts of instability" is not sufficient justification for a reasonable neurosurgeon to fuse a lumbar segment.

24. Respondent fused the L3-4 segment of Patient A's lumbar spine in the absence of sufficient evidence that such a procedure was medically necessary or advantageous to Patient A.

25. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L3-4 segment of Patient A's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

26. In agreeing to allow Respondent to operate on his spine, Patient A placed his trust in Respondent to perform the procedure he represented he would and to exercise appropriate care of Patient A during the planned surgery.

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27. Respondent's extension of the planned surgery to include fusion of the L3-4 segment of Patient A's lumbar spine was completed while Patient A was unconscious and thus exceedingly vulnerable.

28. Fusing an additional segment of Patient A's lumbar spine and correspondingly increasing the spinal hardware used during the spinal surgery increased the amount that could be charged for Patient A's surgery and thus the amount Respondent would be paid for performing the surgery.

COUNT I

NRS 630.301(4) – Malpractice

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

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

31. 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."

32. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when, during Patient A's spinal surgery on June 3, 2016, he fused the L3-4 segment of Patient A's spine without sufficient evidence that such fusion was medically necessary.

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

COUNT II

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain

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

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35. NRS 630.301(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

36. By unnecessarily fusing Patient A's L3-4 lumbar segment in the midst of surgery planned for other spinal segments on June 3, 2016, thereby increasing the cost of the surgery and his corresponding compensation, Respondent engaged in conduct that violated Patient A's trust and exploited his relationship with Patient A to realize a financial or other personal gain.

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

COUNT III

NRS 630.3062(1)(a) – Failure to Maintain Accurate Medical Records

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

39. 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.

40. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A when he failed to include adequate detail in his operative report of Patient A's June 3, 2016, spinal surgery as to: (1) why he examined the L3-4 vertebral segment when preoperative imaging showed it was essentially normal; (2) how he examined the L3-4 vertebral segment; (3) what criteria he used to determine the L3-4 vertebral segment was "grossly abnormal"; and (4) any objective measurement of the alleged instability of the L3-4 vertebral segment.

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

Patient A's Second Surgery by Respondent

42. On January 30, 2017, Patient A went to the emergency room at Spring Valley Hospital Medical Center with low back pain, weakness in his legs that had been getting worse

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over the past week, and rectal bleeding. In addressing the back pain and leg weakness, the emergency room doctor arranged for an x-ray and a computerized tomography (CT) scan of Patient A's lumbar spine, as well as consultation by Respondent.

43. The radiologist who completed the x-ray of Patient A's lumbar spine on January 30, 2017, noted it showed evidence of the June 3, 2016, surgery and that there was no fracture of the hardware or sacrum. However, the "L5-S1 interbody spacer [was] retropulsed[10] 14 mm posteriorly" and there was "lucency associated with the bilateral S1 pedicle screws." The radiologist's impression was that "[t]hese findings suggest hardware loosening."

44. The radiologist also completed a CT scan of Patient A's spine on January 30, 2017, and noted that, consistent with the x-ray, the images "suggest[ed] hardware loosening" but noted these findings were "unchanged compared" to a prior CT scan in September 2016. The radiologist also noted in his impression that there was "[n]o new/acute lumbar spine abnormality detected."

45. Respondent's notes of his consultation with respect to Patient A on January 30, 2017, state in pertinent part, that the imaging showed "a retropulsion of the L5-S1 cage compressing the nerve roots and the cauda equina[11] with pseudoarthrosis and loosening of the L5-S1 screws indicating instability and pseudoarthrosis with a compression of the neural elements" and that he decided to proceed with an immediate "revision of instrumentation."

46. The relevant "Consent to Surgery and Other Invasive Procedures" signed and dated on January 30, 2017, indicates that Patient A authorized Respondent to perform "REVISION POSTERIOR LUMBAR FUSION LUMBAR THREE TO SACRAL ONE WITH REVISION OF INSTRUMENTATION."[12]

47. The "Pre-Procedure Site Verification Note" signed and dated on January 30, 2017, which contains a drawing of a human body to allow marking of where a surgery is to be performed, contains a handwritten phrase to the right of the drawing which reads: "REVISION

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[10] When a body is retropulsed, it has essentially "gone back into the spinal canal." *See Conrad v. Robbi*, 775 A.2d 562, 567 (N.J. Super. Ct. App. Div. 2001)

[11] The cauda equina are "the roots of the spinal nerves that extend beyond the termination of the spinal cord at the first lumber vertebra in the form of a bundle of filaments within the spinal canal resembling a horse's tail." *Cauda equina*, https://www.merriam-webster.com/medical/cauda%20equina (last visited October 24, 2022).

[12] Lumbar "three to sacral one" encompasses the L3-4, L4-5, and L5-S1 vertebral segments.

POSTERIOR LUMBAR FUSION LUMBAR THREE TO SACRAL ONE WITH REVISION OF INSTRUMENTATION."

48. In his operative report of the January 30, 2017, surgery, Respondent indicated his preoperative and postoperative diagnoses were identical: "lumbar pseudoarthrosis,[13] instability, and instrumentation failure with the compression of the cauda equina."

49. Respondent further indicated in the operative report, that he removed and replaced the hardware he had inserted in Patient A's spine on June 3, 2016.

50. However, rather than simply revising the instrumentation from the first surgery, Respondent again fused an additional lumbar segment not previously identified as a candidate for surgery, this time adding the L2-3 segment to the fusion construct.

51. Similar to his justification for extending Patient A's first surgery to an additional lumbar segment, Respondent again relied on his intraoperative "examination" of the target segment and the alleged lack of stability thereof, stating in the operative report: "The L2-L3 segment was also examined and appeared to be grossly unstable with significant amount of abnormal motion present." Also similar to the surprise extension in the prior surgery, Respondent claimed that his decision to perform such an extension was "[p]er [his] previous discussion with the patient and to accomplish better neurological outcome."

52. Reminiscent of the records of the first surgery, in the January 30, 2017, operative report, Respondent failed to explain why the L2-3 segment was "examined" in the midst of the surgery when all relevant preoperative imaging showed it was essentially normal, with no significant canal or foraminal narrowing, and thus not a reasonable candidate for surgery.

53. Respondent also failed to explain how Patient A's L2-3 segment was "examined" in the midst of the January 30, 2017, surgery, when the mere appearance of the segment would be insufficient to demonstrate instability and physical manipulation of the segment would be unwarranted.

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[13] Pseudoarthrosis refers to a failed fusion.

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54. Additionally, Respondent did not explain what criteria he used to determine that the L2-3 segment appeared "grossly unstable" or provide any objective measurement of the alleged "abnormal motion present."

55. Prior to the second surgery on January 30, 2017, Respondent indicated he was "revising" the instrumentation of the June 3, 2016, surgery, that is, fixing the problems with the hardware from the first surgery.

56. There are no preoperative consent forms documenting that Patient A was informed that his L2-3 lumbar segment was at risk of being operated upon during the January 30, 2017, revision surgery.

57. The only reference to Patient A being informed that anything beyond revision of the hardware from the first surgery was a possibility appears in Respondent's record of his January 31, 2017, consultation, which states that after examining Patient A and his CT scan, Respondent decided to "proceed with the urgent neurological treatment the same date consisting of a posterior approach the revision of instrumentation," and states that he and Patient A discussed "the benefits and risks of such an undertaking," including "possibility of need of another surgery in the future as well as the possible extension of the fusion based on intraoperative findings." Although the date of consultation was January 30, 2017, the hospital's records indicate that Respondent dictated the contents of this record on February 2, 2017, and signed it on February 6, 2017.

58. A neurosurgeon would not ordinarily "examine" the stability of a spinal segment during a surgery being performed on other spinal segments, and the "appearance" of a segment is not sufficient to support a clinical determination regarding its stability.

59. Respondent's statement in his January 30, 2017, operative report that Patient A's L2-3 segment was "examined" in the midst of surgery and "appeared to be grossly unstable with significant amount of abnormal motion present" is not sufficient justification for a reasonable neurosurgeon to fuse a lumbar segment.

60. Respondent fused the L2-3 segment of Patient A's lumbar spine in the absence of sufficient evidence that such a procedure was medically necessary or advantageous to Patient A.

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61. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L2-3 segment of Patient A's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

62. In agreeing to allow Respondent to operate on his spine, Patient A placed his trust in Respondent to perform the procedure he represented he would perform and to exercise appropriate care of Patient A during the planned surgery.

63. Respondent's extension of the planned surgery to include fusion of the L2-3 segment of Patient A's lumbar spine was completed while Patient A was unconscious and thus exceedingly vulnerable.

64. Fusing an additional segment of Patient A's lumbar spine and correspondingly increasing the spinal hardware used in the surgery increased the amount that could be charged for Patient A's surgery and thus the amount Respondent would be paid for performing the surgery.

65. On or about October 3, 2018, Patient A filed a complaint in the Nevada State District Court for medical malpractice and other claims against Respondent and other defendants. Respondent was timely served with a summons and complaint and participated in the proceedings.

66. Pursuant to NRS 630.3068(1)(a), a physician is required to report to the Board "[a]ny action for malpractice against the physician not later than 45 days after the physician receives service of a summons and complaint for the action."

67. Respondent did not inform the Board of the service of Patient A's lawsuit against him within forty-five (45) days of his being served with the summons and complaint in the matter.[14]

68. Pursuant to NRS 630.3068(2), if the Board finds that a physician has violated any provision of NRS 630.3068, the Board may impose a fine of not more than five thousand dollars ($5,000) against the physician for each violation, in addition to any other fines or penalties permitted by law.

[14] Respondent had a separate responsibility to respond truthfully to questions posed in his next application for biennial renewal of his medical license. *See* NRS 630.304(1). In his 2019 renewal application, Respondent was asked whether during the period of July 1, 2017, through June 30, 2019, he had been "named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability [or] malpractice, including any military tort claims if applicable." Respondent answered "Y" for "yes," and when prompted for an explanation answered: "Claim filed October 2018," which appears to have referred to Patient A's lawsuit.

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COUNT IV

NRS 630.301(4) - Malpractice

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

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

71. 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."

72. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when, during Patient A's spinal surgery on January 30, 2017, he fused the L2-3 segment of Patient A's spine without sufficient evidence that such fusion was medically necessary.

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

COUNT V

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

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

75. NRS 630.301(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

76. By unnecessarily fusing Patient A's L2-3 lumbar segment in the midst of surgery planned for other spinal segments on January 30, 2017, thereby increasing the cost of the surgery and his corresponding compensation, Respondent engaged in conduct that violated Patient A's trust and exploited his relationship with Patient A to realize a financial or other personal gain.

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77. 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 Accurate Medical Records

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

79. 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.

80. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A when he failed to include adequate detail in his operative report of Patient A's January 30, 2017, spinal surgery as to: (1) why he examined the L2-3 vertebral segment when preoperative imaging showed it was essentially normal; (2) how he examined the L2-3 vertebral segment; (3) what criteria he used to determine the L2-3 vertebral segment appeared "grossly unstable with significant amount of abnormal motion present"; and (4) any objective measurement of the alleged instability of the L2-3 vertebral segment.

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

COUNT VII

NRS 630.3062(1)(e) - Failure to Report Action for Malpractice

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

83. Pursuant to NRS 630.3062(1)(e), the failure of a physician to comply with the requirements of NRS 630.3068 is grounds for initiating discipline against a licensee.

84. Respondent violated NRS 630.3068(1)(a) by failing to report to the Board that Patient A had filed a lawsuit against him alleging a claim for medical malpractice within 45 days of being served with a summons and complaint in the matter.

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

PATIENT B

86. Patient B[15] was a thirty-eight (38) year-old male with a history of low back pain and numbness in his leg when the events described below began.

87. On April 10, 2015, which was almost a year before he met Respondent, Patient B had an MRI of his lumbar spine. In pertinent part, the radiologist who performed the MRI found abnormalities of the L5-S1 segment of Patient B's spine:

> There is a grade 1 spondylolisthesis[16] greater than 10% at the level of L5-S1. The malalignment is on the basis of bilateral spondylolysis[17] at L5. No degenerative disc disease. There is mild/moderate narrowing of the distal most right foramen. This is in the region of the incompletely imaged findings where S 5[18] has an irregular inseparable interface with S1, appears likely to be explained by screening which indicated the patient has had prior trauma, subsequent surgery and hardware removal. If ever indicated CT could be utilized.

88. The April 2015 MRI images show that Patient B's L3-4 and L4-5 vertebral segments were completely normal, and neither of those segments were discussed by the radiologist.

89. Patient B was referred to Respondent's clinic for consultation regarding his back pain, and first presented to Respondent's clinic on March 29, 2016.

90. Respondent's record of his March 29, 2016, encounter with Patient B indicates that his interpretation of the April 2015 MRI, coupled with his own "direct visualization" of Patient B "demonstrate[d] presence of grade 1 spondylolisthesis at the L5-S1 level with severe bilateral foraminal stenosis."

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[15] Patient B'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.

[16] "Spondylolisthesis" is defined as "forward displacement of a lumbar vertebra on the one below it and especially of the fifth lumbar vertebra on the sacrum producing pain by compression of nerve roots." *Spondylolisthesis*, https://www.merriam-webster.com/medical/spondylolisthesis (last visited October 24, 2022).

[17] "Spondylolysis" is defined as "disintegration or dissolution of a vertebra." *Spondylolysis*, https://www.merriam-webster.com/medical/spondylolysis (last visited October 24, 2022).

[18] It appears the radiologist meant L5, as his impression set forth below his findings discusses the "osseous irregularity and interface of L5 with S1."

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91. Respondent's record further indicated that he planned to perform "Transforaminal Lumbar Interbody Fusion w/Wide Decompression at L5S1" on Patient B.

92. Patient B had a second visit with Respondent on July 7, 2016, for a preoperative consultation. Respondent's record of that encounter reiterated that Patient B was "scheduled to undergo transforaminal lumbar interbody fusion with decompression at L5-S1 on 7/11/16."

93. Respondent's records of his two (2) preoperative meetings with Patient B mentioned only the L5-S1 segment of Patient B's spine; the L3-4 and L4-5 segments were never mentioned.

94. On the "Surgery & Procedure Scheduling Form" filed with the hospital regarding the July 11, 2016, procedure, which was signed by Respondent, in the space for "Procedure as it is to appear on the Consent," was entered: "TRANFORAMINAL LUMBAR INTERBODY FUSION FIVE TO SACRAL ONE."

95. Additionally, a "Consent to Surgery or Special Diagnostic, Invasive or Therapeutic Procedures" form signed by Patient B, dated July 8, 2016, indicated that Patient D authorized Respondent to perform 'TRANSFORAMINAL LUMBAR INTERBODY FUSION FIVE TO SACRAL ONE."

96. On the morning of July 11, 2016, Patient B presented to Centennial Hills Hospital Medical Center for the planned transforaminal lumber interbody fusion with decompression at his L5-S1 vertebral level.

97. In his operative report of the July 11, 2016, Respondent stated that after decompressing the L5-S1 level, he made the intraoperative decision to "incorporate" the L3-4 and L-5 levels "into the construct," stating that, "The adjacent levels [were] examined and there appeared to be [grossly[19]] abnormal amount of motion at the L3-L4 and L4-5 level with a presence of a [pars[20]] defect[21] at the L4-L5 level as well which was not appreciated on the preoperative imaging studies."

/ / /

[19] The original B operative record states "closely" here, which appears to be a mistranscription of "grossly."
[20] The original B operative record stated "portion" here, which appears to be a mistranscription of "pars."
[21] Spondylolysis is sometimes referred to as a pars defect.

98. Respondent failed to explain in his July 11, 2016, operative report why Patient B's L4-5 and L3-4 spinal segments were "examined" in the midst of surgery when the preoperative MRI showed that those segments were completely normal, and thus not reasonable candidates for surgery.

99. Respondent also failed to explain how the L4-5 and L3-4 spinal segments were "examined" in the midst of the July 11, 2016, surgery when mere appearance of the segments would be insufficient to demonstrate instability and physical manipulation of the segments would be unwarranted.

100. Further, Respondent failed to explain what criteria he used to determine how the L4-5 and L3-4 segments exhibited an "abnormal amount of motion" or provide any objective measurement of such alleged "abnormal amount of motion."

101. To the extent Respondent refers to the "presence of a [pars] defect at the L4-5 level," the preoperative MRI contradicts that there was a pars defect at Patient B's L4-5 vertebral level.[22]

102. Respondent's records of his two (2) preoperative meetings with Patient B mentioned only his L5-S1 spinal segment, and did not mention his L3-4 or L4-5 segments.

103. A neurosurgeon would not ordinarily "examine" the stability of a spinal segment during a surgery being performed on other spinal segments, and the "appearance" of a segment is not sufficient to support a clinical determination regarding its stability.

104. Respondent's statement in his July 11, 2016, operative report that Patient B's L3-4 and L4-5 segments were "examined" in the midst of surgery and "appeared" to exhibit an "abnormal amount of motion" did not constitute sufficient justification for a reasonable neurosurgeon to fuse those lumbar segments.

105. Respondent's statement in his July 11, 2016, operative report that Patient B's L4-5 segment had a pars defect is clearly contradicted by the preoperative MRI report and is not sufficient justification for a reasonable neurosurgeon to fuse that lumbar segment.

[22] If Respondent meant to refer to a "portion defect," it is not clear what a "portion defect" is; regardless, the lack of specificity or explanation in his operative report fails to support any operation on the L4-5 level of Patient B's spine.

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106. Respondent fused the L3-4 and L4-5 segments of Patient B's lumbar spine in the absence of sufficient evidence that such procedures were medically necessary or advantageous to Patient B.

107. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L3-4 or L4-5 segments of Patient B's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

108. In agreeing to allow Respondent to operate on his spine, Patient B placed his trust in Respondent to perform the procedure he represented he would and to exercise appropriate care of Patient B during the planned surgery.

109. Respondent's extension of the planned surgery to include fusion of the L3-4 and L4-5 segments of Patient B's lumbar spine was completed while Patient B was unconscious and thus exceedingly vulnerable.

110. Fusing two (2) additional segments of Patient B's lumbar spine and correspondingly increasing the spinal hardware used during the spinal surgery increased the amount that could be charged for Patient B's surgery and thus the amount Respondent would be paid for performing the surgery.

111. In his operative report of Patient B's surgery, Respondent listed among the procedures performed on Patient B on July 11, 2016: "Placement of the biomechanical device at the L4-5 and L5-S1 level using Alphatec Battalion peek titanium cage."

112. Similarly, in the "course of surgery" section of the operative report, Respondent stated in pertinent part that, "The L4 and L5 laminectomies were performed, and the biomechanical device was placed at L4-L5 and L5-S1 level using Battalion peek titanium cage with interbody arthrodesis accomplished at both levels with the use of Vitoss mixed with autograft."

113. Contrary to Respondent's statements in his operative report, subsequent imaging and a subsequent revision surgery performed by another surgeon made clear that Respondent did

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not place a cage or other biomechanical device at Patient B's L5-S1 level during the July 11, 2016, surgery.

114. On or about July 11, 2018, Patient B filed a complaint in Nevada State District Court for medical malpractice and other claims against Respondent. Respondent was timely served with the complaint and filed a timely answer thereto.

115. Pursuant to NRS 630.3068(1)(a), a physician is required to report to the Board "[a]ny action for malpractice against the physician not later than 45 days after the physician receives service of a summons and complain for the action."

116. Respondent did not inform the Board of the service of Patient B's lawsuit within forty-five (45) days of him being served with the summons and complaint in the matter.

117. Pursuant to NRS 630.3068(2), if the Board finds that a physician has violated any provision of NRS 630.3068, the Board may impose a fine of not more than five thousand ($5,000) against the physician for each violation, in addition to any other fines or penalties permitted by law.

118. On his 2019 application for biennial renewal of his medical license, Respondent was asked whether during the period of July 1, 2017, through June 30, 2019, he had been "named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability [or] malpractice, including any military tort claims if applicable" (renewal question). Respondent answered "Y" for "yes."

119. When he answered yes to the renewal question, Respondent was prompted to answer a follow-up question: "For the above [renewal] question if your answer is "Yes" for the time period July 1, 2017 – July 1, 2019, or since your last renewal, please type your explanation in this text box." In this text box, Respondent answered merely: "Claim filed October 2018."

120. It appears the "Claim filed October 2018" referred to another lawsuit that indeed was filed against Respondent in October 2018; Respondent failed to accurately include in his renewal application the malpractice suit filed against him by Patient B on July 11, 2018.

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COUNT VIII

NRS 630.301(4) - Malpractice

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

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

123. 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."

124. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when during the surgery planned for Patient B's L5-S1 segment on July 11, 2016, he also fused the patient's L3-4 and L4-5 lumbar segments without sufficient evidence that such additional procedures were medically necessary.

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

COUNT IX

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

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

127. NRS 630.301(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

128. By unnecessarily fusing Patient B's L3-4 and L4-5 lumbar segments in the midst of surgery on July 11, 2016, thereby increasing the cost of the surgery and his corresponding compensation, Respondent engaged in conduct that violated Patient B's trust and exploited his relationship with Patient B to realize a financial or other personal gain.

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129. 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 Accurate Medical Records

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

131. 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.

132. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient B when he falsely stated in his operative report of Patient B's July 11, 2016, spinal surgery that he had placed a biomechanical device at Patient B's L5-S1 vertebral segment on that date.

133. Respondent further failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient B when he failed to include adequate detail in his operative report of Patient B's July 11, 2016, spinal surgery as to: (1) why he examined the L3-4 and L4-5 vertebral segments when preoperative imaging showed they were normal; (2) how he examined the L3-4 and L4-5 vertebral segments; (3) what criteria he used to determine the L3-4 and L4-5 vertebral segments exhibited an "abnormal amount of motion"; and (4) any objective measurement of the alleged instability of the L3-4 and L4-5 vertebral segments.

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

COUNT XI

NRS 630.3062(1)(e) - Failure to Report Action for Malpractice

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

136. Pursuant to NRS 630.3062(1)(e), the failure of a physician to comply with the requirements of NRS 630.3068 is grounds for initiating discipline against a licensee.

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137. Respondent violated NRS 630.3068(1)(a) by failing to report to the Board that Patient B had filed a lawsuit against him alleging a claim for medical malpractice within forty-five (45) days after being served with a summons and complaint in the matter.

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

COUNT XII

NRS 630.304(1) – Misrepresentation in Obtaining or Renewing License

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

140. NRS 630.304(1) provides that obtaining, maintaining or renewing a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement constitutes grounds for initiating disciplinary action.

141. In his 2019 application to renew his medical license, when asked whether he had been "named as a defendant . . . to a legal action involving professional liability [or] malpractice" from July 1, 2017, through June 30, 2019, Respondent answered that a single complaint had been filed against him in October 2018, and failed to include that he had also been so named in a complaint filed by Patient B on July 11, 2018, which was false, misleading, inaccurate or incomplete.

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

PATIENT C

143. Patient C[23] was a sixty-one (61) year-old female with a history of low back pain and sciatica when the events described below began.

144. On June 15, 2015, which was approximately eight (8) months before she met Respondent, Patient C had a CT scan of her lumbar spine. In pertinent part, the radiologist who performed the CT scan determined that there was no fracture or dislocation of Patient C's spine,

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[23] 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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and that her L5 vertebra was degenerating on both sides of her spine but was not displaced; specifically, the radiologist's impression was:

> 1. There is L5 bilateral chronic spondylolysis without spondylolisthesis.
> 2. There is no acute fracture or dislocation.

145. Patient C presented to Respondent's clinic for the first time on February 23, 2016. Respondent's record of that encounter indicates that he reviewed the CT scan from June 2015 and, consistent with the CT radiologist, determined that it "demonstrated presence of pars defect at the L5-S1 level" but contrary to the radiologist, stated that it was "with the presence of spondylolisthesis" (emphasis added).

146. Respondent's record of the February 23, 2016, visit also indicates that he recommended Patient C get a "STAT MRI of the lumbar spine for further evaluation of her symptoms," and discussed with Patient C "the possibility of a surgical treatment which we will further discuss based on the MRI result."

147. Patient C apparently did not undergo an MRI of her lumbar spine prior to presenting to the emergency room at Spring Valley Hospital Medical Center five (5) days after meeting Respondent, on February 28, 2016, for worsening back pain radiating to her right leg.

148. The attending physician in the emergency room recorded that Patient C "was told by [Respondent] to come in if pain gets worse." Respondent was consulted via telephone by medical staff at the hospital.

149. On the same day she went to the emergency room, Patient C had an MRI of her lumbar spine. The radiologist who performed the MRI found a "large right lateral disk herniation" at Patient C's L3-4 vertebral level, but no stenosis at any other level of her spine:

> Vertebral bodies align normally. There are no compression fractures. Marrow signal is normal. Small cysts are identified in the right kidney.
>
> At L1-L2 there is no central or neural foraminal stenosis.
>
> At L2-3 no central or neural foraminal stenosis.
>
> At L3-4 there is a large right lateral disk herniation causing mass effect upon the right L3 and L4 nerve roots. Lesion shows mild

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> cranial migration posterior to the L3 vertebral body and results in the severe narrowing of the lateral recess and neural foramen. The craniocaudal measurement of the herniation is 2.6 cm with an AP measurement of 7 mm and a transverse measurement of 11 mm. The central canal and left neuroforamen are patent.
>
> L4-5 there is moderate facet arthropathy no central or neural foraminal stenosis.
>
> At L5-S1 facet arthropathy is present. No central or neural foraminal stenosis.

The radiologist's impression was:

> Large right disk herniation at L3-4. This results in neural foraminal stenosis and lateral recess stenosis with mass effect upon the right L3 and descending L4 nerve roots.

150. Hospital records indicate Respondent instructed hospital staff to admit Patient C and prepare her for spinal surgery the next day, February 29, 2016.

151. There is no documentation that Patient C tried physical therapy or interventional pain management prior to her surgery, or that Respondent inquired into such treatment prior to ordering that she undergo spinal surgery.

152. Documentation related to the surgery indicates it was unclear to the participants which vertebral levels Respondent would be operating on. In a subsequent lawsuit filed by Patient C against Respondent, Patient C asserted that she believed Respondent was going to perform a fusion on a single level: L5-S1.

153. Meanwhile, the hospital's records indicate that Patient C signed consent paperwork for posterior lumbar decompression and fusion at two (2) other levels, L3-4 and L4-5. The "Consent to Surgery or Special Diagnostic, Invasive or Therapeutic Procedures," signed by Patient C on the morning of her surgery, noted in pertinent part that her "surgeons/physicians have recommended the following operation or procedure: "Posterior Lumbar decompression and Fusion Lumbar Three four and four five." Similarly, the "Pre-Procedure Site Verification Note," signed by Patient C on the morning of her surgery also indicated that her procedure would consist of "Posterior Lumbar Decompression + Fusion Lumbar three, four +four five."

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154. And Respondent's operative report of the February 29, 2016, surgery indicates Respondent told Patient C that he would be operating on all three (3) levels: "After detailed discussion with the patient given the presence of neurological deficit and the presence of instability in the lumbar spine it was decided to proceed with the surgical treatment consisting of L3-S1 lumbar decompression and fusion."

155. Contrary to Respondent's reference to "the presence of instability in the lumbar spine," neither the CT scan nor the MRI demonstrated instability of Patient C's lumbar spine.

156. Respondent apparently did not record any presurgical examination of Patient C on February 29, 2016, other than that set forth in his operative report: "On physical examination, she had weakness in her iliopsoas with 4/5 as well as the dorsiflexion weakness on the or [sic] right side with 4/5 and progressive worsening of the numbness in her lower extremities."

157. Ultimately, Respondent operated on three (3) levels of Patient C's spine on February 29, 2016: first, the L3-4; then the L5-S1; and finally, the L4-5.

158. The sizable disk herniation at Patient C's L3-4 segment indicated a discectomy at that level was a reasonable treatment, however, as there was no stenosis or instability at that level, fusing the L3-4 segment was neither medically necessary nor advantageous to Patient C.

159. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L3-4 segment of Patient C's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

160. After a decompression and fusion at the L3-4 level "was accomplished, [Respondent's] attention was turned to the L5 and S1 level with pars defect," which he also fused. As spondylolysis can be a source of chronic back pain, fusion at L5-S1 was arguably reasonable.

161. Although no evidence existed that Patient C had any issues at her L4-5 vertebral level that required surgical attention, Respondent next fused her L4-5 level based on an interoperative "appearance" of "instability," which he documented with a single sentence: "The L4-L5 segment was also [sic] appeared to be unstable and it was decided to incorporate this into the construct."

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162. The appearance of a vertebral segment is not sufficient to support a clinical determination of its stability.

163. Respondent did not explain in his February 29, 2016, operative report what criteria he used to determine the L4-5 segment was unstable, nor did he provide any objective measurement of its alleged instability.

164. As there was no stenosis or instability at Patient C's L4-5 segment, fusion of this level was neither medically necessary nor advantageous.

165. Respondent's records do not reconcile why, prior to the surgery, he procured Patient C's written consent to fuse the L4-5 level, but his operative report indicates his decision to operate on the L4-5 level was made intraoperatively.

166. Respondent fused the L4-5 segment of Patient C's lumbar spine in the absence of sufficient evidence that such a procedure was medically necessary or advantageous to Patient C.

167. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L4-5 segments of Patient C's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

168. In agreeing to allow Respondent to operate on her spine, Patient C placed her trust in Respondent to perform the procedure he represented he would and to exercise appropriate care of Patient C during the planned surgery.

169. Respondent's (1) fusion of the L3-4 segment of Patient C's lumbar spine when only a discectomy was called for at the level, and (2) fusion of the L4-5 level in the absence of sufficient evidence that such procedure was necessary, were completed while Patient C was unconscious and thus exceedingly vulnerable.

170. Fusing segments of Patient C's lumbar spine that did not require them and increasing the spinal hardware used during the spinal surgery increased the amount that could be charged for Patient C's surgery and correspondingly, the amount Respondent would be paid for performing the surgery.

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COUNT XIII

NRS 630.301(4) - Malpractice

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

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

173. 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."

174. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when during Patient C's surgery on February 29, 2016, he went beyond performing a discectomy at Patient C's L3-4 lumbar segment and also fused that spinal segment without sufficient evidence that such fusion was medically necessary.

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

COUNT XIV

NRS 630.301(4) - Malpractice

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

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

178. 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."

179. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when during Patient C's surgery on February 29, 2016, he fused Patient C's L4-5 lumbar segment without sufficient evidence that such fusion was medically necessary.

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

COUNT XV

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship With the Patient for Financial or Other Personal Gain

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

182. NRS 630.301(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

183. By unnecessarily fusing Patient C's L3-4 and L4-5 lumbar segments in the midst of surgery, thereby increasing the cost of the surgery and his corresponding compensation, Respondent engaged in conduct that violated Patient C's trust and exploited his relationship with Patient C to realize a financial gain.

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

COUNT XVI

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

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

186. 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.

187. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient C because his operative report of Patient C's February 29, 2016, spinal surgery: (1) stated that he was operating in part to address "the presence of instability in the lumbar spine" when preoperative imagining did not demonstrate any instability; and (2) failed to include adequate detail explaining why or how he examined the L4-5 vertebral

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segment, what criteria he used to determine the L4-5 vertebral level "appeared to be unstable," or any objective measurement of the alleged instability of the L4-5 vertebral segment.

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

PATIENT D

189. Patient D[24] was a seventy-five (75) year-old female with a history of low back pain when the events described below began.

190. On August 27, 2015, which was approximately three (3) months before she met with Respondent, Patient D had an MRI of her lumbar spine. In pertinent part, the radiologist who performed the MRI found nonexistent to mild stenosis of the central spinal canal; insignificant to mild foraminal stenosis; and minimal spondylolisthesis at the L1-2 vertebral level:

> L1-L2: Broad-based disk bulge, eccentric toward the right, flattening the ventral thecal sac. *Minimal retrolisthesis of L1 on L2.*[25] *No significant spinal stenosis*. Midline AP thecal sac diameter 12 mm.
>
> Mild flattening of the right lateral recess. *Mild right neural foraminal narrowing*. Slight progression since previous.
>
> L2-L3: Mild broad-based disk bulge and posterior osteophyte formation, slightly impressing upon the ventral thecal sac. *No spinal stenosis.* Facet hypertrophy and ligamentum flavum thickening are present with impression upon the right dorsal sac thecal sac. *Mild right neural foraminal narrowing*. No significant interval change.
>
> L3-L4: Mild broad-based disk bulge, slightly flattening the thecal sac. Left foraminal lateral bulge or [sic] *No spinal stenosis*. Midline thecal sac diameter 13 mm. Mild facet hypertrophy present. *No significant canal stenosis. Mild inferior left neural foraminal narrowing*. Little interval change.
>
> L4-L5: 3mm diffuse disk bulge, which flattens the ventral thecal sac. When combined with ligamentum flavum thickening and facet hypertrophy, there is mild lateral recess narrowing. Midline AP thecal sac diameter 10 mm, with *mild spinal canal stenosis*. Facet hypertrophy contributes to *mild left neural foraminal narrowing*, similar to previous.
>
> L5-S1: Broad-based disk bulge, with 3.5 mm central disk protrusion. This slightly indents the ventral thecal sac, *without significant spinal*

[24] 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.

[25] "*Retrolisthesis* is a specific form of spondylolisthesis . . . where the superior body slips backwards on the lower body." *Redmann v. Martin's Wine Cellar*, 51 So. 3d 41, 45 n.4 (La. Ct. App. 2010) (internal quotation omitted).

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stenosis. Midline AP thecal sac diameter 12 mm. Moderate facet arthropathy and synovitis cyst associated with facet joints. *No significant neural foraminal compromise*.

(Emphases added.)

191. Patient D was referred to Respondent's clinic for consultation regarding her back pain, and first presented to Respondent's clinic on December 8, 2015.

192. Respondent's records of his encounter with Patient D on December 8, 2015, refer to a "[c]omprehensive intake sheet filled out by the patient, [which was] reviewed, scanned and made part of the patient's record." However, the records provided to the Board by Respondent pursuant to NRS 629.061(1)(g) did not contain such a comprehensive intake sheet.

193. Respondent's record of the encounter with Patient D on December 8, 2015, indicated in part: "Direct visualization and independent interpretation of MRI of the lumbar spine demonstrates severe degenerative changes with the presence of scoliosis and post kyphoplasty[26] changes of L1 vertebra, with a severe central and foraminal stenosis from L1 to S1, with a various degree of spondylolisthesis at the L3-L4, L4-L5 and L5-S1 levels."

194. Respondent's statement that the MRI showed "severe" central stenosis from the L1 segment to the S1 segment of Patient D's spine was false and directly contradicted by the MRI, which showed no significant spinal stenosis at L1-2 and L5-S1; no spinal stenosis at L2-3 and L3-4; and only mild spinal canal stenosis at L4-5.

195. Respondent's statement that the MRI showed "severe" foraminal stenosis from L1 to S1 is likewise contradicted by the MRI image showing mild or no significant foraminal narrowing.

196. The only finding on the MRI that there was any spondylolisthesis in Patient D's spine was a reference to "minimal retrolisthesis" at her L1-2 vertebral level, and thus

[26] Patient D apparently had a kyphoplasty approximately five (5) months prior to meeting Respondent. "During [a kyphoplasty], the patient is placed prone on an operating table and the level of fracture of the vertebra is identified using a fluoroscope. A 'K-wire' (a large-diameter device with a pointed end) is inserted through the skin into the pedicle (a conduit into the vertebral body). A drill is used to penetrate the pedicle, and a portion of the sheath is pulled out and replaced with a cannula (a tube used for delivery of material into the vertebra). A balloon is inserted into the drill hole to the proper depth, and the balloon is tamped and filled with water. This decompresses the vertebra, creating a space into which bone cement is injected and allowed to harden. The bone cement remains in the space permanently." *Baker v. Texas Med. Bd.*, No. 03-12-00313-CV, 2013 WL 490749, at *2 (Tex. App. Feb. 6, 2013) (Memorandum Opinion).

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Respondent's claim that the MRI showed spondylolisthesis at Patient D's L3-4, L4-5, and L5-S1 vertebral levels was false.

197. Patient D's preoperative imaging supported nothing more extensive than a simple decompression at the L4-5 and L5-S1 levels, however, Respondent recommended to Patient D "surgical treatment consisting of posterior approach with L1 to S1 lumbar decompression and fusion."

198. Patient D had a second visit with Respondent on February 4, 2016, for a preoperative consultation, when he reiterated that Patient D was "scheduled to undergo L1 to S1 lumbar decompression and fusion."

199. On the morning of February 10, 2016, Patient D presented to Southern Hills Hospital and Medical Center for the planned surgery.

200. In his operative report of the February 10, 2016, surgery, Respondent explained that he began the operation by decompressing and fusing Patient D's L1-2 and L2-3 vertebral segments.

201. Before Respondent moved on to the rest of the planned surgery, Patient D exhibited cardiac abnormalities; although Respondent decided to abridge the procedure, he also proceeded to fuse Patient D's L1 to L5 lumbar levels:

> they [sic] were some irregularities in the blood pressure and cardiac rhythm noted, which quickly normalized. The patient remained stable hemodynamically. Because of the concern for a cardiac abnormality, intraoperatively it was decided to shorten the procedure and the Alphatec pedicle screws were placed at the L1, L2, L3, L4 and L5 levels bilaterally to address severe instability present at the lower lumbar segments. . . . The screws were connected with rods and crosslinks. The exposed body surfaces were decorticated and L1 to L5 posterolateral arthrodesis was accomplished with the use of VITOSS mixed with autograft. The patient at the time of the extubation was stable hemodynamically, was taken to recovery in stable condition. Cardiology consult was called to workup potential cardiac issues.

202. An amendment to the February 10, 2016, operative report indicated that the "cardiac issues" experienced by Patient D during the surgery were somewhat serious, noting that

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"per anesthesiologist, [Patient D] had bradycardia[27] and ST elevation[28] and required 2 units of blood to be given intraoperatively."

203. There was no preoperative evidence of significant stenosis or instability in Patient D's L1-2, L2-3, or L3-4 vertebral segments and no medically necessary basis for Respondent to fuse or otherwise operate on them.

204. A neurosurgeon exercising the reasonable care, skill, or knowledge ordinarily used in performing spinal surgery would not fuse the L1-2, L2-3, or L3-4 segments of Patient D's lumbar spine in the absence of sufficient evidence that it was medically necessary or advantageous to do so.

205. The mild stenosis at Patient D's L4-5 and L5-S1 spinal segments arguably supported simple decompression at those levels of her spine; ironically, these segments were not decompressed during Patient D's February 10, 2016, surgery.[29]

206. In agreeing to allow Respondent to operate on her spine, Patient D placed her trust in Respondent to perform medically necessary procedures.

207. Fusing segments of Patient D's spine that did not require it increased the amount that could be charged for Patient D's surgery and correspondingly, the amount Respondent would be paid for performing the surgery.

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[27] "Bradycardia . . . is a slow heart rate. The hearts of adults at rest usually beat between 60 and 100 times a minute. If you have bradycardia, your heart beats fewer than 60 times a minute. Bradycardia can be a serious problem if the heart rate is very slow and the heart can't pump enough oxygen-rich blood to the body." *Bradycardia*, Mayo Clinic, at https://www.mayoclinic.org/diseases-conditions/bradycardia/symptoms-causes/syc-20355474 (last visited October 24, 2022); *see also United States v. Beam*, 506 F.Supp.3d 1192, 1200 n.8 (N.D. Ala. Dec. 11, 2020) (quoting similar definition from Mayo Clinic website).

[28] The ST-segment is a wave section on an electrocardiogram (EKG). https://my.clevelandclinic.org/health/diseases/22068-stemi-heart-attack (last visited October 24, 2022). The sensors from an EKG detect the heart's electrical activity, which is then displayed as a wave pattern, with different parts being labeled alphabetically from P to U. *See id.* "When there's an elevation is the ST segment, that often means there's a total blockage of one of the heart's main supply arteries." *Id.* The cardiology consultation following her surgery indicated that Patient D suffered a postoperative non-ST elevated myocardial infarction.

[29] Patient D had two (2) additional spinal surgeries in which Respondent was involved: one (1) in September 2016, which was performed by another surgeon, but assisted by Respondent; and another in January 2017, performed by Respondent.

COUNT XVII

NRS 630.301(4) - Malpractice

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

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

210. 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."

211. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he fused the L1-2, L2-3, and L3-4 lumbar segments of Patient D's spine without sufficient evidence that such procedures were medically necessary.

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

COUNT XVIII

NRS 630.301(7) – Engaging in Conduct That Violates the Trust of a Patient and Exploits the Relationship with the Patient for Financial or Other Personal Gain

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

214. NRS 630.301(7) provides that "engaging in conduct that violates the trust of the patient and exploits the relationship between the physician and the patient for financial or other personal gain" constitutes grounds for initiating discipline against a physician.

215. By unnecessarily fusing Patient D's L1-2, L2-3, and L3-4 spinal segments on February 10, 2016, thereby increasing the cost of the surgery and his corresponding compensation, Respondent engaged in conduct that violated Patient D's trust and exploited his relationship with Patient D to realize a financial gain.

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

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COUNT XIX

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

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

218. 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.

219. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient D, as the records he made of her care contained numerous falsehoods, including that a comprehensive intake sheet was made part of the patient's record, that her MRI showed severe central and foraminal stenosis from her L1 to S1 vertebral segments, and that her MRI showed spondylolisthesis at the L3-4, L4-5, and L5-S1 vertebral levels.

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

PATIENTS A, B, C AND D

221. As demonstrated by the above-outlined facts, Respondent has evinced a pattern of failing to use the reasonable care, skill, or knowledge ordinarily used by neurosurgeons in good standing by repeatedly performing unnecessary surgical procedures in the absence of sufficient evidence that such procedures were medically necessary.

222. In performing unnecessary surgical procedures, Respondent wrongfully increased the costs of patients' surgeries, including the cost of the spinal hardware used, and therefore increased the amount he stood to be compensated for the patients' surgeries, and has thus repeatedly violated his patients' trust and exploited his relationship with such patients in order to realize a financial gain for himself.

223. Respondent's repeated violations of the Medical Practice Act as set forth above undermines the public's trust and respect for the medical profession and thereby bring the medical profession into disrepute.

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COUNT XX

NRS 630.306(1)(g) – Continual Failure to Practice Medicine Properly

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

225. NRS 630.306(1)(g) provides that "continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field" constitutes grounds for initiating discipline against a physician.

226. By repeatedly committing malpractice, Respondent has continually failed to exercise the skill and diligence and use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in his field of neurosurgery.

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

COUNT XXI

NRS 630.301(9) – Disreputable Conduct

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

229. NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute constitutes grounds for initiating discipline against a physician.

230. As demonstrated by, but not limited to, the above-outlined facts, by repeatedly performing unnecessary surgical procedures in the absence of sufficient evidence that such procedures were medically necessary and by repeatedly violating his patients' trust and exploiting his relationship with them in order to realize a financial gain for himself, respondent engaged in conduct that brings the medical profession into disrepute.

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

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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 24th day of October, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN, J.D.
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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 24 day of October, 2022.

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 24th day of October, 2022, I served a file-stamped copy of the foregoing **COMPLAINT**, with an accompanying **PATIENT DESIGNATION** and required fingerprinting materials via USPS Certified Mail to the following parties:

YEVGENIY ANATOLIY KHAVKIN, M.D.
c/o Maria Nutile, Esq.
Nutile Law
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Las Vegas, NV 89120
maria@nutilelaw.com
Tracking No.: 9171 9690 0935 0254 7634 20

DATED this 24th day of October, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners