

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. 23-35041-1

6 **Against:**

7 **YEVGENIY ANATOLIY KHAVKIN, M.D.,**

8 **Respondent.**

FILED

JUN 26 2023

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 Brandee Mooneyhan, Deputy General Counsel and attorney for the IC,
13 having a reasonable basis to believe that Yevgeniy Anatoliy Khavkin, M.D., (Respondent) violated
14 the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code
15 (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the
16 IC's 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. 13271). Respondent was
19 originally licensed by the Board on August 26, 2009, and specializes in neurological surgery.

20 2. Patient A² was a fifty-six (56) year-old male with a history of pain in his neck and
21 lower back when the events described below began.

22 3. Patient A was referred by his primary care physician to Respondent for
23 consultation regarding his pain, and Patient A first presented to Respondent's clinic on
24 March 14, 2017.

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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., (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.

1 4. Respondent’s record of the March 14, 2017, encounter indicates that Patient A
2 “ha[d] not had any recent conservative treatment and now presents for neurological evaluation.”

3 5. Respondent ordered magnetic resonance imaging (MRI) of Patient A’s cervical and
4 lumbar spine; pursuant to Respondent’s order, Patient A had an MRI of his lumbar spine on
5 March 31, 2017.

6 6. In pertinent part, the radiologist who performed the MRI of Patient A’s lumbar
7 spine found mild stenosis³ in the lumbar segments between Patient A’s L4 and L5 vertebrae (L4-
8 5)⁴ and in the lumbosacral joint between the L5 vertebra and the sacrum (L5-S1):

9 L4-5: There is mild, unchanged disc bulge eccentric to the left
10 without central canal stenosis. Mild bilateral facet osteoarthritis.
11 Mild bilateral neuroforaminal stenosis.

12 L5-S1: There is mild, unchanged disc bulge without central canal
13 stenosis. Mild bilateral facet osteoarthritis. Mild bilateral
14 neuroforaminal stenosis.

15 The radiologist found the vertebral segment between Patient A’s L3 and L4 vertebrae (L3-4)
16 essentially normal, with no central canal or neuroforaminal stenosis:

17 L3-4: There is mild, unchanged disc bulge without central canal
18 stenosis. Mild bilateral facet osteoarthritis. No neuroforaminal
19 stenosis.

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

- 21 1. No appreciable interval change in mild multilevel degeneration
22 of the lumbar spine as detailed above with disc desiccation and
23 bulge at multiple levels but no central canal stenosis.
24 2. Mild bilateral L4-L5 and L5-S1 neural foraminal stenosis.

25 7. Patient A returned to Respondent’s clinic on April 11, 2017, for Respondent to
26 review the MRIs he had ordered.

27 ³ “Spinal stenosis is narrowing of the spinal column that causes pressure on the spinal cord, or narrowing of
28 the openings (called neural foramina) where spinal nerves leave the spinal column.” See “*Spinal stenosis*,” Medical
Encyclopedia, <https://medlineplus.gov/ency/article/000441.htm> (last visited June 22, 2023). Such “narrowing puts
pressure on [the] nerves and spinal cord and can cause pain.” See “*Spinal Stenosis*,” Health Topics,
<https://medlineplus.gov/spinalstenosis.html> (last visited June 22, 2023).

⁴ “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).

1 8. Respondent’s records of the April 11, 2017, encounter state that his “[d]irect
2 visualization and independent interpretation” of the MRI of Patient A’s lumbar spine showed
3 “there are degenerative changes, most prominent at L4-L5 and L5-S1, with lumbar stenosis, both
4 central and foramen, as well as facet arthropathy.”⁵ Respondent indicated that he planned to
5 perform a “Transforaminal Lumbar Interbody Fusion w/Wide Decompression^[6] [at] L45 L5S1”⁷
6 on Patient A.

7 9. Respondent’s records of the April 11, 2017, encounter further state that he “had an
8 extensive discussion with the patient regarding [his] condition,” and “[c]onsidering the
9 progressive nature of the symptoms and the fact that the patient failed to respond to aggressive
10 conservative measures, the patient is interested in proceeding with a surgical treatment consisting
11 of a posterior approach with transforaminal lumbar decompression and interbody fusion at L4-L5
12 and L5-S1.”

13 10. Respondent’s records did not explain the discrepancy between his statement in the
14 record of his March 14, 2017, encounter that Patient A “ha[d] not had any recent conservative
15 treatment” and his statement in the record of his April 11, 2017, encounter that Patient A had
16 “failed to respond to aggressive conservative measures.” There is no documentation of any
17 conservative measures ordered or taken to address Patient A’s back pain, such as chiropractic
18 therapy, physical therapy, or pain management therapy, before Respondent recommended surgery.
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20 ⁵ Facet arthropathy is “a disease or abnormality of the facet joints”; as one federal district court explained:

21 The facet joints connect the vertebral bodies to one another, and like the hip and
22 the knee, they can also become arthritic and painful, and can be a source of back
23 pain. The facet joints are located at the back of the spine and counterbalance the
24 intervertebral discs. They help keep the normal alignment of the spinal vertebrae
 and limit motion. The pain and discomfort that is caused by degeneration and
 arthritis of this part of the spine is called facet arthropathy, which simply means a
 disease or abnormality of the facet joints.

25 *Wiley v. United of Omaha Life Ins. Co.*, No. 5:16-CV-1936-CLS, 2019 WL 2172708, at *16 (N.D. Ala. May 20,
26 2019) (internal citation omitted).

27 ⁶ In the context of spinal surgery, decompression refers to the surgical relief of pressure on the spinal cord or
28 nerves.

⁷ “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).

1 11. Included in Respondent's medical records for Patient A is a "Procedure Check
2 List," dated April 11, 2017, which indicates that Patient A's diagnosis is "lumbar stenosis," that
3 the procedure contemplated is "L45, LFS1 TLIF," and that the surgery was scheduled for
4 May 19, 2017.

5 12. Patient A had another visit with Respondent on May 11, 2017, for a preoperative
6 consultation. Respondent's record of the preoperative consultation states that Patient A was
7 "scheduled to undergo a lumbar decompression and fusion." A narrative under the heading "Plan"
8 states in its entirety: "We went over the benefits and the risks. He acknowledged understanding
9 and wants to proceed." The record indicates that it was electronically signed by Respondent on
10 June 30, 2017, several weeks after the encounter, and after the surgery referred to therein.

11 13. On the "Surgery & Procedure Scheduling Form/Physician Pre-Operative
12 Admission Orders" regarding the procedure, which appears to have been signed by Respondent
13 and transmitted to the hospital on or about May 11, 2017, in the space for "Procedure as it is to
14 appear on the Consent," was entered: "POSTERIOR APPROACH TRANFORAMINAL
15 LUMBAR INTERBODY FUSION WITH DECOMPRESSION FOUR TO SACRAL ONE."⁸

16 14. The "Consent to Surgery and Other Invasive Procedures" regarding the planned
17 procedure, which was signed and dated on or about May 11, 2017, indicates that Patient A
18 authorized Respondent to perform "POSTERIOR APPROACH TRANSFORAMINAL LUMBAR
19 INTERBODY FUSION LUMBAR WITH DECOMPRESSION FOUR TO SACRAL ONE."

20 15. On May 19, 2017, Patient A presented to Spring Valley Hospital Medical Center
21 for the planned transforaminal lumbar interbody fusion with decompression at his L4-5 and L5-S1
22 vertebral segments.

23 16. The "Pre-Procedure Site Verification Note" regarding Patient A's surgery, dated
24 May 19, 2017, which includes a drawing of a human body to allow marking of where a surgery is
25 to be performed, contains a handwritten phrase to the right of the drawing which reads: "posterior
26 approach transforaminal lumbar interbody fusion with decompression four to sacral one."

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⁸ 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.

1 17. As set forth above, all preoperative records regarding Patient A’s May 19, 2017,
2 surgery indicate that only the L4-5 and L5-S1 segments of Patient A’s spine were to be operated
3 upon; there is no indication that the L3-4 segment was a candidate for surgery.

4 18. During the May 19, 2017, surgery, in addition to performing the planned
5 procedures at the L4-5 and L5-S1 segments, Respondent operated on the L3-4 segment of
6 Patient A’s spine.

7 19. In his operative report of the May 19, 2017, surgery, Respondent stated that he
8 made an intraoperative decision to extend the surgery to the L3-4 segment:

9 L3-L4 segment was examined and appeared to be grossly unstable
10 with significant amount of abnormal motion present. Per my
11 previous discussion with the patient to accomplish better clinical
12 postoperative outcome and to avoid neurological deficits, it was
13 decided to incorporate the L3-L4 segment.

14 20. Respondent failed to explain in his operative report why the L3-4 segment was
15 “examined” in the midst of the May 19, 2017, surgery when the preoperative MRI showed it was
16 essentially normal, with no canal or foraminal narrowing, and thus not a reasonable candidate for
17 surgery.

18 21. Neither did Respondent explain how Patient A’s L3-4 segment was “examined” in
19 the midst of the May 19, 2017, surgery, when mere appearance of the segment would be
20 insufficient to demonstrate instability and physical manipulation of the segment would be
21 unwarranted.

22 22. Nor did Respondent explain what criteria he used to determine that the L3-4
23 segment was “grossly unstable” or provide any objective measurement of its alleged instability.

24 23. A neurosurgeon would not ordinarily “examine” the stability of a spinal segment
25 during a surgery being performed on other spinal segments, and the “appearance” of a spinal
26 segment is not sufficient to support a clinical determination regarding its stability.

27 24. Respondent’s statement in his operative report that Patient A’s L3-4 segment was
28 “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.

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

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

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

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

12 29. Fusing an additional segment of Patient A's lumbar spine and correspondingly
13 increasing the spinal hardware used during the spinal surgery increased the amount Respondent
14 would be paid for performing the surgery.

15 **COUNT I**

16 **NRS 630.301(4) – Malpractice**

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

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

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

24 33. Respondent failed to use the reasonable care, skill or knowledge ordinarily used
25 under similar circumstances when, during Patient A's spinal surgery on May 19, 2017, he fused
26 the L3-4 segment of Patient A's spine without sufficient evidence that it was medically necessary
27 to do so.

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

3 **COUNT II**

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

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

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

11 37. By unnecessarily fusing Patient A’s L3-4 lumbar segment in the midst of surgery
12 planned for other spinal segments on May 19, 2017, thereby increasing the cost of the surgery and
13 his corresponding compensation, Respondent engaged in conduct that violated Patient A’s trust
14 and exploited his relationship with Patient A to realize a financial or other personal gain.

15 38. 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 630.3062(1)(a) – Failure to Maintain Accurate Medical Records**

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

21 40. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
22 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
23 grounds for initiating discipline against a licensee.

24 41. Respondent failed to maintain accurate and complete medical records relating to
25 the diagnosis, treatment and care of Patient A when he failed to include adequate detail in his
26 operative report of Patient A’s May 19, 2017, spinal surgery as to: (1) why he examined the L3-4
27 vertebral segment when preoperative imaging showed it was essentially normal; (2) how he
28 examined the L3-4 vertebral segment; (3) what criteria he used to determine the L3-4 vertebral

1 segment was “grossly unstable”; and (4) any objective measurement of the alleged instability of
2 the L3-4 vertebral segment.

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

5 **COUNT IV**

6 **NRS 630.301(9) – Disreputable Conduct**

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

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

11 45. As demonstrated by, but not limited to, the above-outlined facts, by performing an
12 unnecessary surgical procedure and violating Patient A’s trust and exploiting his relationship with
13 Patient A in order to realize a financial or other personal gain, Respondent engaged in conduct that
14 brings the medical profession into disrepute.

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

17 **WHEREFORE**, the Investigative Committee prays:

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

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

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

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

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

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

DATED this 26th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan
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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 26 day of June, 2023.

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 26th day of June, 2023, I served a file-stamped copy of the foregoing **COMPLAINT** as well as file-stamped copy of the **PATIENT DESIGNATION** and required fingerprinting materials, via USPS Certified Mail, postage pre-paid, to the following parties:

YEVGENIY ANATOLIY KHAVKIN, M.D.
c/o Maria Nutile, Esq.
Nutile Law
7395 S. Pecos Road, Ste. 103
Las Vegas, NV 89120

Tracking No.: 9171 9690 0935 0255 6830 00

DATED this 26th day of June, 2023.



MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners