

NEVADA STATE BOARD OF MEDICAL EXAMINERS



IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

IRA MICHAEL SCHNEIER, M.D.

ADJUDICATION

Case No: 24-40539-1

Date: September 12, 2025

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BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 24-40539-1

Against:

MICHAEL IRA SCHNEIER, M.D.,

Respondent.

FILED

JUL 30 2024

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Ira Schneier, 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. 14728). Respondent was originally licensed by the Board on March 8, 2013, and has a specialty in spine surgery.

2. Patient A² was a forty-nine (49) year-old male at the time of the events at issue.

3. Patient A was admitted to Sunrise Hospital on December 26, 2019, with complaints of lower back pain, weakness, and inability to walk. Patient A underwent an MRI of the lumbar spine on December 27, 2019, which demonstrated severe canal narrowing at the T11-T12 level. Patient A then underwent an MRI of the thoracic spine on December 30, 2019, which demonstrated severe central stenosis at the T10-T11 level, with abnormal cord signal at this level.

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 Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela J. Beal.

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. On December 31, 2019, Respondent performed a thoracic laminectomy for spinal
2 cord decompression with pedicle screw fixation and onlay lateral transverse fusion (hereinafter
3 referred to as the "laminectomy"), intended to be performed at the T10-T11 level. According to
4 Respondent's preoperative diagnosis, Respondent diagnosed Patient A with thoracic
5 myelomalacia myelopathy with spinal stenosis at the T10-T11 level.

6 5. Respondent performed the December 31, 2019, laminectomy at the T9-T10 level
7 and failed to perform surgery on Patient A's main pathology at the T10-T11 level.

8 6. Patient A returned to Sunrise Hospital on January 22, 2020, with complaints of
9 continued severe pain, spasms, and numbness in the bilateral lower extremities. A CT scan
10 performed during Patient A's admission demonstrated that on December 31, 2019, Respondent
11 performed the laminectomy at the T9-T10 level and not the T10-T11 level as originally intended.
12 During Patient A's hospitalization, there was also concern of a medial breach of the left T9 screw.

13 7. On January 23, 2020, Respondent performed a second surgery on Patient A, by
14 removing the T9 pedicle screws and rods. Although again, Respondent did not address the severe
15 stenosis at the T10-T11 level during the second surgery.

16 8. There is no documentation that Respondent informed Patient A that the initial
17 laminectomy was performed at the incorrect level, or that Patient A still required operation on the
18 T10-T11 level.

19 9. On February 4, 2020, Patient A underwent a repeat MRI of the thoracic spine,
20 which demonstrated continued severe stenosis at the T10-T11 level. On February 13, 2020,
21 Respondent reported spasticity in his lower extremities and functional decline. Patient A
22 underwent further MRI testing on February 15, 2020, and May 13, 2020, both of which
23 demonstrated continued severe central stenosis at the T10-T11 level.

24 10. On May 29, 2020, Patient A presented to another hospital with continued
25 complaints of back pain, lower extremity pain, and spasticity. On or about June 4, 2020, Patient A
26 underwent a T10-T11 laminectomy, which was performed by another surgeon.

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COUNT I

NRS 630.301(4) – Malpractice

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

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

13. 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.”

14. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when treating Patient A, by failing to recognize and address Patient A’s continued spinal stenosis at the T10-T11 level, after performing surgery at the incorrect spinal level on December 31, 2019. Respondent’s failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances includes, but is not limited to, the failure to address Patient A’s T10-T11 spinal stenosis during the second surgery Respondent performed on January 23, 2020.

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

COUNT II

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

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

17. 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.

18. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, by, among other things, Patient A’s continued stenosis at the T10-T11 level after the

1 December 31, 2019, procedure. Thus, Respondent's medical records were not timely, legible,
2 accurate, and complete.

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

5 **COUNT III**

6 **NRS 630.306(1)(g) – Continual Failure to Exercise Skill or Diligence**

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

9 21. Continual failure by the Respondent to exercise the skill or diligence or use the
10 methods ordinarily exercised under the same circumstances by physicians in good standing
11 practicing in the same specialty or field is grounds for disciplinary action against a licensee
12 pursuant to NRS 630.306(1)(g).

13 22. Respondent continually failed to exercise skill or diligence as demonstrated by his
14 repeated failure, after December 31, 2019, to recognize and address Patient A's continued spinal
15 stenosis at the T10-T11 level, despite multiple imaging studies indicating that the spinal stenosis
16 at the T10-T11 level had not resolved.

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

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

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

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

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

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

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

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

5 DATED this 30th day of July, 2024.

6 INVESTIGATIVE COMMITTEE OF THE
7 NEVADA STATE BOARD OF MEDICAL EXAMINERS

8 By:



9 WILLIAM P. SHOGREN

10 Deputy General Counsel

11 9600 Gateway Drive

12 Reno, NV 89521

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15 Attorney for the Investigative Committee
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VERIFICATION

STATE OF NEVADA)
 : ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 30th day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



CHOWDHURY H. AHSAN, M.D., PH.D., FACC
Chairman of the Investigative Committee

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 24-40539-1

Against:

IRA MICHAEL SCHNEIER, M.D.

Respondent.

FILED

AUG 21 2024

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

ERRATA TO COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC hereby submit this Errata to its Complaint in Case No. 24-40539-1, filed July 30, 2024, and should be appended thereto. An inadvertent clerical error was discovered on page 1, line 7, in the case caption and on page 1, line 13, in which Respondent's name should read as "Ira Michael Schneier, M.D."

DATED this 21st day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



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

3 * * * * *

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5 **In the Matter of Charges and**
6 **Complaint Against: IRA MICHAEL**
7 **SCHNEIER, M.D.,**
8 **Respondent.**
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Case No. 24-40539-1

FILED

JUL 31 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

10 **FINDINGS AND RECOMMENDATIONS/SYNOPSIS OF RECORD**

11 **I. INTRODUCTION**

12 The formal hearing in this matter occurred on May 28, 2025. Present in the Reno office of the
13 Nevada State Board of Medical Examiners (the "Board") were William Shogren, Esq. on behalf of
14 the Investigative Committee of the Nevada State Board of Medical Examiners (the "IC"), by Zoom,
15 and the undersigned Hearing Officer, together with the certified court reporter. Appearing remotely
16 by Zoom on behalf of the Respondent Ira Michael Schneier, M.D. was his attorney, Melanie L.
17 Thomas, Esq..

18 IC witness Johnna LaRue, Deputy Chief of Investigations for the Board, and IC's designated
19 expert witness orthopedic surgeon Vadim Goz, M.D. appeared and testified remotely by Zoom.
20 Respondent Ira Michael Schneier, M.D. and Respondent's designated expert witness Raj Agrawal,
21 M.D., appeared and testified remotely by Zoom. All witnesses were sworn prior to testifying. The
22 undersigned Hearing Officer did not invoke the rule of exclusion as the witnesses, other than Ms.
23 LaRue, were either a party (Dr. Schneier) or a designated expert witness (Dr. Goz and Dr. Agrawal).
24 See, NRS 50.155.

25 IC's Exhibits 1, 2, 3, 4 and 10 were initially admitted into evidence prior to testimony. IC's
26 Exhibits 5, 7, 8 and 9 were subsequently admitted into evidence during the course of the hearing.
27 Respondent's Exhibits A, B, E, F, G, H, I, J, K, L, M, N, O, and P were initially admitted prior to
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1 testimony. Respondent's Exhibit C, designated as "Digital Imaging (various dates)" was
2 subsequently admitted during the course of the hearing, as was Exhibit Q, Dr. Schneier's CV.

3 **II. ALLEGATIONS**

4 The Complaint in this matter alleges three counts against Respondent. Count 1 is captioned
5 "Malpractice." Count 2 is captioned "Failure to Maintain Complete Medical Records." Count 3 is
6 captioned "Continual Failure to Exercise Skill or Dilligence."

7 All three counts are premised on the allegation that on December 31, 2019, Respondent
8 performed a laminectomy (as defined in the Complaint) at the T9-T10 level of Patient A's spine to
9 *address spinal stenosis* when said procedure should have been performed at the T10-T11 level.
10 Thus, the first base allegation is that Dr. Schneier performed a **wrong level spine surgery** on January
11 31, 2019. The second base allegation is that Dr. Schneier then failed to recognize and did not address
12 the wrong level surgery issue or continuing spinal stenosis (the "complication") when he performed a
13 second surgery on Patient A on January 23, 2020. According to the IC's Complaint, that second
14 surgery *allegedly failed to address continuing severe stenosis* in Patient A's thoracic spine. See
15 generally, Complaint, para 14.

16 In his Answer and Notice of Defense, Respondent denies that the December 31, 2019 surgery
17 was performed at the incorrect level of Patient's A's thoracic spine or that he failed to address
18 Patient A' spinal stenosis in either surgery he performed.

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

21 Thus, the core issues in this matter are whether the IC has proven "malpractice" by a
22 preponderance of the evidence; specifically that Respondent's December 31, 2019 surgery was
23 performed on the wrong level of Patient A's thoracic spine, and that Respondent's second surgery
24 failed to address this "complication."¹

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¹ The IC is not claiming that Respondent's surgical procedures themselves were performed below the standard of care aside from the issue of the level where the surgeries occurred.

1 **III. EVIDENCE, WITNESSES AND TESTIMONY**

2 The evidence that was presented at the hearing was extensive. The IC’s exhibits totalled
3 around 100 pages of material and Respondent’s “culled” exhibits included upwards of 700 pages of
4 medical records and other material.

5 Given the nature of this case (alleged wrong level spinal surgery), much of the key evidence
6 and testimony involved expert opinions on various imaging studies (the scan images themselves and
7 the reading radiologists’ impressions) of Patient A’s lumbar and thoracic spine. This testimony in the
8 hearing transcript can be confusing because much of it occurred while witnesses were referring to
9 imaging studies that were displayed on the television monitor.

10 Respondent presented two demonstrative exhibits that contained images from various
11 diagnostic tests. These were identified as “Exhibit C—Combined imaging studies patient marked”
12 (15 pages of images) and “Exhibit C—005 and 013 side by side” (one page). These images were
13 enhanced with colored arrows pointing toward various vertebral levels and anatomical features.
14 Given the extent of testimony concerning these enhanced images, they are attached hereto as
15 Appendix “A” and “B” respectively. Patient identifying information has been redacted. When
16 discussed herein, images from Appendix A will be referenced as “CIS” with the image number
17 following.

18 Additionally, the summary of testimony below is detailed by necessity. This is necessary for
19 a complete understanding of the issues in the case, and whether by a preponderance of the evidence
20 the IC established that Respondent indeed performed a wrong level spinal surgery and thereafter
21 failed to address this “complication.” This is a serious allegation that requires careful and serious
22 analysis.

23 As a final prefatory note, in the hearing testimony that is summarized below, testimony that
24 is key to the Hearing Officer’s ultimate findings is set forth in *italics*, underline, **bold**, or a
25 combination thereof. Testimony that is most salient to the issues presented is identified with **all**
26 **three**.

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1 A. IC witness **Johnna LaRue**

2 *Direct examination*

3 The first witness called by the IC was Johnna LaRue. Ms. LaRue is Deputy Chief of
4 Investigations and Compliance Officer for the Board. She has worked for the Board for 19 years.
5 TR 19:13-25. Ms. LaRue was the investigator for the instant matter.

6 Ms. LaRue testified that as part of her investigation she was required to obtain medical
7 records. TR 20:9. She was specifically asked about the IC's Exhibit 5, which were records from
8 Clinical Neurology Specialists. TR 21:20. Based on Ms. LaRue's testimony, those records were
9 admitted into evidence. TR 23:3.

10 Next, Ms. LaRue testified about IC's Exhibit 8, which were records from Khavkin Clinic.
11 Based on Ms. LaRue's testimony, as well as the fact that records from Khavkin Clinic were also
12 submitted as Respondent's Exhibit K, which had been previously admitted, IC's Exhibit 8 was
13 admitted into evidence. TR 24:20-24:2.

14 *Cross examination*

15 On cross-examination, Ms. LaRue was asked a series of questions about her investigative
16 activities outside of gathering medical records. She testified that she requested a response to the
17 allegations from Dr. Schneier. TR 25:14-15. (IC's Exhibit 1). She testified that she did not select
18 the IC's expert. TR 25:20.

19 After this, Ms. LaRue was asked questions about the underlying complaint the Board
20 received, which elicited objections from IC counsel based upon the confidentiality of the
21 investigative file materials. There was also an extended discussion between counsel and the Hearing
22 Officer regarding the name of the complainant, and whether such name was covered by the
23 confidentiality rules. Eventually, the IC's objection based upon confidentiality was sustained, subject
24 to further discussion. TR 31:16-20.

25 Ms. LaRue testified that she provided medical record to the IC's expert witness, Dr. Goz. TR
26 43:20.

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1 Ms. LaRue was then asked about what Respondent's counsel referred to as the "community
2 complaint" and whether the same was provided to Dr. Goz. This elicited an objection from IC
3 counsel, again based on confidentiality of investigative materials. Respondent's counsel argued that
4 by disclosing material to the expert Dr. Goz, the confidentiality was waived. The issue was reserved
5 as being more properly addressed in the context of Dr. Goz' testimony. TR 39:13-18.

6 There were no credibility issues with respect to Ms. LaRue's testimony.

7 **B. IC witness Vidam Goz, M.D.**

8 ***Direct examination***

9 The second witness called by the IC was expert witness orthopedic surgeon Vadim Goz,
10 M.D.. Dr. Goz has been licensed to practice medicine in Nevada for "about five years." TR 43:18-
11 19. He is a practicing spinal surgeon and member of the American Academy of Orthopedic Surgery.
12 TR 44:16; 45:6-7. He performs between 200 and 250 spinal surgeries a year, including
13 laminectomies and fusions. The total number of thoracic fusions was "probably a few hundred." TR
14 45:10-20.

15 Dr. Goz testified that he was familiar with Dr. Schneier's case, and that based upon his
16 training and experience, he was familiar with the standard of care that applied to the case. TR 48:24-
17 49:6.²

18 Dr. Goz testified that in his opinion, there was a "departure from the standard of care" in this
19 case. TR:52:12-13. Specifically:

20 "In my opinion, the departure from the standard of care was the failure
21 to recognize the wrong-level surgery over a prolonged period of time,
22 and the failure to address that complication. And I want to be clear in
23 my opinion, you know, I think the report is very clear that wrong-level
24 surgery is a well documented complication or potential risk of surgery,
25 especially at the thoracic spine, and *while having that complication in*
26 *itself, in my opinion, is not malpractice,* it is the repeat failure to
27 recognize that complication and adjust it in a timely manner.
28 That constitutes the departure from standard of care, in my opinion. "

TR:52-20-53:9.

² At this point, IC's Exhibit 9, a 2008 article from the publication "SPINE" entitled "The Prevalence of Wrong Level Surgery Among Spine Surgeons" was admitted into evidence over Respondent's objection based upon Dr. Goz' testimony that it was used as one of his data points in forming his opinions. TR 51:24-52:2. Dr. Goz did not thereafter directly refer to this article during the balance of his testimony.

1 Dr. Goz read into the record the admission notes for Patient A from Sunrise Hospital dated
2 12/26/2019. Those records indicated that Patient A was experiencing left lower back pain and
3 presented to the ER complaining of worsening left low back pain with issues of inability to walk for
4 two months. On the day of admission, the pain got worse to the point of calling his orthopedic
5 surgeon, who told him to go to the ER. He was also experiencing mild numbness and tingling in the
6 legs. TR 54:9-19.

7 Dr. Goz then reviewed an MRI report of Patient A's lumbar spine dated 12/27/2019. IC
8 Exhibit 3, NSBME 060. The first impression read: "The canal narrow at T11-T12 with likely cord
9 edema at this level. Recommend contrast-enhanced thoracic spine MRI." TR 55:4-6 and the
10 referenced IC exhibit. He explained that the reason for a contrast enhanced MRI was that such a scan
11 can provide additional detail regarding the presence of identifying inflammatory tissues and the
12 nature of the cord edema that was present. TR 55:9-14.

13 *It is noted that when providing this testimony, Dr. Goz was referring to the radiologist's*
14 *reading/interpretation of this lumbar MRI, not to any actual image(s) from that scan.*

15 Dr. Goz then reviewed the MRI report of Patient A's thoracic spine dated 12/30/2019. IC
16 Exhibit 3, MSBME 061-62. The radiologist's impression read: "Mild T7-T8, mild T9-T10. Mild
17 T11-T12. Severe T10-T11. Central canal stenosis without normal cord signal at T10-T11 and
18 possibly T7-T8." TR 56:7-9.

19 He went on to define "stenosis" as a narrowing of the nerve canal and central canal stenosis
20 as the narrowing of the central tunnel where the spinal cord resides. He indicated that "stenosis" is
21 not a specific term as to any one pathology. TR 57:5-16.

22 The "without normal cord signal" reference on this thoracic MRI report of December 30,
23 2019 indicated bruising or damage to the spinal cord, commonly referred to as "myomalacia."
24 Further, Dr. Goz stated that the reference to "severe T10-T11 stenosis" meant that the stenosis
25 deformed the spinal cord without any fluid remaining around it. TR 57:23-58:10. According to Dr.
26 Goz, severe symptomatic thoracic stenosis, left untreated, can lead to permanent neurologic deficits.

1 TR 59:5-7. Under those circumstances, treatment should be done in a “timely fashion” and “probably
2 sooner is better than later.” TR 60:2-18.³

3 *It is again noted that when providing this testimony, Dr. Goz was referring to the*
4 *radiologist’s reading/interpretation of the enhanced thoracic MRI of 12/30/2019, not any actual*
5 *image(s) from that scan.*

6 Dr. Goz was then asked about Dr. Schneier’s operative report of 12/31/2019. IC Exhibit C,
7 NSBME 056-057. He noted that the pre-operative diagnosis was “thoracic myelomalacia myelopathy
8 with spinal stenosis, T10-T11.” TR 61:1-2. He explained that myelomalacia myelopathy meant that
9 there was increased inflammation and edema in the spinal column (myelomalacia) with spinal cord
10 dysfunction (myelopathy) at the T10-T11 level. TR 61:7-17. According to the operative report, the
11 surgery itself included a thoracic laminectomy at T10-T11 for cord decompression, use of
12 intraoperative fluoroscopy with pedicle screw fixation, T10-T11 with onlay lateral transfer of fusion
13 with allograft autografted bone fusion. TR 61:20-25. Dr. Goz described a laminectomy as
14 removing the lamina, which is the bony portion of the spinal canal, to take pressure off the spinal
15 cord, which was a “common procedure.” TR 62:3-8. “Pedicle screws” were part of the fusion, and a
16 fusion is performed if a surgeon believes that the laminectomy would destabilize the spine. TR
17 62:21-25. “Decompression” means removing bones and ligaments that are leading to the stenosis,
18 thereby widening the nerve tunnel. TR 63:5-7.

19 After describing Dr. Schneier’s December 31, 2019 operative report, Dr. Goz was asked how
20 a spinal surgeon determines what area needs to be worked on. **“Based on a combination of the**
21 **patient’s clinical symptoms and the MRI or advanced imaging findings.”** TR 63:17-19. He then
22 testified that the preoperative diagnosis on Dr. Schneier’s operative report was in agreement with the
23 12/30/2019 MRI previously discussed. TR 64:14-20.

24 IC’s Exhibit C, NSBME 024-36, are ER records from Sunrise Hospital on Patient A dated
25 1/22/2020. These records detail Patient A’s medical/surgical history (which includes not only Dr.
26 Schneier’s 12/31/2019 surgery but also left hip surgery on 1/9/2020) as well as presenting symptoms
27 (primarily back pain, difficulty walking and inability to straighten the left leg.). These ER records

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³ Dr. Goz also testified that in the case of a spinal cord injury with pressure on the spinal cord decompression should be performed within 48 hours from injury. TR 60:6-12.

1 also state that Patient A “underwent T10-T11 laminectomy cord decompression, pedicle screws
2 fixation on light fusion on 12/31/2019.” TR 65:25-66:2.

3 Dr. Goz was then directed to the “clinical impression” section of the ER report of 1/22/2020
4 (NSBME 035) which reads: “Primary impression, back pain. Secondary impression, focal
5 neurologic deficit, post-op pain, seroma.” TR 66:18-20. He described “seroma” as a collection of
6 postoperative fluid. TR 66:22-23.

7 Following this, Dr. Goz was asked about a thoracic CT scan *report* for Patient A dated the
8 day of the Sunrise ER visit, 1/22/2020 (NSBME 052). First, he noted that a CT scan is better at
9 showing bony structures, whereas an MRI is better at showing soft tissues. TR 67: 7-9. After
10 reading the history and comparison sections of the CT report, he read the report’s “impression”
11 section: “Interval laminectomy at T9 and T10 with a unilateral left-sided pedicle screw and rod
12 construct, left T9 screw reaches.... the medial cortex of the left T9 pedicle, approximately 50 percent
13 of the width of the screw projects into the lateral aspect of the central canal at T9. Partially
14 visualized, small simple-appearing postoperative fluid collection favor a small seroma.” TR 68:4-9.

15 Dr. Goz then testified:

16 Q. According to the impression, where were the laminectomies
17 performed?

18 A. T9-T10.

19 Q. In this record, is there any mention of the a (sic) laminectomy
20 being performed at the T10-T11?

21 A. There is not.

22 Q. In your opinion, does this CT report differ from Dr. Schneier’s
23 postoperative analysis from December 31, 2019?

24 A. It does.

25 Q. In your opinion, how does it differ?

26 A. Dr. Schneier’s operative report indicated a T10-T11 laminectomy,
27 whereas this *report* indicates the laminectomy was performed at T9-
28 T10.

Q. And, generally, how does—a professional that interprets the CT,
how do they determine where the laminectomy is?

A. It’s fairly evident on the CT as an area of bone that has been
removed.

1 Q. In your opinion, it's fairly easy to determined based off of a CT or
2 MRI where the laminectomy was done?

3 A. Yes.

4 TR 68:14-69:11.

5 *It is again noted that when providing this testimony, Dr. Goz was referring to the*
6 *radiologist's reading/interpretation of the thoracic CT scan of 1/22/2020, not the actual scan image*
7 *itself.*

8 Following this, Dr. Goz was asked to read into the record certain assertions contained in Dr.
9 Schneier's attorney's response to the Board, IC Exhibit 2, dealing with Patient A's condition on his
10 return to the ER on January 22, 2020 and Dr. Schneier's review of the thoracic CT scan. One such
11 assertion Dr. Goz read: "Dr. Schneier noted that he reviewed the CT scan, found no CSF
12 extravasation, and the thecal sac was not impinged. He planned to take Patient A to surgery, remove
13 the screws, and get a further MRI without the...." TR 70:14-71:10.

14 Next, Dr. Goz was asked about the second surgery Dr. Schneier performed on Patient A
15 which occurred on 1/23/2020. He was directed to Dr. Schneier's operative report, and read the
16 preoperative diagnosis as: "Question of T9 medial pedicle screw or medial breach of the T9 pedicle
17 with the pedicle screw" and the procedure as: "Removal of the T9-T10 pedicle screw, screw lock
18 implant." TR 72:3-8. He explained that this meant that the screws that were previously implanted, as
19 well as the rods, were taken out, which is a common procedure. TR 72:9-15. The finding section of
20 the report read: "Medial wall pedicle intact with ball-tip palpation T9, T10. No CFS leak noted with
21 Valsalva." TR 72:18-20. This implied that the pedicle screw was not too medial, as the CT scan
22 implied. TR 73:9-10.

23 Dr. Goz then testified that Dr. Schneier's surgical intervention of 1/23/2020 fell below the
24 standard of care. He testified that based on Patient A's ongoing symptoms of myelopathy and spinal
25 cord dysfunction, as well as the CT scan that indicated there may be a wrong-level surgery, "the
26 appropriate intervention would be to extend that laminectomy or do a decompression at the correct
27 level where the area of stenosis is. But instead of doing that, a removal of hardware was performed."
28 TR 73:11-74:7. Dr. Goz further explained: "if the stenosis or the significant compression of the

1 spinal cord is at what we're calling the T10-T11 level, and the decompression is performed at T9-
2 T10, the appropriate solution would be to extend the decompression inferiorly, taking the rest of the
3 T10 lamina and the superior aspect of the T11 lamina in order to address the area of stenosis." TR
4 74:10-17.

5 Next, Dr. Goz was directed back to IC's exhibit 2, which is the response letter Dr. Schneier's
6 attorney sent to investigator LaRue dated August 29, 2022. After going through several portions of
7 that letter, including references to Dr. Schneier's follow-up progress notes of February 4, 2020
8 wherein he noted that Patient A was being evaluated for inpatient rehabilitation, Dr. Goz was asked
9 whether he believed that Dr. Schneier had departed from the standard of care as of that date
10 (February 4, 2020), to which Dr. Goz responded: "I believe he did.... At this point, there are multiple
11 imaging studies that indicate a wrong-level surgery was performed and there's continued severe canal
12 stenosis that appears to be symptomatic, and Dr. Schneier did not address the continued stenosis."
13 TR 76:10-20.⁴

14 Dr. Goz' attention was then directed to IC Exhibit 5, NSBME 066, which is an April 30, 2020
15 report from Dr. Leo Germin at Clinical Neurology Associates regarding Patient A. He read into the
16 record Dr. Germin's first impression: "Weakness in the lower extremities associated with tightness
17 and spasm in the distal legs and feet in a patient diagnosed with thoracic myelomalacia, status post
18 T10-T11 laminectomy December 2019, with a revision in January of 2020 at Sunrise Hospital by Dr.
19 Schneier. Limited database." Dr. Goz further read from this Dr. Germin report that a repeat MRI of
20 the thoracic spine after thoracic surgery and a revision revealed persistent cord compression at T10-
21 T11; decompression similar in intensity to a prior MRI of February 4, 2020; and ventral CSF effaced
22 by fluid, probable post-operative blood product. TR 77:15-25. Quoting Dr. Germin's report, Dr.
23 Goz then read into the record the impression section of another thoracic MRI dated 5/13/2020
24 (NSMNE074): "Severe spondylotic degenerative changes with severe central spinal stenosis at T10-
25 T11, and moderate canal stenosis at T9-T10. AP diameter at the T10-T11 level is 6 millimeters." TR
26 78:7-12.

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28

⁴ Again, when testifying on direct examination, Dr. Goz was not referring to imaging studies themselves but was rather reading radiologist's interpretation of same.

1 It is again noted that when providing this testimony, Dr. Goz was not reviewing any actual
2 MRI scan images but rather Dr. Germin's quote of the scan's findings.

3 Dr. Goz was then directed to a portion of IC Exhibit 8, which was an operative report on
4 Patient A from Dr. Yevgeniy Khavkin dated June 6, 2020 (NSBME 095). According to the report,
5 this operation consisted of a T10-T11 laminectomy and related procedures. Dr. Goz read into the
6 record a portion of Dr. Khavkin's operative report: "The patient is thought to have a severe spinal
7 cord compression at the T10-T11 level. The patient was told previously that this level was addressed
8 by another physician at his previous surgery, but, unfortunately, the surgery that he had was
9 performed at the level above, and they were-- [blank in report]-- the patient's pathology, which
10 resulted in significant and worsening of his condition." TR 79:11-20.

11 The final record Dr. Goz discussed in his direct examination was a note from Dr. Khavkin
12 dated 8/26/2020, IC Exhibit 8, NSBME 097, wherein Dr. Khavkin noted that Patient A reported
13 significant improvement of his symptoms and that he was able to stand on his own, which he could
14 not do prior to surgery. TR 80:3-8.

15 Dr. Goz then summarized his opinion that Dr. Schneier committed malpractice:

16 It is the delay in both identifying the complication of the surgery and
17 the delay in appropriately addressing that complication that I believe
 fell below the standard of care.

18 I want to be clear that I don't think that a single episode of wrong-
19 level surgery, if identified in a timely fashion, constitutes malpractice.
20 But failing to identify the wrong level of surgery that was performed
21 and the continued severe stenosis at T10-T11, which then led to a
 delay in the appropriate decompression is what, in my opinion, falls
 below the standard of care. TR 80:21-82:8.

22 Dr. Goz also testified that Dr. Schneier should have identified the "likely" wrong level
23 surgery at least by the time of the post-surgery CT scan of 1/22/2020 if not after two other MRIs that
24 identified continued severe stenosis at the T10-T11 level. TR 81:24-82:3.

25 **Finally, Dr. Goz testified that Dr. Schneier's records were "appropriate."** TR 82:6.

26 ***Cross Examination***

27 Initially, Dr. Schneier's counsel questioned Dr. Goz about the medical records and imaging
28 studies he received and the manner in which he received them. TR 83:6-85:23. There was then a

1 discussion, and argument, regarding whether Dr. Goz received something called the “community
2 complaint” and whether there was a waiver present as to certain items Dr. Goz received. Ultimately,
3 the IC’s objection to these matters was sustained on confidentiality grounds. See, generally, TR
4 85:24-93:5. Respondent’s counsel moved to strike the testimony of Dr. Goz, arguing that anything
5 reviewed by an expert must be disclosed to the other side out of fairness. That issue was preserved
6 for the record. TR 93:8-18.

7 There was next a discussion, and argument, regarding the disclosure of any report prepared
8 by Dr. Goz and transmitted to the Board. The IC’s objection as to the report disclosure was
9 sustained. TR 95:19-20. Respondent’s counsel then asked Dr. Goz to read his report that he
10 provided to the board into the record. IC counsel objected and the objection was sustained. TR 96:3.

11 With these preliminary evidentiary issues addressed and preserved on the record, cross-
12 examination questioning resumed.

13 *Dr. Goz testified that he had been performing “unsupervised” spine surgery for about 5*
14 *years, beginning approximately September 2020.* TR 99:1-3.⁵ According to Dr. Goz: “My training
15 and experience as a spine surgeon gives me the expertise necessary to offer opinions, regardless of
16 when the surgery occurred.” TR 99:8-10. Dr. Goz was further pressed, repeatedly, on his
17 qualifications to opine on matters that occurred in 2019. TR 99:16-101:11.

18 Eventually, cross examination moved on to other matters.

19 Dr. Goz testified about his experience as a reviewer for the Board and related matters. TR
20 101:12-104:1. He was asked about his time that he spent reviewing material and his compensation.
21 TR 104:6-105:18. There were again further questions regarding Dr. Goz’ records review, his report
22 as well as who might have interviewed him. TR 105:19-108:8.

23 Eventually, substantive cross examination resumed.

24 Dr. Goz testified that he reviewed actual diagnostic films (MRIs/CT) and not just reports. TR
25 109:3-110:9. He acknowledged that while he was not a neuroradiologist, reviewing and interpreting
26 imaging studies was a “core competency of spine surgeons.” TR 110:19-20. His review included
27
28

⁵ This was obviously after Dr. Schneier’s involvement as a physician for Patient A, and his two surgeries.

1 both the radiology reports and the actual films. TR 110:25. He did not have any significant
2 disagreements with the interpretations of the radiologists. TR 111:3-6.

3 Dr. Goz did note that interpreting imaging studies and what he sees during the actual
4 surgery are “separate processes....One is in surgery, and the other is my thought process in
5 interpreting imaging studies.” TR 112:23-113:4.

6 Dr. Goz did not know whether he had performed a T10-T11 laminectomy within the last year
7 without looking at his case log. TR 116:1-7. He also testified that during surgery, he typically uses a
8 “surgical loop” which is a type of microscope that you wear on your glasses. TR 117:1-4. **Further,**
9 **addressing problems at the T10-T11 are a “very small component” of Dr. Goz’ practice.** TR
10 118:2-14.

11 Dr. Goz was then asked a series of questions regarding his understanding of Patient A’s
12 medical history. This included references to Patient A’s prior hip replacements, his complaints about
13 being unable to straighten a leg for an MRI, his complaints of increased back pain and falls prior to
14 seeing Dr. Schneier, difficulties with walking, Patient A’s leaving from rehabilitation centers against
15 medical advice, alleged history of substance dependency/abuse with positive drug screens and the
16 like. TR 119:15-124:18.

17 Dr. Goz was then shown the study film *images* (not just radiologists’ interpretations) that had
18 been marked for identification purposes with colored arrows directed at individual vertebral levels,
19 Appendix A hereto (“CIS”).

20 Dr. Goz was shown image CIS 001 (lumbar MRI dated 12/27/2019), and asked to identify the
21 level of the spine depicted by the red arrow:

22 Q. What level is depicted by the red arrow?

23 A. It depends.

24 Q. It depends on what?

25 A. It depends on how you count.

26 TR 126:14-17.

27 Dr. Goz explained that you could count from the first multiple disc, you can count down from
28 T2, you can count from the thoracic spine. This is where the “tricky thing” is with spine surgery. TR

1 126: 20-24. He then testified that the red arrow on CIS 001 could refer to either the L5 or S1,
2 depending on how you count. TR 127:8-9; 129:21-23.

3 Dr. Goz was then asked whether it would be important to determine, with certainty, what
4 level a vertebrae is. His response:

5 A better way to frame this, in my opinion, is that it would be most
6 important to localize an area of high stenosis and operate on the
area of severe or high stenosis, high degree of stenosis.

7 So whether you call the area of severe stenosis T9-T10 and you
8 operate in that area, or you call it T10-T11, you operate on that area.
That's the most important part.

9 But if you call an area of high stenosis T10-T11 and you operate at
10 T9-T10 and the area of severe stenosis remains, that's when you
have a problem.

11 TR 130:6-17.

12 Dr. Goz specifically testified that "you operate on pathology." TR 130:21. "The important
13 part is not the number, it is where the pathology is and if you can accurately identify the pathology
14 is in the operating room." TR 131:5-9.⁶

15 Dr. Goz was then asked to identify the level of the spine depicted by the green arrow on CIS
16 001, which was from the lunbar MRI of December 27, 2019. After then referring to the radiologist's
17 report of the scan (IC exhibit 3, NSBME 059) where severe spinal canal narrowing was identified at
18 the T11-T12 level, Dr. Goz stated that he would be "speculating" as to where that was in relation to
19 the green arrow on the CIS 001 since he would need multiple series that are cross-referenced to give
20 an accurate depiction. TR 134:1-14.⁷ He did see some cord edema on the study, potentially one
21 level up from the green arrow. TR 134:23-135:1.

22 Dr. Goz was then shown image CIS 004, which was from a thoracic MRI on 12/30/2019. Dr.
23 Goz described this as a "scout image" used to help localize a rough picture to help count or label the
24

25 ⁶ This testimony on cross examination regarding operating on pathology is different from Dr. Goz' direct examination
26 testimony. When asked on direct examination how a spinal surgeon determines what level needs to be worked on, he
27 testified: "Based on a combination of the patient's clinical symptoms and the MRI or advanced imaging findings."
28 TR 63:17-19. Pathology identified in the operating room was not (initially) mentioned.

⁷ As Dr. Goz was asked to review various imaging studies during cross examination and identify spinal levels on the
images, he repeatedly testified that he needed multiple images or multiple studies to do that. It is again noted that
while testifying on direct examination, Dr. Goz did not review to any imaging studies themselves but rather focused
on the radiologists' interpretations of the images. (He did make it clear that during his review process of the case, he
did look at all scans and images provided to him.)

1 level. TR 139:2-10. He was asked to identify the level with the red arrow, and he testified: “If we
2 use the method of counting down from the T1, that would be T1.” TR 139:14-16.

3 Dr. Goz was shown image CIS 005, which was also from the December 30, 2019 thoracic
4 MRI. There was again a red arrow in the film. He was unable to identify the vertebral level where the
5 red arrow was located, based on the single image he was shown. TR 140:2 (See, fn 7). He was able
6 to identify likely cord narrowing on the film, with the location being the level above the red arrow
7 (slightly) and “pretty severe stenosis” one level below the red arrow. TR 141:11-19. Dr. Goz also
8 identified osteophytes on the film, most prominently two segments below the red arrow. TR 144:6-
9 22. He was also able to see the potential for cord edema at the level of the red arrow and other areas
10 as well. TR 145:2-12.

11 Dr. Goz then described how to correlate scan findings intraoperatively (i.e. during surgery).
12 “Well, you have to consider how you’re numbering.” TR 147:22-23. If counting from the top, you
13 could look at where the rib is located, making sure that you can see the rib on the MRI. TR 148:4-10.
14 If counting up from the lumbar disc spaces, then it is necessary to cross-reference both the lumbar
15 and thoracic MRI scans. TR 148:11-13. He elaborated:

16 “[I]nstead of blindly following the numbers the radiologist
17 recommend, you have to actually be able to reliably cross-reference
18 the MRI in whatever method you’re going to use, and if you can’t
19 identify a reliable marker that is present on both the thoracic and the
20 lumbar imaging, or if you can’t count down from the top of T2, then,
21 as happened in this case you could always implant an identifiable
22 marker, such as doing a kyphoplasty that is readily, you know, radial
23 image—repeat imaging with that radial marker and go from there. It
24 really depends. And it depends on what you can identify during the
25 surgery and how you can cross-reference the thoracic and the lumbar
26 MRI’s as reliable.”

27 TR 148:14-149:3.

28 Dr. Goz also testified that an osteophyte is a “terrible landmark” and is not a unique identifier
TR 149:6-7; 12. “[T]hat’s the reason why it’s so easy to do a wrong-level surgery in the thoracic
spine. It is tricky.” TR 149:21-23.

After this, Dr. Goz was asked about Dr. Schneier’s pre and postoperative diagnosis for Patient
A, which was “thoracic myelopathy with spinal stenosis, T10-T11.” He acknowledged that this

1 meant that the spinal cord was compressed in the thoracic region. TR 150:23-151:1. Dr. Goz also
2 testified:

3 **Q. So what was the issue in this case, then?**

4 **A. Compression of the spinal cord, which can both directly**
5 **impact the neurologic structures as well as the vascular supply of**
6 **the spinal cord.**

7 **Q. So this makes surgical intervention at the compressed level**
8 **urgent versus elective, correct?**

9 **A. Yes.**

10 **Q. And the point of surgery was to address the pathology, the**
11 **constriction; correct?**

12 **A. Yes.**

13 **Q. And the constriction was what was causing the spinal cord**
14 **edema; correct?**

15 **A. Presumably.**

16 TR: 151:12-24.

17 Dr. Goz was then directed to medical records from Dr. Khavkin, who performed another
18 thoracic surgery on Patient A on June 5, 2020. (The Khavkin operative report is found at IC Exhibit
19 8, NSBME 095-96). He noted that prior to that surgery, a kyphoplasty procedure was performed in
20 order to facilitate localization of the correct level for the surgery. TR 152:15-23.⁸ This would be a
21 “reasonable solution” to the problem of identifying the correct level for the June 5, 2020 surgery,
22 even when there was a laminectomy defect present from the prior surgery. See generally, TR 153:6-
23 154:6. Dr. Goz also did not think it was important where Dr. Schneier’s 12/31/2019 surgery was in
24 comparison to the subsequent kyphoplasty marker. TR 157:21. “[T]he important bit from a clinical
25 perspective is that Dr. Schneier’s surgery was one level above the level he *listed* it as, making it a
26 wrong level surgery....what’s important is that the level that was initially operated on was above the
27 level of the severe stenosis, the multiple images afterwards demonstrated continued severe stenosis
28 despite the original surgery.” TR 157:23-158:9.

⁸ The primary purpose of kyphoplasty is to treat vertebral compression fractures. TR 156:15-17.

1 Dr. Goz was then directed to CIS 006, which is an image from the January 22, 2020 thoracic
2 CT scan. He testified that the yellow arrow on that image was pointing to an osteophyte, but that
3 such a feature was a “relatively unreliable” landmark because it’s common to have multiple
4 osteophytes. TR 159:3-12. He did acknowledge that other osteophytes on the image were
5 “significantly smaller” than the one next to the yellow arrow. TR 159:24-25. He also reviewed CIS
6 005, which was an image from the December 30, 2019 thoracic MRI (pre-Dr. Schneier surgery) and
7 **testified that the area of most significant stenosis was one level above the large osteophyte which**
8 **was identified by a red arrow.** TR 160:9-11. He also testified that from this image it looked like
9 *below* the arrow is an area of potentially significant stenosis. TR 160:23-25.

10 Dr. Goz was shown CIS 007, which was an image with a red arrow pointing to the
11 kyphoplasty location from June 4, 2020. TR 161:12-15. After this, Dr. Goz was shown two images
12 from a June 4, 2020 thoracic MRI (CIS 012 and 13) and agreed that the red arrows on those images
13 showed the level where the kyphoplasty was performed. TR 162:4-163:1.

14 There was then testimony regarding the radiologist’s report for the kyphoplasty of June 4,
15 2020. Dr. Goz pointed out that the procedure was actually a vertebroplast with a history of
16 “localization for surgery.” TR 164:9-10, discussing NSBME 091-92 (IC Exhibit 7). He
17 acknowledged that the radiologist located the T11 vertebral body by counting cranially from the L5
18 vertebral body, and that the radiologist’s impression was “Status post T11 kyphoplasty.” TR 164:21-
19 165:10. **When asked whether the radiologist actually performed the procedure at T11, Dr. Goz**
20 **reiterated “it depends on how you count...[i]s]ometimes its going to be T11, maybe in another**
21 **form of counting it’s T12, maybe the last form of counting is T10.** The important part is really
22 where that cement is relative to the severe stenosis.” TR 165:16-25. **As to numbering, there can be**
23 **“ambiguity” to what one person calls T11 and another person calls T10.** TR 167:19-22.

24 Dr. Schneier’s counsel then directed Dr. Goz to two side by side images from the thoracic
25 MRI from December 30, 2019 (left) and June 4, 2020 (right). Appendix B. These images have
26 various arrows on them. Dr. Goz testified that the red arrow on the left image and the red arrow on
27 the right image were “most likely” pointing to the same vertebral level. TR 169:15. It was also
28 “most likely” the site where the kyphoplasty was performed. TR 170:3. He also testified that there

1 was edema in the spinal cord depicted on the left 2019 image where the two white arrows pointed,
2 and that the yellow arrows on the right 2020 image were at the same level. TR 170:7-21. He
3 couldn't "conclusively say" one way or another whether the patient's spinal cord had expanded from
4 December 30, 2019 to June 4, 2020. TR 171:6-13.

5 Dr. Goz was then asked about the radiology report from Spring Valley Hospital from
6 6/4/2020 (Respondent's Exhibit E, Schneier 953), where he agreed that the interpreting radiologist
7 found that "[t]he spinal cord demonstrates normal signal intensity." TR 172:6-9. This finding
8 demonstrates the absence of edema. TR 173:6-8. **Dr. Goz was unable to "opine on the impact of**
9 **delaying surgery and delaying appropriate intervention had on this patient."** TR 174:20-25.

10 ***Redirect examination***

11 On re-direct examination, Dr. Goz testified that even though he was licensed in Nevada in
12 2020, he was familiar with the standard of care as of 2019, and there had been no changes in that
13 standard of care between 2019 and 2020. TR 177: 9-21. He also estimated that he reviewed
14 somewhere between 4,000 and 5,000 pages of medical records in this matter.

15 The IC had no other witnesses.

16 **C. Respondent's witness Raj Agarwal, M.D.**

17 Raj Agarwal, M.D. is a board certified neuroradiologist who also practices interventional
18 radiology. TR 180:24-181:1. *He has been in practice at Desert Radiology in Las Vegas for 27*
19 *years, since 1998.* TR 181:6-11.

20 Dr. Agarwal was asked to review diagnostic films regarding Patient A. In reviewing various
21 films from 2019 and 2020, Dr. Agarwal identified an anatomic anomaly in Patient A's spine—a
22 "segmentation anomaly." He described this as a situation where some of the vertebral bodies and
23 disc spaces were fused. TR: 182:8-10. Dr. Agarwal explained:

24 "[T]he most common site is—we see at the lumbar sacral junction of
25 the L5, S1, which is not that uncommon, where you will see either the
26 S1 segment, which looks like a lumbar vertebral body, but we call it
27 'lumbarized,' the L5 vertebral body can look like the sacrum, we call it
28 'sacralized.' In this case, what was a little bit unusual was that the L5
vertebral body was completely sacralized. So by that, what I mean is
that the L5 vertebral body and S1 vertebral body had no disc space so it
was completely bony fused, that's a congenital anomaly and because
of that, when you're numbering, it becomes very difficult because the
L5 level looks exactly like the S1 level."

1 TR 182:11-24.

2 This anomaly means that if you look at all the reports, depending on where the scout film was
3 taken, the numbering is different between all radiologists and neuroradiologists. TR 183:3-6. This
4 also means that if reading a study from the lumbar to count, you will get a different level, versus if
5 you use the cervical spine to count, you get a different level. That is why there is an "anatomic
6 ambiguity." TR 183:12-17.

7 Dr. Agarwal was then directed to CIS 001, (image from the December 27, 2019 lumbar MRI)
8 and the corresponding report for that scan, Respondent's Exhibit B, pages 13-15. TR 183:18-
9 184:12.⁹ Dr. Agarwal reviewed the enhanced image CIS 001 and testified that the reviewing
10 radiologist (Dr. Bleazard), read the vertebral body next to the red (lower) arrow as "one" (this would
11 be S1) and the level next to the green arrow as L1. This means that two levels above the green arrow
12 would be T12 and T11. TR 184:20-185:7. Dr. Agarwal was then shown two more enhanced images
13 from the December 27, 2019 lumbar MRI, CIS 002 and 003, and testified that the red arrows on each
14 were at S1 and the green arrows on each were at L1, according to the interpreting radiologist's report.
15 TR 185:8-21.

16 Dr. Agarwal then testified that Patient A had another anatomical anomaly, bilateral
17 hypoplastic ribs, which go "hand in hand" with the other anomaly. "[S]o because we are reading the
18 completely sacralized L5 vertebral body S1, the L1 vertebral body ends up having small ribs." TR
19 186:1-8. Both of these conditions were present from birth. TR 186:12. "What's unusual about this
20 case is the complete sacralization of L5. We also get some partial, but it's clear in this case when the
21 radiologists who read it at the time they were reading the study, they completely assumed just
22 looking at the lumbar spine films, that the S1 level was S1. Usually we have clues. They didn't even
23 comment on the report because they thought it was the S1." TR 186:15-23.

24 Dr. Agarwal also noted another significant finding on image CIS 003 that could be used as a
25 clue, which was a single large osteophyte at the T12-L1 level, based on the reviewing radiologist's
26

27 ⁹ The transcript here is confusing. Specifically, after directing Dr. Agarwal to the enhanced image exhibit C page one
28 (taken from the December 27, 2019 lumbar MRI) and the corresponding radiologist report for that scan, Dr.
Schneier's counsel then directed Dr. Agarwal to page 12 of exhibit C. Page 12 of exhibit C (TR: 184:13-15),
however, is an image from a June 4, 2020 scan. The flow of testimony, however, makes it clear that counsel and Dr.
Agarwal were referring to page 1 of exhibit C, not page 12.

1 counting. TR187:5-12. This osteophyte, counting from L1, was right above L1. This means that the
2 large osteophyte was at the T12-L1 level, counting from the lumbar spine. TR 187: 13-22. **For**
3 **Patient A, this large osteophyte is a useful landmark.** TR 188:3-5.

4 Dr. Agarwal then discussed the relationship between the large osteophyte and the severe spinal
5 stenosis with cord edema. “You can see it. This is the midline scan, and so the midline sagittal
6 images where we see most of the spinal cord, the center, and as neuroradiologist, that’s where we use
7 degree of—spinal stenosis cannot occur circumferentially, but the midline cut is the most important
8 cut, because if the spinal cord is compressed, it will always be compressed in the midline also. So
9 you can see it just above the one level. If we’re calling this T12 a ‘one,’ then the severe spinal
10 stenosis is at T11-T12, one level above.” TR 188:9-20.

11 Q. **So is it a correct statement that, regardless of how the vertebrae are numbered, there is**
12 **severe spinal stenosis with cord edema at the level above the large interior osteophyte?**

13 A. **That is correct.**

14 TR 189:8-12.

15 Next, Dr. Agarwal was directed CIS 004, which is from the December 30, 2019 thoracic
16 MRI scout film. There is an “X” on this image, which is placed over T1. The “bottom” of this image
17 has the number I268, and this corresponds with the top of T11. TR 190:2-11. This image does not
18 show the entirety of the thoracic spine. This scout film image is “purely for numbering.” TR 190:14-
19 16.

20 Following this, Dr. Agarwal was shown additional images from the December 30, 2019
21 thoracic MRI, CIS 005, together with the interpreting radiologist’s (Dr. Lev) report. He testified that
22 there were differences in interpreting the level of pathology between Dr. Bleazard’s report of the
23 December 27, 2019 lumbar MRI and the report of the December 30, 2019 thoracic MRI from Dr.
24 Lev: “Dr. Lev is purely counting from the cervical spine, and so she comes to the conclusion that the
25 severe stenosis is at T10-T11. When you count from the lumbar spine, it’s the same level as T11-
26 12.” Additionally, Dr. Lev designated the *large osteophyte* at a different level than Dr. Bleazard. TR
27 191:4-17. He explained how one reading radiologist, Dr. Bleazard, placed the large osteophyte at
28 T12-L1 whereas the second reading radiologist, Dr. Lev, placed the same large osteophyte at T11-

1 T12. Both radiologists were nevertheless both describing the same level of the spine where the
2 osteophyte was located. TR 191:20-192:1.

3 Dr. Agarwal testified that in comparing the two radiologist reports for the two scans taken
4 three days apart, both radiologists were talking about the same area of the spine, but they were just
5 labeling them differently based on which scout film they used. This resulted in ambiguity in
6 assigning vertebral levels on the patient. TR 192:19-193:7.

7 Dr. Agarwal was then shown the two side-by-side images of patient A's thoracic spine
8 (Appendix B), the first from December 30, 2019 (the one read by Dr. Lev) and a subsequent thoracic
9 MRI from June 4, 2020. The two yellow arrows on the June 4, 2020 image (the right image) were at
10 the same level as the white arrows on the December 30, 2019 image (the left image). TR 194:16-19.
11 He testified that based on his review of all film images, the June 4, 2020 image showed that
12 prior edema and swelling had "completely resolved" and that the prior spinal stenosis had been
13 decompressed. TR 194:23-195:5. The June 4, 2020 MRI (taken before patient A's surgery with Dr.
14 Khavkin) confirms resolution of cord edema shown on prior films. TR 195:6-8. Dr. Agarwal went
15 on:

16 Q. So what does this all mean?

17 A. So the—despite the ambiguous numbering system, the surgery was done at the level
18 that was the tightest, the spinal stenosis, by Dr. Schneier. And there was decompression of the
19 spinal canal and there was resolution of the spinal edema, based on imaging. TR 195:13-19.

20 After this, Dr. Agarwal was shown the January 22, 2020 thoracic CT scan (CIS 006). He
21 testified that the yellow arrow on this image points to the large osteophyte. He then noted that the the
22 red arrow pointed to the laminectomy site, which is where the maximum stenosis was located. TR
23 196:3-22.

24 Dr. Agarwal then testified that based on the various imaging studies he reviewed, together
25 with Dr. Schneier's operative report, Dr. Schneier decompressed Patient A's spine on December
26 31, 2019 at the level where there was the most serious pathology. TR 197:11-13. He also testified
27 that based on the results of the June 4, 2022 thoracic MRI, the cord edema previously noted before
28

1 Dr. Schneier's December 31, 2019 surgery had *resolved*, indicating a *positive response* to the surgical
2 procedure. TR 197:19-22.

3 Q. And it's true that the pathology that required urgent intervention
4 was one level above the large anterior endpoint osteophytes?

5 A. That is correct. That was one of the landmarks.

6 Q. While multiple radiologists over multiple dates, locations, and
7 spine segments imaged came up with different and inconsistent
8 vertebrae counts, the landmark that remains unchanged is the large
9 anterior endplate osteophyte; correct?

10 A. That is correct.

11 TR 197:23-198:8.

12 Finally on direct examination, Dr. Agarwal was asked an open-ended question whether he
13 had any comments or opinions on the testimony of Dr. Goz, which he had listened to. He first
14 indicated that he did not know what imaging Dr. Goz was using, but neuroradiology is something he
15 (Dr. Agarwal) does every day, including consulting with neurosurgeons and spine surgeons. After
16 mentioning the spinal numbering issue, Dr. Agarwal testified:

17 "For me, regardless of what number we give this area, the question
18 is: What is surgery done on the area of the severest stenosis that the
19 patient presented?

20 And that is, you know, I would say yes, the answer is yes, and that's
21 based on two facts. One is imaging showing that the spinal canal
22 expanded in this area, and the other reason is that the edema has
23 resolved. And spinal edema resolution—so edema is just swelling,
24 so that means that the injury that was there in the spinal cord has
25 gone away because the cause of the injury has been taken away.

26 This patient clearly has a lot of disease, a lot of reasons to have pain,
27 though I can't explain that, but the stenosis has resolved and the
28 swelling in the spinal cord has resolved. If you count from lumbar
29 spine or cervical spine, the area of the surgery is the correct level."

30 TR 200:10-201:18.

31 All of Dr. Agarwal's opinions were expressed to a reasonable degree of medical probability
32 and medical certainty. TR 201:23.

33 //

34 //

35 //

1 ***Cross Examination***

2 IC counsel first covered Dr. Agarwal's background as an expert (30 to 40 cases) and rate of
3 compensation. He has never testified in a similar case to this one. He knows and has worked with
4 Dr. Schneier professionally but not socially. TR 202:10-203:17.¹⁰

5 Dr. Agarwal testified he is a "neurointerventional surgeon." He treats complex anomalies of
6 the brain and spine, strokes, aneurysms, spinal cord tumors and "a lot of kyphoplasties." TR 203:19-
7 24. He does not, however, perform thoracic laminectomies. TR 204:4-5. Nevertheless, he also
8 testified that as a neuroradiologist, he can opine on whether a surgery was done at the right level.
9 "That's my job" and "I do this every day where I talk to the surgeons about what level the problem
10 is." TR 205:9-16.

11 Next, Dr. Agarwal was shown a series of diagnostic scan reports and asked if he agreed with
12 the impressions. The first was the thoracic MRI scan from December 30, 2019 (Respondent's
13 Exhibit B, pages 16-17.) He agreed with those impressions. TR 207:24-208:1. He disagreed with the
14 radiologist impression on a January 22, 2020 thoracic CT that mentions a T9-T10 laminectomy.
15 "The laminectomy is actually at—it's a wide laminectomy, T10-T11, that extended to the T9
16 level...so the laminectomy is at the T10-T11 level. TR 208:13-19.

17 The next MRI discussed was a thoracic MRI dated 2/4/2020. The impression #1 on that
18 report stated: "Post-operative changes from laminectomy at T9 and T10. There has been interval
19 removal of the spinal hardware." Dr. Agarwal testified: "I don't agree with the laminectomy site,
20 that the laminectomy was T9 -T10 and T10-T11, or if it was more T10-T11 and partial T9." TR
21 209:19-210:3.

22 Dr. Agarwal was then asked about another impressions on the 2/4/2020 thoracic MRI report
23 that stated: "There is severe canal stenosis at T10-T11, secondary disc protrusion of scar tissue from
24 the laminectomy at T10" and asked if he agreed that Patient A had continued severe stenosis between
25 December 2019 and February 2020. To this, Dr. Agarwal responded: "Not at the level of the spinal
26 surgery. Can I clarify some of the reports to you?" IC counsel: "Yes." TR 210 4-18.

27
28

¹⁰ Dr. Agarwal acknowledged that he was the reading radiologist for one thoracic MRI on Patient A dated 5/13/2020. He denied actually treating Patient A and testified that reads hundreds of MRI's a day. TR 205:24-205:21.

1 Dr. Agarwal then clarified some of the reports. He made the following points: (i) *Patient A*
2 *had an unusual congenital anomaly and that is why without a full history some doctors have read*
3 *images incorrectly. TR 210:19-211:1. (ii) Dr. Agarwal's own reading of Patient A's thoracic MRI*
4 *from May 13, 2020 (see Fn 10) used a lumbar spine scout which is specific to that MRI magnet. He*
5 *testified that such MRI magnet is the oldest MRI so the resolution is lower, which explains why his*
6 *own reading of the level of stenosis was actually one level above where the severe stenosis was*
7 *actually located. TR 211:10-22. Dr. Agarwal then noted that the MRI magnet where the thoracic*
8 *MRI scan was taken a few weeks later at Spring Valley Hospital on 6/4/2020 is the most powerful,*
9 *and images from that scan show that the level Dr. Agarwal had read as having stenosis only a few*
10 *weeks before did "not look that bad" based upon resolution of that second image due to the type of*
11 *magnet and resolution. TR 212:5-20. Finally, Dr. Agarwal concluded that when the various June*
12 *2020 scans are reviewed, the prior stenosis and cord edema had resolved. "But there's a lot—in*
13 *between, depending on all of us reading different, there's a lot of confusion as to where the levels*
14 *are, so that's why it's hard to tell. He also noted that a laminectomy is best seen on a CT scan. TR*
15 *212:21-213:7.*

16 ***Re-Direct examination***

17 Dr. Agarwal answered four (4) questions on re-direct examination. 1. A radiologist who
18 solely reviews a patient's imaging is not providing treatment to the patient. 2. The cord edema
19 present on December 31, 2019 requiring the surgery by Dr. Schneier resolved by June 4, 2020. 3. In
20 his practice, Dr. Agarwal reviews films and images to help locate the level of the spine with the most
21 serious pathology. 4. To a reasonable degree of medical probability and medical certainty, Dr.
22 Schneier treated Patient A's urgent pathology and this resulted in Patient A's improvement.
23 TR 214:10-215:4.

24 **D. Testimony of Respondent, Dr. Schneier**

25 Dr. Schneier's CV is Respondent's exhibit Q. Briefly stated, he graduated from NYU
26 medical school in 1989 and subsequently performed his residency at Einstein Medical College, had a
27 fellowship at the University of New Mexico and was the director of trauma and spine services at the
28 University of New Mexico for several years. TR 216:23-217:6.

1 Dr. Schneier testified that spinal levels could be identified by counting from the lowest rib
2 and then identifying the level of interest by fluoroscopy or using sacral segmentation as a landmark
3 when counting, and that both methods were appropriate for localization of the level. TR 217:7-20.
4 He also testified that he had the "clinical acumen" to use *intraoperative* means as well, including the
5 use of the anterior oposterphytes. TR 217:21-218:1.

6 Dr. Schneier then described the December 31, 2019 surgical process on Patient A. *First, he*
7 *found a normal spine level (where the spinal cord has normal diameter) above the pathology and*
8 *moved down. A microscope (and Dr. Schneier's "aptitude utilized after the microscope") was used*
9 *during this process. Dr. Schneier recalled Patient A having a severe constriction/compression of the*
10 *spinal cord from an atypical calcified ligament and facet joint encroaching and compressing the*
11 *spinal canal and spinal cord. TR 218:2-23. Dr. Schneier also testified that the microscope he was*
12 *using has a 300 if not greater magnification, whereas the "loop" magnification referenced by Dr.*
13 *Goz as a 3 ½ magnification. TR 219:3-7.*

14 *Dr. Schneier used a microsurgical technique to morselize the bony spurs or invaginated*
15 *overgrowth of atypical calcified ligaments and joints that were compressing the cord. TR 219:8-13.*
16 *He then checked for further compression or constraints on the spinal cord or through the*
17 *cerebrospinal fluid flow, and could see pulsations in the spinal cord. TR 219:14-18. Dr. Schneier*
18 *then used instruments below the laminectomy to make sure that there were no other points that*
19 *showed evidence of constriction or cord compression. TR 219:19-23.*

20 Dr. Schneier agreed with his counsel that there were several inconsistent imaging reads by the
21 radiologists in this matter, noting that according to some radiologists the surgery was performed at
22 the T10-T11 level and others suggesting that the level of the surgery was T9 and T10. TR 220:8-22.

23 Dr. Schneier then agreed that when comparing scans from December 31, 2019 before Dr.
24 Schneier's surgery and June 4, 2020 before additional surgery with Dr. Khavkin (Appendix B) there
25 was improvement, and that such improvement was because he treated Patient A's pathology. TR
26 221:2-8. He agreed with his counsel's assessment that when looking at various images there is
27 evidence that his surgery was performed at the appropriate levels of Patient A's spine. TR 221:9-18.

28 Q. Is there any landmarks on this patient's imaging that did not
change regardless of the vertebral counts that was used?

1 A. The ventral osteophyte one level below the area of coarctation of
2 the cord, or edema of the cord as noted by the radiologist, was a fixed
3 landmark that could be used as a reference point of localization.

4 Q. And regardless of any vertebral counts used, you operated at the
5 level of the most emergent pathology; correct?

6 A. Correct.

7 Q. And that was the constricted edematous portion of the cord?

8 A. The answer to that is yes, but there was also edema and
9 constriction above the level—whether labeled T10-T11, T11-T12,
10 there was also significant arthritic pathology similar to the level of the
11 edema in the cord.

12 Q. The purpose of the surgery was to decompress the spinal cord?

13 A. To relieve the venous congestion clogging the cord.

14 TR 222:19-222:16.

15 Dr. Schneier then testified that when he saw Patient A *after* the first surgery (January 22,
16 2020), Patient A did not have any bowel or bladder incontinence, no Lhermitte pain, and distal
17 movement in his feet and toes, all of which were consistent with healthy function of the spinal cord.
18 TR 226:18-227:6.

19 Dr. Schneier was then asked about the issue of a CSF leak due to the alleged breach of a
20 pedicle screw that projected 50 percent into the left lateral aspect of the central canal. He testified
21 that during the January 23, 2020 procedure (Dr. Schneier's second surgery) intraoperative neuro
22 monitoring was used, and such monitoring would have shown a breach of the spinal canal if there
23 had been one. Such intraoperative monitoring did not show a breach. TR 228:2-17. He also used a
24 ball-tip probe for palpation, and this did not show any evidence of pedicle breach. TR 228:18-23.
25 Further, he was able to visualize the absence of a pedicle breach intraoperatively and there was never
26 any evidence of CSF leak and fluid leak on any CT scan. TR 228:28-229:4.

27 Dr. Schneier attributed Patient A's continuing ambulatory difficulties to his unrelated hip and
28 orthotic implant issues. In his clinical opinion, such ambulatory issues were not consistent with long
tract findings of a spinal cord compression or injury. TR 229:22-230:3.

He then testified that he personally reviewed Patient A's medical records including the
history and physical, personally reviewed the radiographs prior to surgery, personally discussed the

1 surgery with Patient A, personally marked the intended level, used intraoperative radiographs
2 (fluoroscopy) and that the patient's pathology improved after the surgery. TR 230:8-231:2. Finally,
3 he testified that the procedures he performed met the standard of care to a reasonable degree of
4 medical probability and certainty. TR 231:7-11.

5 ***IC cross examination of Respondent***

6 The last time Dr. Schneier saw Patient A was as an outpatient and had him admitted to the
7 hospital because he thought he was going through acute unmonitored narcotic withdrawal, and he
8 was concerned for his well-being. TR 231:22-232:1. He also testified that after December 31, 2019,
9 patient A did not present symptoms of stenosis. TR 233:22-24. References to Patient A having left
10 lower extremity pain following the surgery was not necessarily a symptom of stenosis. TR 234:1-18.
11 He again denied that Patient A had continuing stenosis after December 31, 2019. TR 234:19-21.

12 There were no other witnesses called by Respondent. There were no IC rebuttal witnesses.

13 All witnesses who testified at the hearing appeared genuine and gave credible testimony.
14 That said, the background and experience of the two expert witnesses, Dr. Goz for the IC and Dr.
15 Agarwal for Respondent, are notably different.

16 Dr. Goz is an orthopedic spine surgeon who has been licensed for "*about five years.*" He has
17 been performing "unsupervised" spinal surgeries since September 2020, or about 9 months *after* Dr.
18 Schneier's alleged "wrong level" surgery of December 31, 2019. Additionally, Dr. Goz did not state
19 his opinions to the "reasonable degree of medical probability" standard, as pointed out by Dr.
20 Schneier's counsel in closing arguments. Finally, on direct examination, Dr. Goz relied on
21 radiologist's *reports* of various scans as opposed to *actual images* of those scans, while at the same
22 time admitting that even the radiologists' reports were inconsistent in their vertebral numbering, with
23 a radiologist for one scan labeling an anatomical feature at one level and another radiologist reading a
24 different scan labeling the very same anatomical feature at a different level.

25 Dr. Agarwal is a neuroradiologist who, according to his unimpeached testimony, advises
26 spinal surgeons every day about where spinal problems are located based on imaging. He has been
27 practicing medicine in Nevada for 27 years. Unlike Dr. Goz, Dr. Agarwal identified Patient A's
28 unique anatomy, including the fused vertebrae that impacted how vertebral bodies were identified.

1 Finally, Dr. Agarwal did not just rely on radiologists' reports of scans in giving his testimony, but
2 rather referred to, and testified from, actual scan images.

3 While both Dr. Goz and Dr. Agarwal testified credibly, this Hearing Officer finds that Dr.
4 Agarwal's testimony is entitled to more weight. That said, both experts agreed that when it comes to
5 spinal surgeries, the surgeon needs to **operate on pathology**, regardless of how vertebrae are
6 numbered. This makes complete sense.

7 **IV. FINDINGS**

8 The IC bears the burden to prove, by a preponderance of the evidence, that Respondent Ira
9 Michael Schneier, M.D. committed malpractice and failed to maintain complete medical records as
10 alleged in the complaint.

11 The core issue in the case is whether neurosurgeon Dr. Schneier operated on the wrong level
12 of Patient A's thoracic spine on 12/31/2019 and then did not subsequently address that "complication"
13 during the second surgery on 1/23/2020 (or indeed thereafter.) It must be emphasized that the IC's
14 expert witness, Dr. Goz, testified on more than one occasion that simply performing a wrong level
15 surgery is not, in and of itself, malpractice. He also testified, eventually, that a spine surgeon
16 *operates on pathology*, regardless of how vertebrae are numbered.

17 A. Count I, NRS 630.301(4)—Malpractice and Count III, NRS 630(1)(g) Continual Failure 18 to Exercise Skill or Dilligence

19 These two counts will be addressed together.

20 This is not a simple case, nor is the answer to the core issue of whether Dr. Schneier
21 committed malpractice evident from merely reading the medical records or radiology reports.
22 Rather, the expert medical testimony and most importantly the analysis of diagnostic imaging hold
23 the key to understanding the case.

24 Initially, the testimony of Respondent's expert neuroradiologist Dr. Agarwal establishes that
25 Patient A had an anatomic anomaly/ambiguity that made Patient A's L5 level look "exactly like" the
26 S1 level. The IC's expert, Dr. Goz, did not offer testimony regarding this anatomic
27 anomaly/ambiguity. Dr. Agarwal further testified that such anomaly/ambiguity is why various
28 radiologists placed the "*large osteophyte*" evident on the images (even to an untrained eye) at

1 different levels of the spine. For instance, if counting from the cervical spine such large osteophyte
2 was at T11-T12 per one radiologist (Dr. Lev), but if counting from the lumbar spine then the level of
3 the same large osteophyte was at T12-L1 (Dr. Bleazard). Both radiologists were nevertheless
4 identifying the very same osteophyte feature.

5 Dr. Agarwal's testimony regarding this large osteophyte is convincing. The record is clear
6 that unrelated radiologists interpreting Patient A's films and images came up with different vertebral
7 levels for this same anatomical feature. It must also be kept in mind that when the IC's expert, Dr.
8 Goz, was testifying on direct examination he was reading from the radiologists' interpretations of
9 films and images and the vertebral level designations and was not looking at films or images
10 themselves. Additionally, when shown images on cross-examination and asked to identify vertebral
11 levels, Dr. Goz repeatedly testified that he would need multiple images or multiple studies to do that,
12 and on one occasion also indicated labeling a given vertebral level "depends on how you count."

13 Thus, the answer to whether Dr. Schneier performed a wrong level surgery and then did not
14 correct this "complication" cannot be found by simply reading radiology reports and their vertebral
15 designations alone.

16 IC expert Dr. Goz initially testified on direct examination that a spine surgeon determines
17 where to operate based on a patient's clinical symptoms and MRI or advanced imaging findings. On
18 cross-examination, however, he acknowledged that it is *most important* to operate on the areas of
19 severe or high stenosis, no matter how that level is labeled or numbered. According to Dr. Goz, if
20 severe stenosis is identified at one level but the operation is performed at a different level, "that's when
21 you have a problem." Further, he acknowledged that **"you operate on pathology. The important
22 part is not the number, it is where the pathology is and if you can accurately identify the
23 pathology is in the operating room."**

24 Did Dr. Schneier operate on Patient A's pathology?

25 Dr. Schneier described in detail the surgical process: (i) a normal level of the spine was
26 identified; (ii) he identified where there was a severe constriction/compression of the spinal cord due
27 to an atypical calcified ligament and facet joint that encroached on the spinal cord and spinal canal;
28 (iii) he then morsalized the bony spurs and other structures that were compressing the cord; (iv) then

1 he checked for further compression or constraint on the spinal cord and could see pulsation of the
2 cord; (v) finally he used instruments below the laminectomy site to make sure that there were no
3 other points that showed evidence of constriction or cord compression. Dr. Schneier also used a
4 surgical microscope with a 300 times if not greater magnification, as opposed to the instrument Dr.
5 Goz testified he used in spinal surgeries, a “loop” instrument with a 3 ½ magnification.

6 Dr. Schneier also testified about the second surgery he performed on Patient A, the January
7 23, 2020 procedure. He testified that intraoperative neuro monitoring was used during that
8 procedure, and such monitoring did not show a breach of the spinal canal that had been suggested by
9 imaging. He was unable to find evidence of a breach using a ball-tip probe for palpation. He was
10 able to visualize the absence of a pedicle breach intraoperatively and there was never any evidence of
11 CSF leak and fluid leak on any scan.

12 Obviously, Dr. Schneier testified that he operated on the pathology he found in the operating
13 room during the procedure. Is this testimony supported by other evidence?

14 Dr. Schneier’s expert neuroradiologist, Dr. Agarwal, provides support for the conclusion that
15 Dr. Schneier did indeed “operate on pathology” that he encountered during the procedure. Again, IC
16 expert **Dr. Goz** testified that regardless of how the vertebral levels are numbered, **“you operate on**
17 **pathology.”**

18 Dr. Agarwal testified that it is “his job” to talk to surgeons every day about where spinal
19 problems are located. With respect to Patient A, he identified a large osteophyte on scan images that
20 could be used for a marker/landmark. He testified that regardless of how the vertebrae are numbered,
21 the area where severe cord stenosis and cord compression is located is one level above that large
22 osteophyte. (Again, he also testified that various unrelated radiologists reading various scans
23 identified this large osteophyte at different vertebral levels, despite the obvious fact that such an
24 osteophyte does not move.)

25 When Dr. Agarwal compared scan images for Patient A prior to Dr. Schneier’s 12/31/2019
26 surgery and images from June 4, 2020, the later images showed that the prior edema and swelling had
27 “completely resolved” and the prior spinal stenosis had been decompressed. Stated differently, the
28 cord edema present on December 31, 2019 that required the surgery was resolved by June 4, 2020.

1 Dr. Agarwal testified that despite the ambiguous numbering system, the surgery was done at
2 the spinal level where the *stenosis was the tightest* and that there was decompression of the spinal
3 canal and resolution of the spinal edema, based on imaging. Dr. Agarwal also testified that based on
4 the various imaging studies he reviewed, together with Dr. Schneier's operative report, Dr. Schneier
5 decompressed Patient A's spine on December 31, 2019 at the level where there was the most serious
6 pathology. Thus, he concluded that the level of surgery was correct to address the pathology
7 regardless of the vertebral numbers assigned by reviewing radiologists. Based upon the evidence and
8 testimony presented, this Hearing Officer agrees.

9 The undersigned Hearing Officer finds that the IC failed to establish either Count 1 or Count
10 III by a preponderance of the evidence. Rather, the preponderance of the evidence establishes that on
11 December 31, 2019, Dr. Schneier operated on Patient A's most serious pathology regardless of
12 vertebral numbering assigned by radiologists. Further, the preponderance of the evidence establishes
13 that Dr. Schneier's second surgery of January 23, 2020 was proper as well as there was no need to
14 extend the laminectomy as suggested by Dr. Goz.

15 **B. Count II, NRS 630.3062(1)(a)—Failure to Maintain Complete Medical Records.**

16 IC expert Dr. Goz testified that Dr. Schneier's medical records were "appropriate."
17 Accordingly, the IC did not establish Count II by a preponderance of the evidence.

18 **V. RECOMMENDATION**

19 Based upon the foregoing, I respectfully submit that the IC has not met its burden of proof by
20 a preponderance of the evidence that Respondent, Ira Michael Schneier, M.D. committed acts of
21 malpractice and failed to maintain complete medical records as alleged in the complaint for the
22 reasons stated herein.

23 DATED this 31 day of July, 2025.

24
25 
26 CHARLES BURCHAM

27 Email: charlie@northernnevadaadr.com

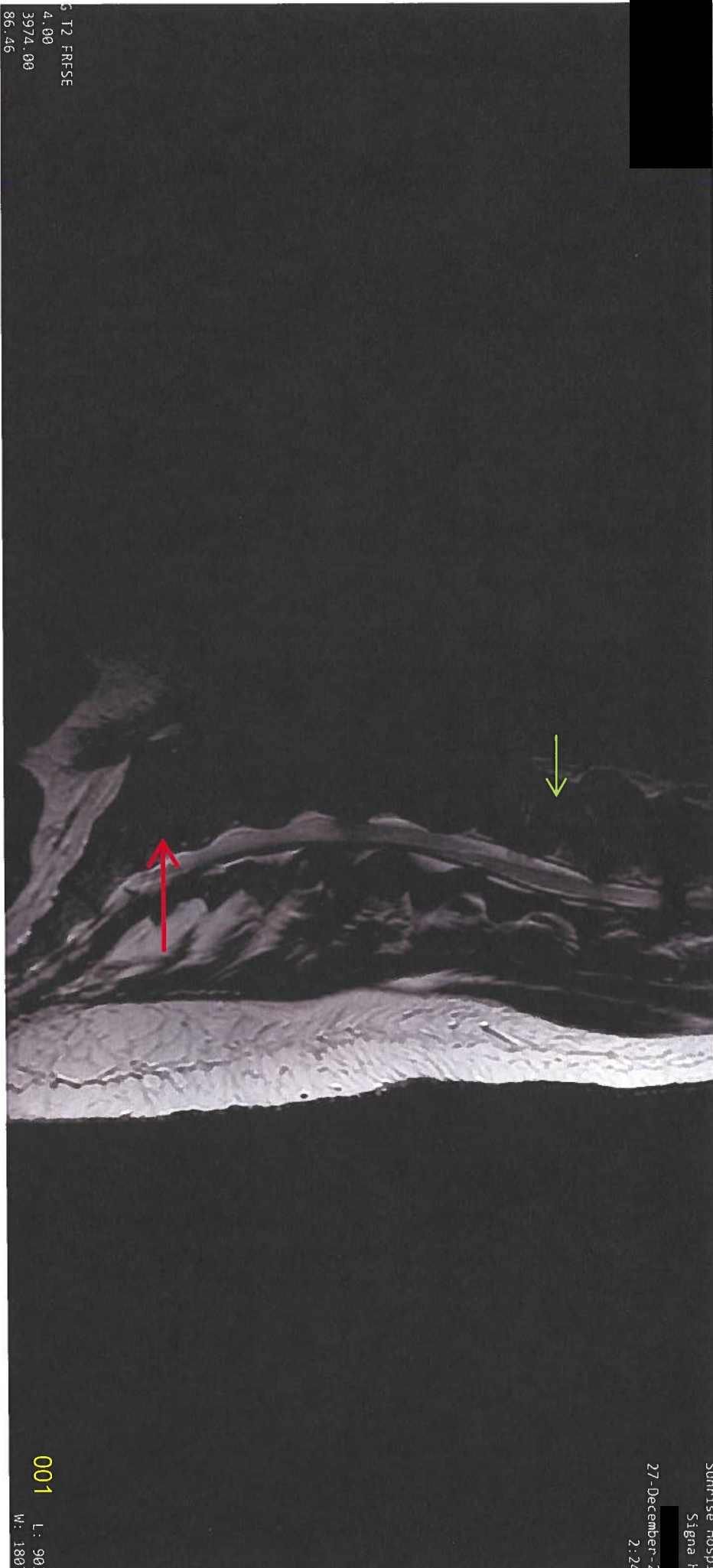
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Hearing Officer

APPENDIX A

(Exhibit C--Combined Imaging Studies)

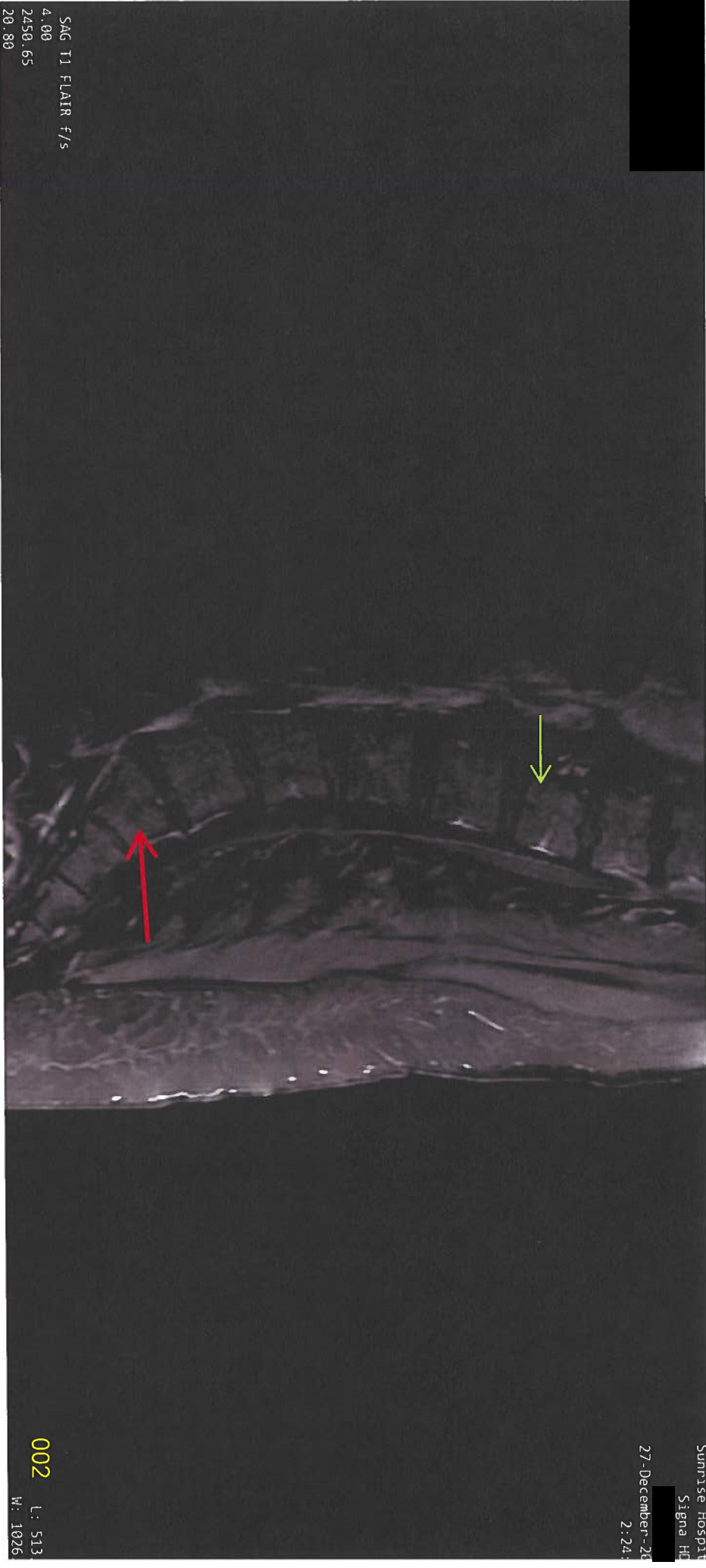
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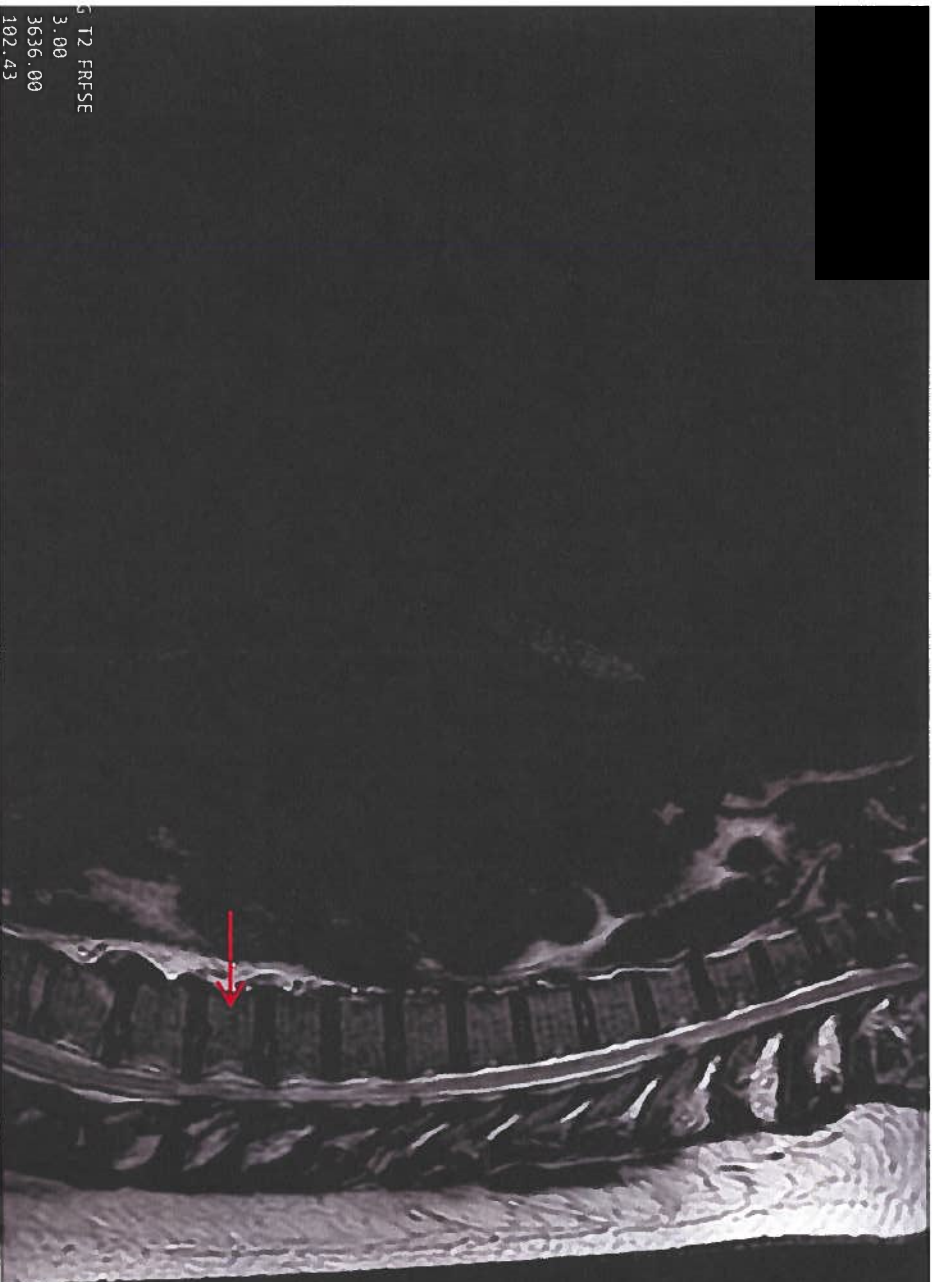
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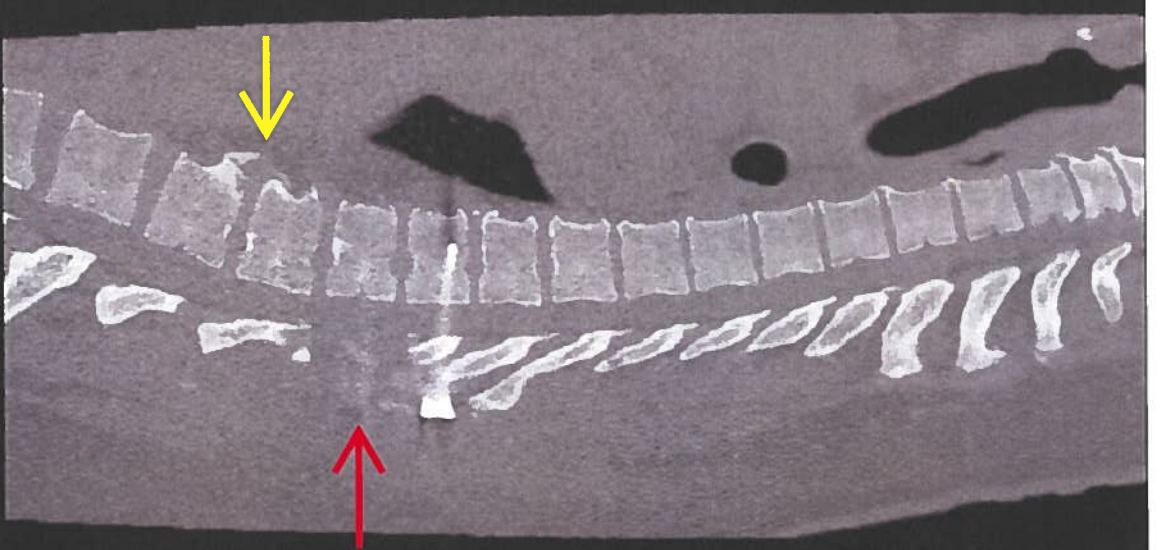


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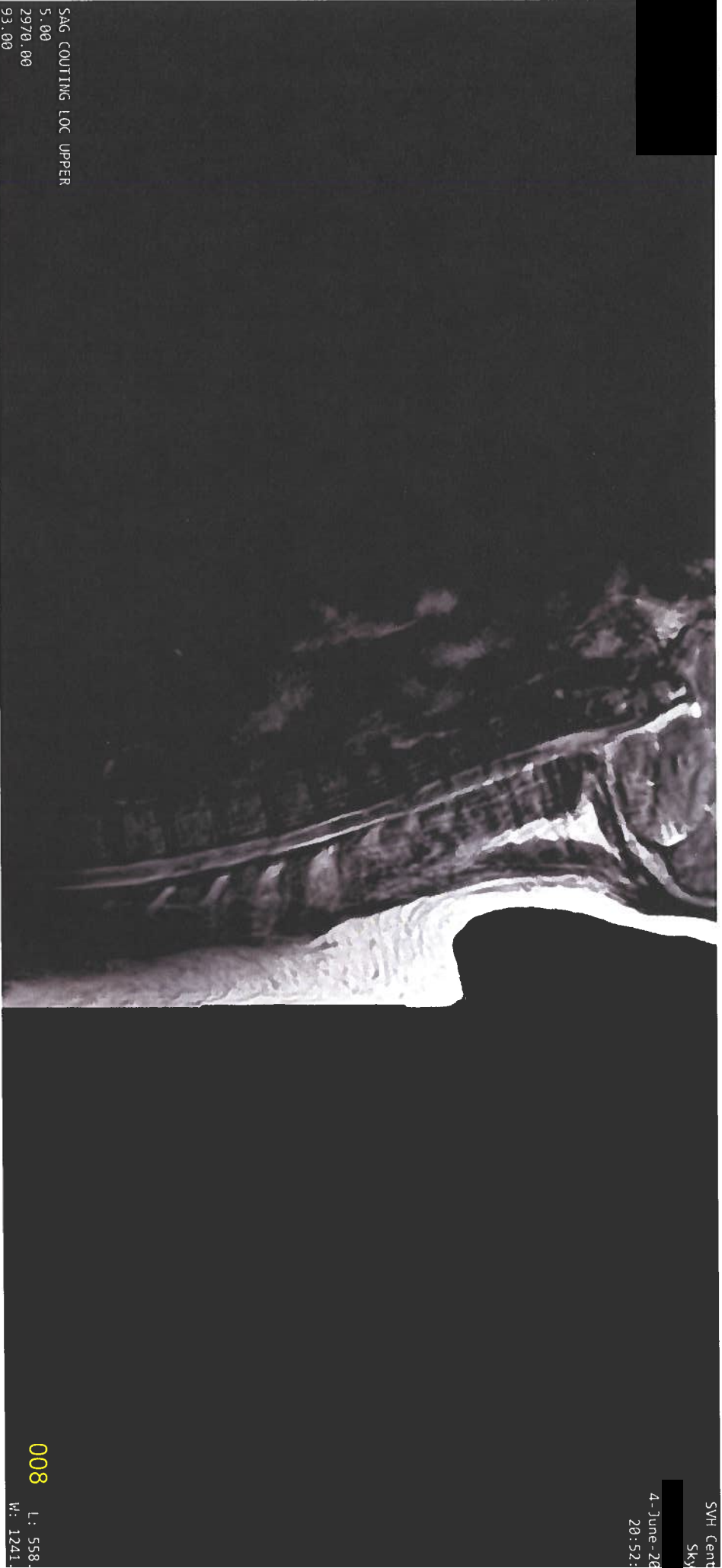
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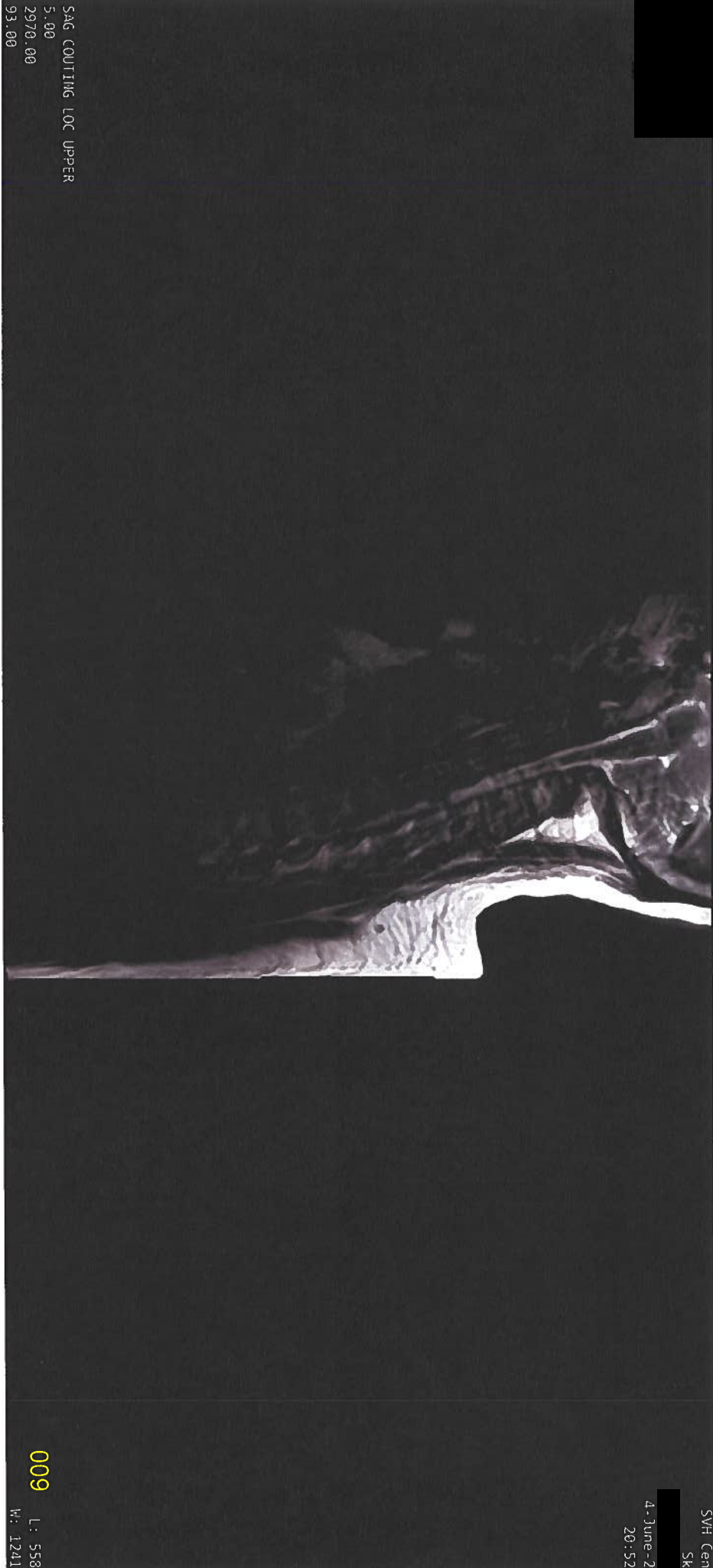
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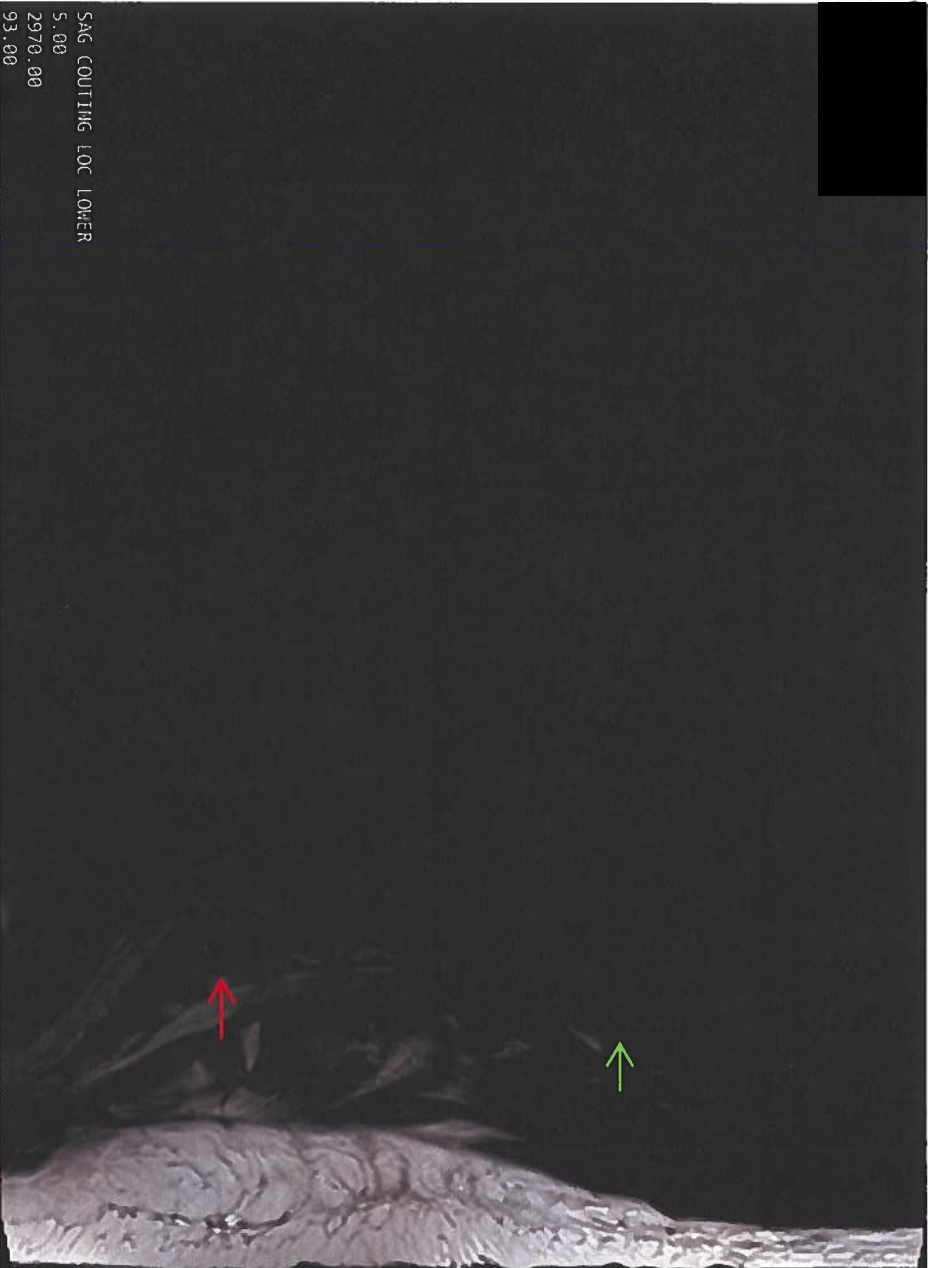
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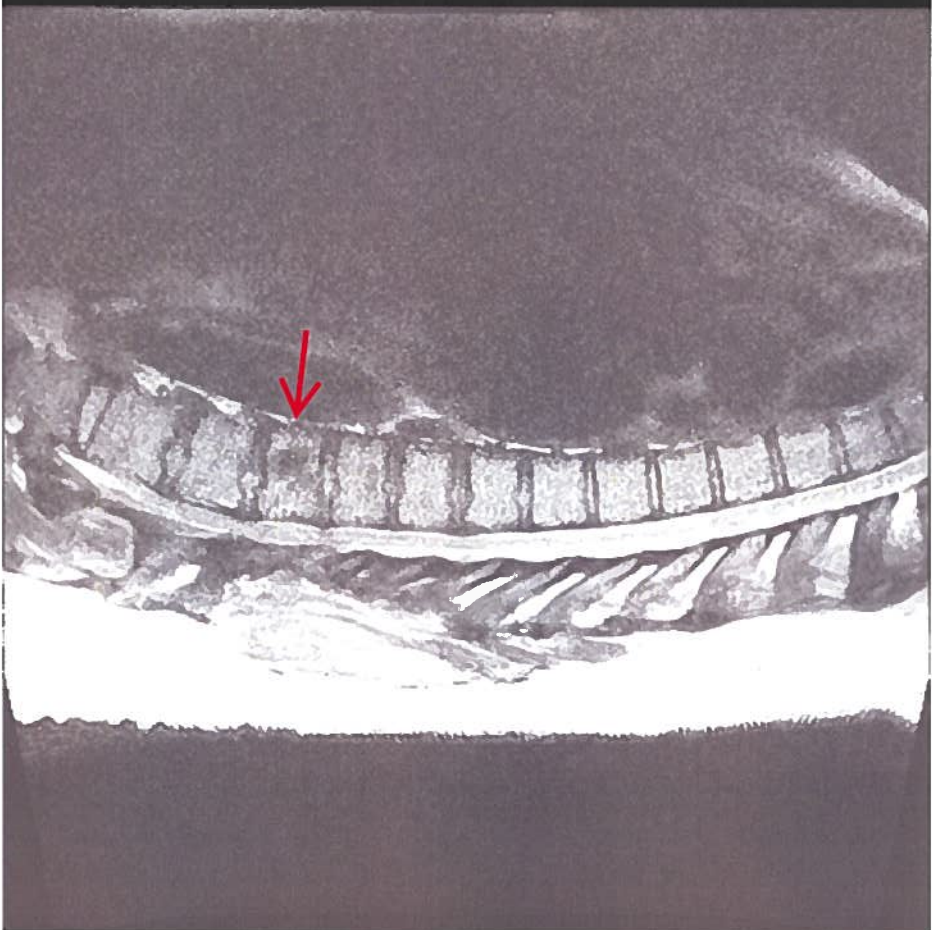
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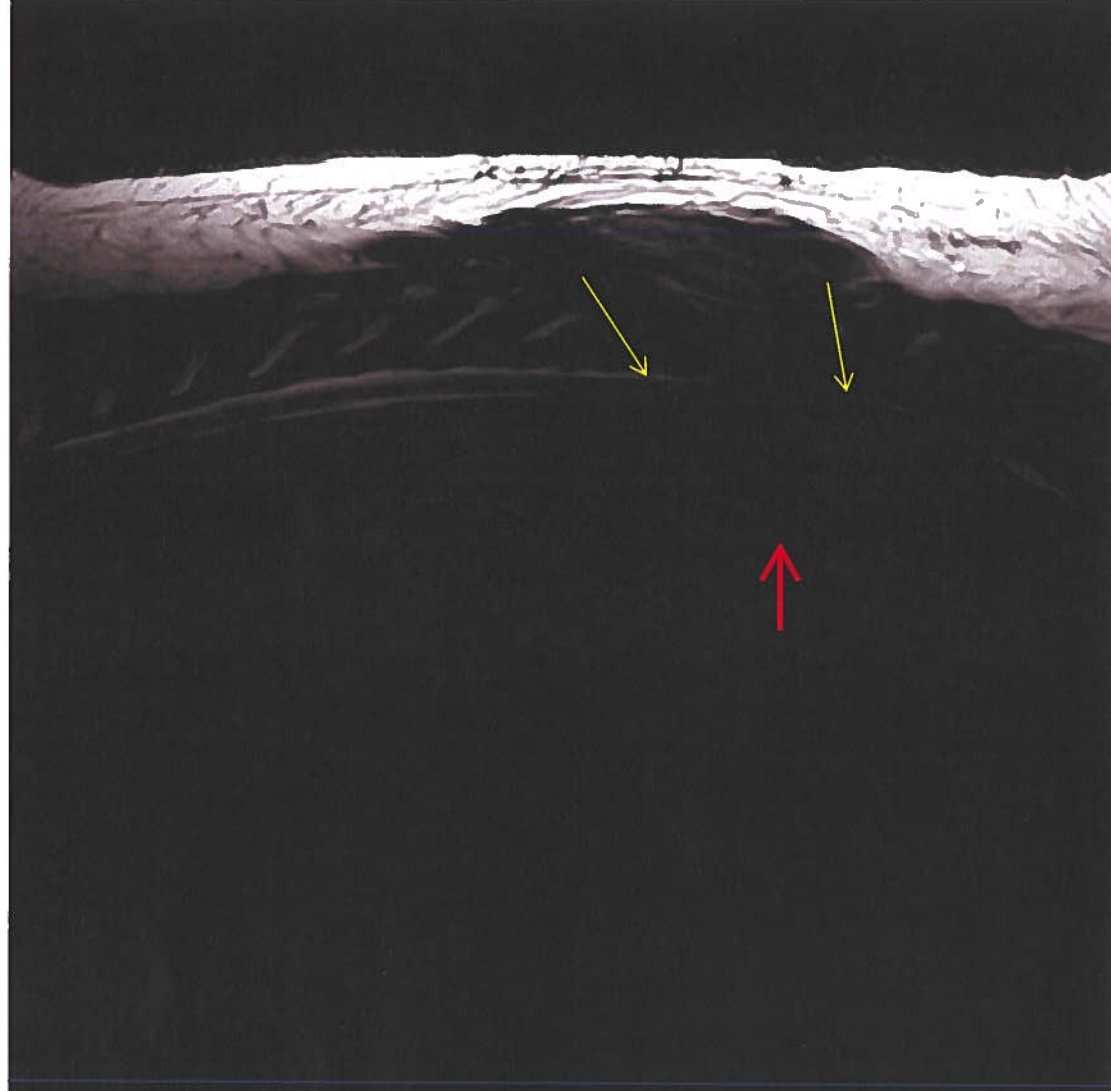
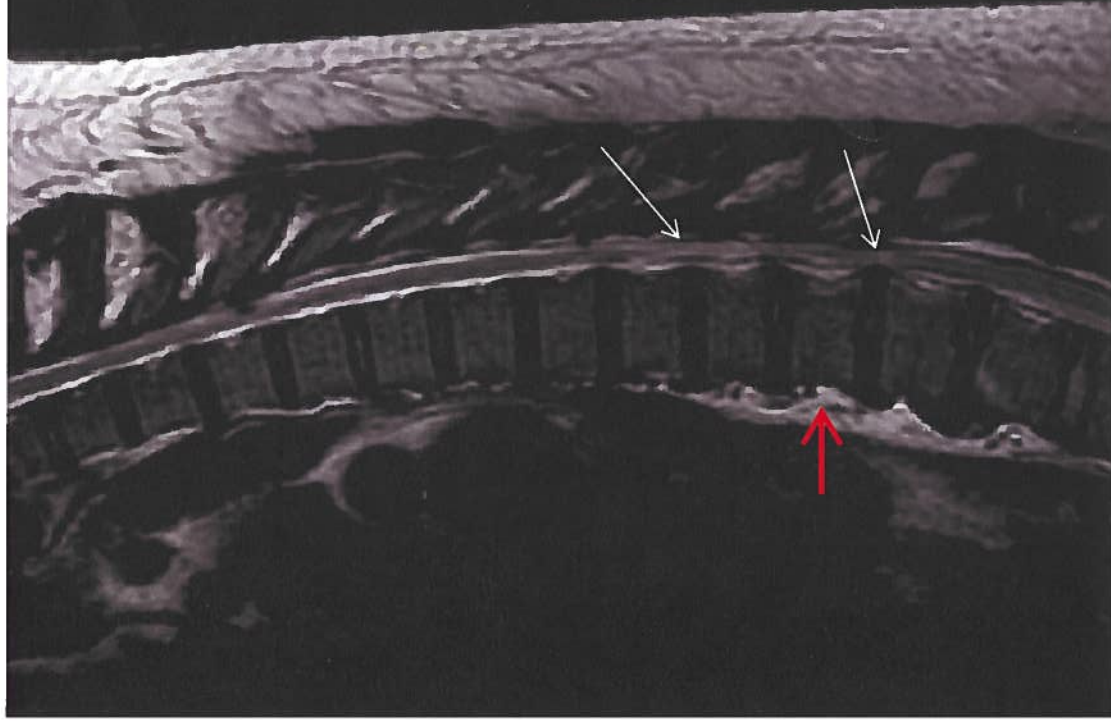
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APPENDIX B

(Exhibit C—Side by Side)

December 30, 2019

June 4, 2020



3

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

In the Matter of the Charges Case No. 24-40539-1
and Complaint Against:

IRA MICHAEL SCHNEIER M.D.,

Respondent.

_____ /

AMENDED TRANSCRIPT OF HEARING PROCEEDINGS

Held at the Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521
and via Zoom

Wednesday, May 28, 2025

Reported by: Brandi Ann Vianney Smith
Job Number: 7266099

A P P E A R A N C E S:

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1 RENO, NEVADA -- MAY 28, 2025 -- 9:00 A.M.

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4
5 HEARING OFFICER BURCHAM: Let's go on the
6 record. All right. This is the time, place set for
7 the formal hearing In the Matter of Charges and
8 Complaint Against Ira Michael Schneier, M.D.

9 Counsel, I'd like you to please state your
10 appearances for the record.

11 MR. SHOGREN: Good morning. This is
12 William Shogren, Deputy General Counsel, on behalf
13 of the Investigative Committee of the Medical Board.

14 MS. THOMAS: Melanie Thomas on behalf of
15 Dr. Schneier.

16 HEARING OFFICER BURCHAM: Thank you.

17 Now, procedurally, this is the history of
18 the case: The complaint was filed on, July 30,
19 2024. Respondent's answer was filed on
20 September 23, 2024. An early case conference was
21 held on October 17, 2024. A hearing was originally
22 set for March 11th and 12th, 2025. There was a
23 deadline in the order on that for filing of
24 prehearing motions. The IC filed a motion in limine
25 on February 11, 2025. Respondent filed the

1 opposition to that on March 3, 2025. The order on
2 that was filed on March 7, 2025. Then the hearing
3 was reset to commence today, May 28th, 2025, at
4 9:00 a.m.

5 Are counsel ready to proceed?

6 MS. THOMAS: Yes.

7 MR. SHOGREN: Yes.

8 HEARING OFFICER BURCHAM: All right. And,
9 Dr. Schneier, I didn't mean to cut you out of that.
10 Welcome to today's proceedings. Do you have any
11 questions as we move forward?

12 DR. SCHNEIER: No.

13 HEARING OFFICER BURCHAM: A couple of
14 housekeeping matters, as I mentioned before we got
15 on the record. Exhibits, I have in front of me the
16 IC's formal hearing Exhibits 1 through 10, and then
17 I also have Dr. Schneier's culled exhibits with a
18 bunch of different numbers on them.

19 Let's turn to the -- what I'd like to do
20 is see whether we have a stipulation on these. To
21 the extent that we have a stipulation, that's great,
22 if we don't, we can deal with it.

23 So first, turning to the IC's Exhibits 1
24 through 10, I would ask, Ms. Thomas, you've reviewed
25 these, any problems, objections with any of them?

1 MS. THOMAS: I don't know that all of them
2 are appropriate for admission. I think part of your
3 order on motion in limine was that -- related to the
4 discussions of subsequent care -- and the Board has
5 not yet advised whether they intend to get into the
6 subsequent care -- I think there needs to be a
7 foundation laid for that, and I think that we should
8 address those records as they come up in the
9 proceedings.

10 And then with regard to the journal
11 article, I think there needs to be a foundation for
12 that, and I'm not sure that that's appropriate
13 evidence for admission.

14 HEARING OFFICER BURCHAM: All right.
15 Well, let's go to number 1. Any problems with
16 number 1, Ms. Thomas?

17 MS. THOMAS: No.

18 HEARING OFFICER BURCHAM: That'll be
19 admitted.

20 (IC's Exhibit 1 was admitted.)

21 HEARING OFFICER BURCHAM: Number 2?

22 MS. THOMAS: No.

23 HEARING OFFICER BURCHAM: Number 3,
24 Patient A medical records, Sunrise. That's about 41
25 pages. Any problems with that one?

1 MS. THOMAS: Other than the fact that
2 these are not complete records, but we also have a
3 competing set of records that are more substantive
4 for these admissions, I have no problem.

5 HEARING OFFICER BURCHAM: Number 3 will be
6 admitted.

7 (IC's Exhibit 3 was admitted.)

8 HEARING OFFICER BURCHAM: Then we have
9 number 4, which appears to be a series of imaging
10 studies. Some of those are, Ms. Thomas, after
11 February-ish of 2020, the last three, it looks like.

12 What's your position on those?

13 MS. THOMAS: I do not have an issue with
14 those studies being admitted.

15 HEARING OFFICER BURCHAM: All right.
16 Those will all be admitted.

17 (IC's Exhibit 4 was admitted.)

18 HEARING OFFICER BURCHAM: Number 5,
19 Patient A medical records, Clinical Neurology
20 Associates?

21 MS. THOMAS: Those are -- and maybe I can
22 shortcut here. Five through 8 are subsequent care,
23 so if the appropriate foundation is laid, I feel
24 like we can deal with that at the time, but, right
25 now, there has been no representation by the Board

1 on whether they intend to canvass that area.

2 HEARING OFFICER BURCHAM: All right.

3 Mr. Shogren comments on that?

4 MR. SHOGREN: The Board does intend to
5 reference this briefly, some of the aftercare. It's
6 mentioned in the Complaint.

7 HEARING OFFICER BURCHAM: Okay. What
8 we'll do is we'll reserve that. I assume that
9 you're going to be going through this with one or
10 more of your witnesses; correct?

11 MR. SHOGREN: Correct.

12 HEARING OFFICER BURCHAM: All right.
13 We'll reserve that.

14 The article, we're going to reserve that
15 one as well. I had made a note of that as kind of
16 the learned treatise, so there's going to need to be
17 some foundation for that laid.

18 And then number 10, Ms. Thomas? It's a
19 CV.

20 MS. THOMAS: I don't have a problem with
21 that being admitted.

22 HEARING OFFICER BURCHAM: Okay. So
23 Exhibits -- this is the IC's exhibits -- 1, 2, 3, 4
24 and 10. Number 9, reserve; 5, with foundation -- 5
25 through 8 same.

1 (IC's Exhibits 2 and 10 were
2 admitted.)

3 HEARING OFFICER BURCHAM: All right.
4 Let's turn to the culled exhibits, the respondent.
5 I did take a little bit of time just to kind of get
6 an idea of what was in this material.

7 Mr. Shogren, you've had a chance to review
8 this material, what's your position regarding it?
9 Stipulated, non stipulated, objections?

10 MS. THOMAS: And I might be able to
11 shortcut this a little bit.

12 I'm willing to go on a case-by-case basis
13 with these exhibits and only admit the portions of
14 them that we use or otherwise state on the record to
15 be admitted, with the exception of Q.

16 HEARING OFFICER BURCHAM: With the
17 exception of what?

18 MS. THOMAS: Q.

19 HEARING OFFICER BURCHAM: Q. Pardon me.
20 I'm not sure I have a Q in here. I go up to P, so I
21 don't even have a Q.

22 MS. THOMAS: It's not our -- if you look
23 at our prehearing statement -- so when I sent the
24 culled exhibits over, that was the only exhibits
25 that had been changed from the time of the

1 prehearing statement.

2 It's paragraph 17 on the list of proposed
3 exhibits, the curriculum vitae. I'm happy to email
4 a copy to you if you like.

5 HEARING OFFICER BURCHAM: Well, if you
6 want to -- yeah, if you want to have it in the
7 record, it's going to need to be there, because I
8 don't see it in materials.

9 MS. FUENTES: I do have it here.

10 HEARING OFFICER BURCHAM: You have it?

11 MS. FUENTES: I do have it here. I can
12 get you a copy.

13 HEARING OFFICER BURCHAM: Okay. We can do
14 that on a break, perhaps.

15 MR. SHOGREN: I have no objection to
16 admitting the respondent's exhibits.

17 HEARING OFFICER BURCHAM: Okay.

18 To the extent that they're going to be
19 used, Ms. Thomas or anybody, then the respondent's
20 culled exhibits, just for the record, they are --
21 you have to kind of read between the lines on
22 this -- A, B, E, F, G, H, I, J, K, and P are
23 admitted for purposes of use in this proceeding.

24 (Respondents Exhibits A, B, E, F,
25 G, H, I, J, K, and P were

1 admitted.)

2 HEARING OFFICER BURCHAM: All right. So
3 taken care of the exhibits.

4 Final housekeeping before we get into the
5 nuts and bolts, what's the anticipated witnesses,
6 Mr. Shogren first, that you anticipate calling
7 today?

8 MR. SHOGREN: I was going to briefly call
9 Ms. LaRue, an investigator here with the Board, to
10 talk about Exhibits 5 through 8, lay a foundation
11 for those.

12 And then we'll be calling the Board's
13 expert witness, Dr. Goz.

14 HEARING OFFICER BURCHAM: Those were the
15 two anticipated witnesses?

16 MR. SHOGREN: Correct.

17 HEARING OFFICER BURCHAM: And, Ms. Thomas,
18 for you?

19 MS. THOMAS: I intend to ask limited, if
20 any, questions of Ms. LaRue, to cross-examine
21 Dr. Goz, and then we will be calling Dr. Agarwal and
22 Dr. Schneier.

23 HEARING OFFICER BURCHAM: There was some
24 hint at one point in time, I think in one of our
25 chats, that Dr. Khavkin is somehow going to

1 testify --

2 MS. THOMAS: Khavkin?

3 HEARING OFFICER BURCHAM: Yeah. How is
4 that pronounced?

5 MS. THOMAS: Kav-kin.

6 HEARING OFFICER BURCHAM: So that doctor,
7 Dr. Khavkin, he is not going to be -- he's on a
8 witness list, but he's not going to be testifying;
9 correct?

10 MS. THOMAS: We do not plan to call him.

11 HEARING OFFICER BURCHAM: All right.

12 And, Mr. Shogren, you don't plan to call
13 him either?

14 MR. SHOGREN: No.

15 HEARING OFFICER BURCHAM: Got it. Okay.

16 There's not a whole lot -- well, there's
17 would be, two experts. The rule of exclusion, you
18 guys want to invoke that?

19 MS. THOMAS: I don't believe that the rule
20 of exclusion applies at trial. I think expert
21 witnesses are an exception to that rule. I would
22 not be asking for exclusion.

23 HEARING OFFICER BURCHAM: Mr. Shogren, how
24 do you -- because there is a hearsay exception on
25 that, and it's within my discretion to invoke it or

1 not under the rule.

2 Any position on that?

3 MR. SHOGREN: Just, generally, I invoke
4 that.

5 HEARING OFFICER BURCHAM: In this
6 instance, since we have two experts and this appears
7 to be -- that appears to be the core of the case and
8 it is discretionary, I'm not going to have the rule
9 of exclusion invoked because it doesn't really apply
10 all that well to experts, in my view, in this and
11 other context. So, anyway, who knows.

12 What I'd like to do now is, Mr. Shogren,
13 you indicated a desire to do a short opening. Feel
14 free.

15 OPENING STATEMENT

16 BY MR. SHOGREN:

17 First off, I'd like to say good morning to
18 everyone. I'd like to thank everyone involved in
19 today's hearing for their participation.

20 Just briefly, I want to lay out that the
21 hearing is to present evidence to determine whether
22 a Dr. Schneier violated parts of the Medical
23 Practice Act, specifically whether or not he
24 committed malpractice as alleged in Count I of the
25 Complaint filed by the Investigative Committee, and

1 failed to maintain complete medical records, as
2 alleged in Count II, and continually failed to
3 exercise skill and diligence as alleged in Count
4 III.

5 I want to briefly outlined what will be
6 discussed, what the evidence will show at today's
7 hearing.

8 The evidence will show that on December
9 31, 2019, Dr. Schneier performed spinal surgery on
10 Patient A to address Patient A's -- aiming to
11 address Patient A's stenosis, however the surgery
12 was performed on the wrong level of the patient's
13 spine.

14 Then Dr. Schneier failed to recognize the
15 wrong-level surgery, despite Patient A's continued
16 issues with lower extremity change and functional
17 deficits and multiple subsequent imaging studies
18 that demonstrated continued stenosis at the T10
19 through T11 level.

20 This also includes failure to address the
21 patient pathology there at that level in a second
22 surgery performed by Dr. Schneier on January 23,
23 2020, when he removed hardware, but still did not
24 revise his laminectomy for the surgery to address
25 the patient's stenosis.

1 The evidence will also show that Dr.
2 Schneier's records did not address Patient A's
3 continued stenosis or discussion of that with the
4 patient after the first surgery, and thus the
5 records are not complete.

6 Finally, the evidence will show that Dr.
7 Schneier continued failed to exercise skills and/or
8 diligence by not addressing Patient A's stenosis at
9 the T10 through T11 level after December 31, 2019.

10 In sum, the testimony and evidence
11 presented here today will establish by a
12 preponderance of the evidence that Dr. Schneier
13 committed malpractice, failed to maintain proper or
14 complete medical records, and continually failed to
15 exercise diligence.

16 Accordingly, Dr. Schneier has failed to
17 meet the standard of care and violated the three
18 provisions of the Medical Practice Act as alleged in
19 the formal Complaint.

20 On behalf of the Investigative Committee,
21 we ask the Board to considering the record that will
22 be presented today and render the appropriate
23 findings and discipline.

24 Once again, thank you, everyone, for being
25 here today.

1 HEARING OFFICER BURCHAM: Thank you,
2 Mr. Shogren.

3 It's my understanding, Ms. Thomas, you
4 will reserve any opening at the present time?

5 MS. THOMAS: Yes. Thank you.

6 HEARING OFFICER BURCHAM: All right.
7 Mr. Shogren, ball's in your court. You can call
8 your first witness.

9 The way we'll do it is you can call him,
10 the court reporter will then administer the oath,
11 and you can go forward. Okay?

12 MR. SHOGREN: Okay. The IC will first be
13 calling Johnna LaRue as their first witness.

14 HEARING OFFICER BURCHAM: Ms. LaRue, can
15 you hear us?

16 THE WITNESS: I can hear you. Can you see
17 me and hear me?

18 HEARING OFFICER BURCHAM: Yes.

19 Can everybody else see and hear Ms. LaRue?

20 MS. THOMAS: Yes, we can.

21 HEARING OFFICER BURCHAM: All right. Ms.
22 LaRue, please state your name for the record, and
23 then I'm going to have the court reporter swear you
24 in. Okay?

25 THE WITNESS: Well, hold on. I have to

1 turn my volume up. I'm having trouble hearing you.
2 Okay. You asked me for my name?

3 HEARING OFFICER BURCHAM: Yeah. Just
4 state your name for the record, then the court
5 reporter is going to swear you in, and then
6 Mr. Shogren will ask you some questions.

7 THE WITNESS: Okay. My name is Johnna
8 LaRue, L-A-R-U-E.

9 (The oath was administered.)

10 HEARING OFFICER BURCHAM: Mr. Shogren?

11 DIRECT EXAMINATION

12 BY MR. SHOGREN:

13 Q. Good morning, Mr. LaRue. First off, where
14 do you work?

15 A. The Nevada State Board of Medical
16 Examiners.

17 Q. And in what capacity do you work for the
18 Board of Medical Examiners?

19 A. I'm the Deputy Chief of Investigations.

20 Q. Do you have any other roles besides doing
21 investigations?

22 A. Compliance officer.

23 Q. And how long have you worked for the
24 Board?

25 A. 19 years.

1 Q. Okay. We're here today for a hearing to
2 present evidence so that the Board can determine if
3 Dr. Schneier violated the Medical Practice Act.

4 Are you the investigator who is assigned
5 to this case with regards to Dr. Schneier?

6 A. Yes.

7 Q. As part of your investigation for the
8 case, were you required to obtain medical records?

9 A. Yes.

10 Q. And as part of the investigation in this
11 case, were you required to serve orders or requests
12 issued by the Investigative Committee to obtain
13 medical records?

14 A. Yes.

15 Q. Thank you.

16 I'm going to ask you a couple of questions
17 directed towards some of the exhibits. Do you have
18 a binder in front of you?

19 A. Yes, I do.

20 Q. The IC's exhibits, go to Exhibit 5, it's
21 been marked.

22 A. Okay.

23 Q. Do you recognize these documents?

24 A. Yes.

25 Q. And looking at what's been marked as

1 Bates-stamped page 64.

2 A. Yes.

3 Q. What is this document?

4 A. This is my request for medical records to
5 the Clinical Neurology Specialists.

6 Q. Turning to page 65, what is this document?

7 A. This is the custodian of records that I
8 received from -- her name is, it looks like Gina
9 Martinez from the Clinical Neurology Specialists.

10 Q. And then looking at the rest of the pages
11 in this exhibit, are you familiar with these
12 documents?

13 A. Yes. These were the records that were
14 provided to me.

15 Q. Do you recall receiving these documents?

16 A. Yes.

17 Q. Do these documents appear to be true -- a
18 true and correct copy of Patient A's medical records
19 from Clinical Neurology Specialists?

20 A. Yes.

21 MR. SHOGREN: At this time, I'll ask for
22 admission -- or move to admit Exhibit 5 into the
23 record.

24 HEARING OFFICER BURCHAM: Ms. Thomas?

25 MS. THOMAS: I don't think that this

1 states -- that this witness has laid the foundation
2 for how these records relate to whether Dr. Schneier
3 has committed malpractice, prepared incomplete
4 records, or did not meet his standard of care of the
5 patient.

6 And, secondarily, only because there are
7 other records in this binder that are accompanied by
8 custodian of records affidavit, I would want to be
9 sure that this witness is certain that the entirety
10 of the records from Dr. Germin are produced in
11 Exhibit 5.

12 HEARING OFFICER BURCHAM: Ms. Thomas, let
13 me ask you this: Have you seen these records
14 before?

15 MS. THOMAS: The ones in Exhibit 5 or Dr.
16 Germin's record as a whole?

17 HEARING OFFICER BURCHAM: The ones in
18 Exhibit 5.

19 MS. THOMAS: When the Board disclosed
20 them, I've seen them.

21 HEARING OFFICER BURCHAM: Okay. And is it
22 your position that this is not the entirety of these
23 records?

24 MS. THOMAS: I don't know.

25 HEARING OFFICER BURCHAM: All right.

1 Whether they are or -- whether they are or are not
2 complete, they have been proposed, marked, and they
3 will be admitted for purposes of this hearing.

4 (IC's Exhibit 5 was admitted.)

5 HEARING OFFICER BURCHAM: Go ahead,
6 Mr. Shogren.

7 BY MR. SHOGREN:

8 Q. Ms. LaRue, the only other exhibit I'm
9 going to have you look at is Exhibit 8.

10 A. Okay.

11 Q. Are you familiar with this exhibit?

12 A. Yes.

13 Q. What does this exhibit appear to be?

14 A. This is my request for records from the
15 Khavkin Clinic. The whole of it is the custodian of
16 records, and then there's a few reports attached.

17 Q. Just to be clear, what page is your letter
18 on?

19 A. Page 93 is my request letter.

20 Q. You mentioned a custodian of record, what
21 page is that on?

22 A. Page 94.

23 Q. And do you recall receiving these records
24 from the Khavkin Clinic?

25 A. Yes.

1 Q. Do these documents appear to be a true and
2 correct copy of Patient A's medical records from the
3 Khavkin Clinic?

4 A. Yes, what's in here is from the Khavkin
5 Clinic.

6 MR. SHOGREN: At this point, I move to
7 admit Exhibit 8 into the record.

8 HEARING OFFICER BURCHAM: Ms. Thomas?

9 MS. THOMAS: I have the same objection.
10 The witness did not answer that these were the
11 complete set of records, but that they were records
12 from the Khavkin Clinic.

13 Also, there has not been a foundation laid
14 for how subsequent care and information contained
15 with what is hearsay evidence would establish that
16 Dr. Schneier committed malpractice, prepared
17 incomplete records, or didn't meet the standard of
18 care, which are the issues we are here to discuss
19 today.

20 HEARING OFFICER BURCHAM: It appears that
21 Exhibit 8, which is what we're talking about, is
22 also respondent's Exhibit K, already been admitted.
23 I haven't gone through each and every case, there's
24 not that many of them, but it includes a lot of the
25 same material.

1 They'll be admitted -- 8.

2 (IC's Exhibit 8 was admitted.)

3 HEARING OFFICER BURCHAM: Mr. Shogren?

4 MR. SHOGREN: I have no further questions.

5 HEARING OFFICER BURCHAM: Cross?

6 CROSS-EXAMINATION

7 BY MS. THOMAS:

8 Q. Yes, just a couple of questions, Ms.
9 LaRue.

10 As part of your investigation in this
11 case, did you only request records?

12 A. No, I didn't only request records.

13 Q. Okay. What else did you do?

14 A. I would have requested a response from Dr.
15 Schneier.

16 Q. Anything else?

17 A. No.

18 Q. Did you select the Board's expert witness
19 in this case?

20 A. No, I did not.

21 Q. How did you identify what records to
22 obtain?

23 A. Via the complaint that we receive.

24 Q. And when -- who did you receive the
25 complaint from?

1 MR. SHOGREN: Objection. I think that's
2 part of the confidential --

3 HEARING OFFICER BURCHAM: Part of the
4 confidential? Can you explain, please?

5 MR. SHOGREN: That goes into the
6 investigative process, part of the investigated
7 file, and is confidential by law.

8 HEARING OFFICER BURCHAM: The name of the
9 person only; is that correct?

10 MR. SHOGREN: Correct.

11 HEARING OFFICER BURCHAM: That was the
12 question.

13 I'll allow it as to the name of the
14 person, but beyond that, no.

15 MR. SHOGREN: I'm sorry. What do you say?

16 HEARING OFFICER BURCHAM: I said I will
17 allow the question as to the name of the person, but
18 that's about as far as we're going on that.

19 THE WITNESS: I'm sorry. I cannot provide
20 you the name of the complainant, that's protected by
21 the statute, 630.336, as part of the confidential
22 process of the investigation. I can't provide
23 you -- I can't provide the name of the complainant
24 or how we received it.

25 We received the complaint and we

1 investigated it.

2 HEARING OFFICER BURCHAM: Okay. With that
3 explanation for what -- the way the process
4 worked -- I didn't know whether it was an office
5 staff person, I didn't know whether that -- if
6 that's the case, objection sustained.

7 Move forward, please.

8 MS. THOMAS: I would just like to respond
9 to that. We do not believe that the name of the
10 complainant is confidential. We believe that the
11 statute protects the investigation.

12 I'm not trying to get into what happened
13 once they received the complaint, but the complaint
14 is not part of the investigation. It is from the
15 complaint that an investigation is opened, but it is
16 not yet in the investigative stage at the time the
17 complaint is received.

18 HEARING OFFICER BURCHAM: Mr. Shogren, any
19 response to that?

20 MR. SHOGREN: I disagree with that
21 assertion. I think the statute is clear. I think
22 there is case law that actually goes into,
23 specifically, the confidentiality of the
24 complainant.

25 But once again, it's a part of the

1 investigative file, it's now being used today, it is
2 part of the hearing, it's confidential under NRS
3 630.336.

4 HEARING OFFICER BURCHAM: All right. This
5 is, for future reference, something that would have
6 been nice to have been in a hearing -- a pretrial
7 motion, frankly. That having been said, I do not
8 want to tread on confidentiality.

9 Based upon what I have heard just now, the
10 objection is sustained as to the complainant.

11 Go forward.

12 BY MS. THOMAS:

13 Q. So I need to ask some questions whether
14 there is a sustained objection on them or not. I
15 need to make the record.

16 Was the complainant Patient A?

17 MR. SHOGREN: Objection. Confidential.

18 HEARING OFFICER BURCHAM: I believe that
19 that would be kind of a backdoor to the
20 confidentiality.

21 Objection is sustained.

22 MS. THOMAS: And I'm just going to look up
23 the statute quickly.

24 For the record, NRS 630.336 does not
25 protect the identity of the complainant. It

1 protects disclosure of the complaint and the
2 associated investigation, but nowhere in the statute
3 does it say that the identity of the complainant is
4 protected.

5 And the statute -- legislative
6 interpretation dictates that any silence in the
7 statute is deemed intentional.

8 HEARING OFFICER BURCHAM: Mr. Shogren?

9 MR. SHOGREN: I believe -- I'm looking, a
10 case, State of Nevada -- Sarfo v. State of Nevada
11 Board of Medical Examiners, for that issue about the
12 identity of the complainant.

13 I believe the court in that case -- I'm
14 just looking up, I don't feel like I have time to
15 full brief this issue, but I believe the court ruled
16 that complainant is confidential.

17 MS. THOMAS: What is the cite for that
18 case?

19 MR. SHOGREN: It is -- I'm sorry. I'm
20 having trouble finding the case.

21 MS. THOMAS: How do you spell it?

22 MR. SHOGREN: How to spell --

23 MS. THOMAS: The case name.

24 MR. SHOGREN: Sarfo, S-A-R-F-O, 429 P.3d
25 650.

1 HEARING OFFICER BURCHAM: Ms. Thomas, I
2 have a question for you as we're doing some legal
3 research, I suppose. Are you only interested in the
4 name, and then that was going to be it?

5 MS. THOMAS: Yes.

6 HEARING OFFICER BURCHAM: Going to be it;
7 correct?

8 MS. THOMAS: Correct.

9 HEARING OFFICER BURCHAM: I don't want to
10 burn too much daylight here looking up cases. As I
11 said, this would be an interesting legal issue,
12 perhaps.

13 Ms. LaRue, you're going to be around, I'm
14 assuming, today; correct?

15 THE WITNESS: Yes. Yeah, I'm in the
16 office until 4:00.

17 HEARING OFFICER BURCHAM: Okay. Here's my
18 idea to throw out as people are researching this
19 particular issue. You've heard -- and I'll call it
20 a "preliminary sustaining of that objection as to
21 the identity," I would like to move ahead.

22 If that's the only question, Ms. Thomas,
23 that you had as to the identity and then you were
24 going to move on, we can reserve that issue as
25 necessary, because I don't know whether you would be

1 using that later on in any of your direct or
2 cross-examination.

3 Would you anticipate using that name?

4 MS. THOMAS: Well, it's important to --
5 it's potentially important to how this whole thing
6 shapes up. I am nearly through the decision. If it
7 is the position of the Nevada Supreme Court that the
8 identity of the individual is not subject to
9 disclosure, then I obviously accept -- accept that.

10 But the answer to that question could
11 dictate the approach taken in these proceedings.

12 I don't need to get into the investigative
13 file, but I think the identity of the person from
14 which this investigation stemmed is relevant and
15 it's not subject to protection.

16 HEARING OFFICER BURCHAM: All right.
17 Well, I feel a little bit queasy about the --
18 violating confidentiality and violating the rules
19 regarding that, so the objection is sustained,
20 subject to further discussion later on.

21 I want to move forward. Okay?

22 MS. THOMAS: Okay.

23 HEARING OFFICER BURCHAM: So with that,
24 proceed.

25 MS. THOMAS: Okay.

1 BY MS. THOMAS:

2 Q. How did you determine the dates of service
3 to request in making your records request?

4 A. It was based on the information that I
5 received in the complaint.

6 Q. Was it solely based on the information you
7 received in the complaint?

8 A. Yes. The original date of service that I
9 put would have been based on the complaint, the
10 information that I received.

11 Q. Did you use the same dates of service in
12 every request that you made?

13 A. I'd have to look. If you give me a
14 minute, I can look at my request letter and
15 determine that.

16 Q. Yes, please do.

17 (Witness reviewed documents.)

18 THE WITNESS: Yes, same date of service.

19 BY MS. THOMAS:

20 Q. And one last question, which I don't know
21 if it will catch an objection, but in order to
22 preserve the record, was the complainant a medical
23 provider?

24 MR. SHOGREN: Objection.

25 HEARING OFFICER BURCHAM: Sustained.

1 BY MS. THOMAS:

2 Q. Are there any records that you requested
3 that do not appear within the exhibits disclosed by
4 the Board and their prehearing statements?

5 A. I -- well, honestly, I don't know if I can
6 answer that because I don't have my investigative
7 case file in front of me to determine if what I
8 requested is everything that's presented here.

9 Everything that's presented here as
10 exhibit are all things that I requested and got as
11 part of my investigation.

12 Q. Do you request records that you do not
13 subsequently disclose as part of the evidence in a
14 formal hearing?

15 A. As I'm not the attorney of the record, I
16 can't answer that question. I can only tell you
17 what I gather and that's it. I don't --

18 Q. I'm sorry. What did you say?

19 A. I don't make the determination of what
20 exhibits are presented in a hearing, that's not part
21 of my position or my job.

22 Q. Did you remove any records from the sets
23 that you received in this case that have been
24 disclosed?

25 A. I did not remove any records, no.

1 Q. Did you interview any witnesses?

2 A. Not directly, no.

3 Q. What do you mean?

4 A. No, I didn't do any interviews. I did not
5 directly contact anyone.

6 Q. Did you indirectly conduct interviews?

7 A. Indirectly, yes. When I sent Dr. Schneier
8 a letter and asking him to respond to the
9 allegations in the Complaint, that would be what I
10 would consider an indirect interview, me asking
11 questions and him giving me answers.

12 Q. Do you have any medical training?

13 A. No.

14 Q. Were you responsible for providing the
15 records to Dr. Goz?

16 A. Yes.

17 Q. Did you provide him the entirety of the
18 records that are in the Board's prehearing
19 statement?

20 A. Yes.

21 Q. Did you provide him anything else?

22 A. No.

23 Q. Did you provide him with a copy of Dr.
24 Schneier's prehearing statement and the culled
25 exhibits?

1 A. No.

2 Q. Are you the only one that provides Dr. Goz
3 with records related to this investigation?

4 A. Yes.

5 Q. Do you direct Dr. Goz in his review of the
6 records in any way?

7 A. No.

8 Q. Have you used Dr. Goz in regard to other
9 cases before the Board?

10 A. I can't answer that question. I can only
11 answer that I used him directly for this case.

12 Q. Can you not answer that question because
13 you don't know the answer?

14 A. Well, I don't -- yes and no. I don't know
15 what other cases he's used because I don't assign
16 him as a reviewer or an expert witness.

17 But also any other information would not
18 be relevant because they would not be related to
19 this specific investigation, so I don't have that
20 information.

21 Q. How is the reviewer assigned to an
22 investigation?

23 A. It would be based on the decision of the
24 committee that reviewed the case.

25 Q. Who was the committee that reviewed this

1 case?

2 A. I don't know if I know what committee this
3 case went to. I don't know that I can answer that
4 question.

5 Choices about being a reviewer is also
6 made on specialty and location.

7 Q. How does the location influence whether a
8 reviewer is assigned to a case?

9 A. The process of choosing a reviewer is
10 determined on the location of the physician at
11 question and the location of the reviewer. Dr. Goz
12 was located in the north, so he doesn't have any
13 direct influence or direct contact with the
14 respondent.

15 We choose people who don't know each
16 other, who have no interaction with any of the
17 patients involved in any of our cases so that it is
18 a completely unbiased review.

19 Q. So it's your understanding that
20 Dr. Schneier does not do business in Northern
21 Nevada?

22 A. It's my understanding that Dr. Schneier
23 doesn't have any contact with Dr. Goz specifically.
24 I don't know if Dr. Schneier does business in
25 Northern Nevada or not.

1 Q. Was Dr. Goz provided with the complaint?

2 A. I can't -- he would have been -- Dr. Goz
3 would have been provided with all of the information
4 that I received.

5 Q. So the community complaint that -- from
6 which your investigation began was provided to Dr.
7 Goz?

8 A. I --

9 MR. SHOGREN: Objection.

10 HEARING OFFICER BURCHAM: Hang on, hang
11 on, there's an objection.

12 Let's hear it.

13 MR. SHOGREN: This goes too much into the
14 investigative file, which is confidential. The
15 Board, through the IC, presented its exhibits, what
16 it intends to be using today. I think anything else
17 is part of the investigative file and is
18 confidential.

19 MS. THOMAS: My response to that is that,
20 one, Dr. Goz is not an employee of the Medical
21 Board, he is a private practitioner, by providing
22 him information that is alleged to be protected by
23 statute, that privilege or that confidentiality has
24 been waived.

25 And, secondarily, the disclosure of

1 Dr. Goz in the Board's prehearing statement is not
2 limited to the exhibits or records disclosed
3 therein, but states that he has conducted a medical
4 review of this case and is expected to testify
5 regarding his medical review of this case and the
6 applicable standard of care. If his review included
7 items such as the complaint, we are entitled to know
8 that.

9 I would also argue that that addresses an
10 earlier objection that was made that that
11 information is now no longer protected.

12 HEARING OFFICER BURCHAM: Dr. Goz, it's my
13 understanding, is going to be testifying, and all of
14 these questions are going to be asked -- in other
15 words, what did you review?

16 I'm wondering whether this discussion that
17 we're having should be more directed towards that
18 type of testimony, as opposed to with this witness.

19 I just want to keep things moving along.
20 I don't want to fight about things or have a fight
21 about things.

22 At this time, it's -- if the witness, the
23 medical witness is going to be testifying, you can
24 ask him what he reviewed, then Mr. Shogren can
25 respond to that. I just don't know whether it's --

1 this witness is the proper one to go through all of
2 that.

3 That's my comment, it's not really a
4 ruling or anything, but any comments to that?

5 MS. THOMAS: I just think for the sake of
6 completing a record here in preserving all
7 objections and bases for those objections in the
8 event that judicial review is at some point
9 warranted or necessary is important.

10 I am happy to ask the same questions of
11 Dr. Goz, and I don't want to spend that much time
12 arguing either. I -- I want to keep things flowing.

13 HEARING OFFICER BURCHAM: All right.
14 Let's do this: Why don't you direct those questions
15 to Dr. Goz, i.e., what he reviewed, what he was
16 provided, what he reviewed, and and any other
17 questions. You're going to be able to have full
18 cross-examination rights on that. Okay?

19 MS. THOMAS: Okay.

20 HEARING OFFICER BURCHAM: Let's move
21 forward with this witness.

22 MS. THOMAS: Sure. I'm just making a note
23 of your ruling so I don't run afoul of it.

24

25

1 BY MS. THOMAS:

2 Q. Are there any records you requested that
3 you did not receive?

4 A. No.

5 Q. Did you ask Dr. Goz to memorialize his
6 opinions in writing?

7 A. Yes.

8 Q. Did he?

9 A. Yes.

10 Q. Were his opinions memorialized in writing
11 on one occasion or revised?

12 A. If I recall, I believe it was just one
13 occasion.

14 Q. Was he provided all of the information
15 that you gave him in one transmission, or did you
16 provide the information over multiple transmissions?

17 A. I believe it was one transmission, one
18 time he got all the information.

19 Q. How did you provide that information,
20 electronically, hard copies in the mail, some other
21 mechanisms?

22 A. An encrypted file transfer.

23 Q. As you sit there today, are you able to
24 say whether he was provided more medical records
25 than the excerpt provided in the Board's prehearing

1 statement?

2 A. My answer to that is that I provided him
3 everything that I received.

4 Q. Did you request anything other than
5 medical records in this case?

6 A. No. Only the statement from Dr. Schneier.
7 Would that include images and X-rays?

8 Q. Yes. That's a good question.

9 Did you -- are all of the images and
10 X-rays that you requested part of the Board's
11 Exhibit 4?

12 A. Well, because the exhibits, says they're
13 on a USB, I couldn't tell you, but I did collect
14 images and X-rays.

15 Because I don't have USB in front of me, I
16 don't have that information.

17 Q. So -- okay.

18 MS. THOMAS: I have no further questions.
19 Thank you.

20 HEARING OFFICER BURCHAM: Redirect?

21 MR. SHOGREN: No further questions.

22 HEARING OFFICER BURCHAM: All right. Ms.
23 LaRue, as I indicated, you may be brought back, so
24 don't leave without letting us know. Okay?

25 THE WITNESS: Okay. I'm here until 4:00.

1 Mercedes can let me know if you guys need me again.

2 HEARING OFFICER BURCHAM: Okay. Thank
3 you.

4 THE WITNESS: Thank you.

5 HEARING OFFICER BURCHAM: Mr. Shogren,
6 next witness?

7 MR. SHOGREN: The IC will next be calling
8 a Dr. Goz.

9 HEARING OFFICER BURCHAM: Doctor, hi. Can
10 you hear us?

11 THE WITNESS: Hi there.

12 HEARING OFFICER BURCHAM: Good. Can you
13 hear us?

14 THE WITNESS: Yes, sir.

15 HEARING OFFICER BURCHAM: All right.
16 Welcome.

17 What I'm going to have you do is to state
18 your name for the record, then the court reporter is
19 going to swear you in, and then you'll be asked some
20 questions.

21 For the lawyers, it's -- how long do you
22 guys want to go until we take a break? I usually
23 like to go about an hour and a half on proceedings
24 and then take a break, which would be about another
25 half hour or so. That sound okay?

1 MS. THOMAS: Sure.

2 HEARING OFFICER BURCHAM: Okay.

3 MR. SHOGREN: That's fine.

4 HEARING OFFICER BURCHAM: All right. So
5 with that, Ms. Court Reporter, please, swear in the
6 witness.

7 (The oath was administered.)

8 HEARING OFFICER BURCHAM: Mr. Shogren,
9 proceed.

10 DIRECT EXAMINATION

11 BY MR. SHOGREN:

12 Q. Good morning, Dr. Goz.

13 A. Good morning.

14 Q. First of all, are you licensed as a
15 medical doctor in the State of Nevada?

16 A. I am.

17 Q. How long have you been licensed?

18 A. I've been licensed to Nevada for about
19 five years.

20 Q. Are you licensed anywhere else?

21 A. California.

22 Q. How long have you been licensed in
23 California?

24 A. About the same.

25 Q. And where did you go to medical school?

1 A. Mount Sinai medical school in New York
2 City.

3 Q. And what was your residency in?

4 A. Orthopedic surgery.

5 Q. And where did you complete that?

6 A. University of Utah.

7 Q. Do you have any certifications?

8 A. Can you be more specific?

9 Q. Are you certified by the American Board of
10 Medical Specialties?

11 A. Yes, the American Board of Orthopedic
12 Surgery, so I'm a board-certified orthopedic
13 surgeon.

14 Q. What kind of medicine do you practice
15 right now?

16 A. Spine surgery.

17 Q. And where do you practice medicine?

18 A. Reno, Nevada.

19 Q. And do you practice in a facility or
20 office or hospital?

21 A. I'm part of a private practice.

22 Q. And how long you've been practicing as a
23 orthopedic spine surgeon?

24 A. About five years.

25 Q. And what role do you concurrently work?

1 A. I'm a spine surgeon.

2 Q. Do you have any other positions?

3 A. No.

4 Q. Are you a member of any professional
5 societies?

6 A. Member of the American Academy of
7 Orthopedic Surgery.

8 Q. And how many spinal surgeries do you
9 performed yearly?

10 A. Somewhere between 200 and 250 surgeries a
11 year.

12 Q. And how many laminectomies have you
13 performed?

14 A. I'm not sure. Many.

15 Q. Do you know how many spinal fusions you
16 have performed?

17 A. Again, I'm not sure the number, but about
18 250 surgeries -- 200 to 250 surgeries a year for
19 five years, thoracic lumbar fusion is a common
20 procedure, so, I don't know, probably a few hundred.

21 Q. I would like you turn briefly to the IC's
22 Exhibit 10.

23 A. And where am I turning to?

24 Q. There should be a binder in front of you,
25 labeled --

1 A. Is it this guy?

2 Q. There should be another one. I believe
3 that's respondent's exhibits. It's a smaller
4 binder.

5 A. Let me see if I can track it down. I'm
6 not sure if I have a small binder in front of me.
7 One moment.

8 Yeah, I don't think I have the binder
9 you're referring to in front of me.

10 Q. Dr. Goz, I believe we sent that to you
11 earlier. You were provided a copy of it at least
12 few weeks ago.

13 A. It may be at my office. I'm not
14 completely sure. I'm at my home office today.

15 MR. SHOGREN: Mr. Burcham, do you mind if
16 we take a brief break?

17 HEARING OFFICER BURCHAM: No, not at all.
18 We can go off the record. You can also, I think,
19 maybe do a screen share. Mercedes might be able to
20 figure that out so you could show him. It's a CV,
21 it looks like, it's what you're referring to; right?

22 MR. SHOGREN: Correct. But also Dr. Goz
23 needs the IC's exhibits in the binder, all of them,
24 I will be referring to those.

25 HEARING OFFICER BURCHAM: Yeah, exactly.

1 I figured you would be. Let's -- yeah, let's go off
2 the record to sort this out.

3 (Recess from 10:10 A.M. to 10:18
4 A.M.)

5 HEARING OFFICER BURCHAM: We're back on
6 the record. It's my understanding we're going to be
7 doing some screen sharing, and then maybe during a
8 break or lunch or whatever try to retrieve the
9 actual record, something along those lines.

10 MR. SHOGREN: Yes. If okay with everyone,
11 no one objects, we'll be just screen sharing the
12 IC's exhibits with Dr. Goz to reference.

13 HEARING OFFICER BURCHAM: As long as the
14 witness has access to the documents, to your
15 documents, that's great. We want to be able to make
16 sure that he sees them, and that everybody that's
17 online here knows exactly what the witness is
18 looking at.

19 Mr. Shogren, continue, please.

20 BY MR. SHOGREN:

21 Q. Dr. Goz, I want to refer you to Exhibit
22 10, premarked Exhibit 10.

23 MR. SHOGREN: And for the record, this
24 exhibit has already been admitted and it's now being
25 screen shared.

1 BY MR. SHOGREN:

2 Q. Dr. Goz, have you seen this document
3 before?

4 A. Yes.

5 Q. Does this document accurately summarize
6 your experience and education?

7 A. It does.

8 Q. Did you prepare this document?

9 A. Yes.

10 Q. Is there anything you'd like to add?

11 A. No.

12 Q. Is this document complete?

13 A. I believe so.

14 Q. Okay. And, Doctor, have you served as a
15 peer reviewer for the Board before?

16 A. I served as a peer reviewer for the Board
17 for a few years, a number -- I don't remember my
18 exact starting. It might be on the CV if you scroll
19 down.

20 Q. And how many cases have you reviewed for
21 the Board?

22 A. Maybe about five or six, if I had to
23 guess.

24 Q. Are you familiar with the Board's case
25 number 24-40539-1 regarding Dr. Schneier?

1 A. Yes.

2 Q. Based on your training and experience, do
3 you feel you're familiar with the standard of care
4 to which medical practitioners should be held
5 regarding the facts of this case?

6 A. Yes.

7 Q. Do you have experience in the subject
8 matter, after review, regarding the facts of the
9 case?

10 A. I do.

11 Q. Were you provided the material by the
12 Board in your review of this case?

13 A. Yes.

14 Q. Do you remember what was included in the
15 materials?

16 A. Broadly speaking, hospital records as well
17 as billing records, and imaging records as well as
18 images themselves.

19 Q. If could you turn to the IC's Exhibit 9.
20 Do you recognize this document?

21 A. I do.

22 Q. And what is this document?

23 A. It is a published manuscript that was used
24 as a reference in my report.

25 Q. Did you submit this article to the Board?

1 A. I did.

2 Q. And is this a true and correct copy of the
3 article you submitted to the Board?

4 A. Yes.

5 MR. SHOGREN: At this point, the IC moves
6 to admit Exhibit 9 into evidence.

7 HEARING OFFICER BURCHAM: Ms. Thomas?

8 MS. THOMAS: The relevance of the document
9 has not yet been established.

10 HEARING OFFICER BURCHAM: So the objection
11 is as to relevance?

12 MS. THOMAS: Yes.

13 HEARING OFFICER BURCHAM: Counsel,
14 Mr. Shogren?

15 BY MR. SHOGREN:

16 Q. Dr. Goz did you reference this article
17 when coming to your opinion on a case?

18 A. I did.

19 MR. SHOGREN: An offer that it is
20 relevant.

21 HEARING OFFICER BURCHAM: I looked at this
22 and I believe that -- let me ask the doctor a
23 question.

24 Do you believe that this is reliable
25 authority within the medical community?

1 THE WITNESS: Ask me that again?

2 HEARING OFFICER BURCHAM: Do you believe
3 that this article, "Prevalence of Wrong Level
4 Surgery Among Spine Surgeon," is a reliable
5 authority in the spinal medical community, spinal
6 surgeons?

7 THE WITNESS: A reliable what?

8 HEARING OFFICER BURCHAM: Authority.

9 THE WITNESS: Authority?

10 HEARING OFFICER BURCHAM: It's a reliable
11 authority?

12 And the reason I use that specific term is
13 that under learned treatise evidence under the
14 Nevada Revised Statute, it needs to be established
15 that this is a reliable authority. And I just want
16 to make sure, you used it for your report, do you
17 believe that it's a reliable authority?

18 THE WITNESS: I would say I'm not an
19 expert on what qualifies as a reliable authority.

20 HEARING OFFICER BURCHAM: Did you --

21 THE WITNESS: This is -- go ahead.

22 HEARING OFFICER BURCHAM: Did you rely on
23 it to some extent?

24 THE WITNESS: I used it as one of the data
25 points to generate my report.

1 HEARING OFFICER BURCHAM: All right.
2 It'll be admitted. Thank you.

3 (IC's Exhibit 9 was admitted.)

4 BY MR. SHOGREN:

5 Q. Dr. Goz, were you asked by the Board when
6 you're provided materials to make an objective
7 determination whether in your professional opinion
8 there was departure from the proper standards of
9 medical care by Dr. Schneier?

10 A. Yes, I was.

11 Q. What was your opinion?

12 A. That there was a departure from the
13 standard of care.

14 Q. And how did you come to this
15 determination?

16 A. After my thorough review of the medical
17 records.

18 Q. And can you briefly explain what the
19 departure was?

20 A. In my opinion, the departure from the
21 standard of care was failure to recognize the
22 wrong-level surgery over a prolonged period of time,
23 and failure to address that complication.

24 And I want to be clear in my opinion, you
25 know, I think the report is very clear that

1 wrong-level surgery is a well-documented
2 complication or potential risk of surgery,
3 especially at the thoracic spine, and while having
4 that complication in itself, in my opinion, is not
5 malpractice, it is the repeat failure to recognize
6 that complication and adjustment it in a timely
7 manner.

8 That constitutes departure from standard
9 of care, in my opinion.

10 Q. Okay. Thank you, Doctor.

11 I'm going to ask some more specific
12 questions with regards to the facts of this case by
13 going over some of the records that were admitted
14 previously. If you could turn to the IC's
15 Exhibit 3. First I would like to go to
16 Bates-stamped 54.

17 And also, Dr. Goz, I'd ask when we're
18 referring to the medical records that you not refer
19 to the patient's name on the record, that you
20 referred to the patient as "Patient A."

21 A. Okay.

22 Q. So for the record, this is Exhibit 3 which
23 was previously admitted as Patient A's medical
24 records from Sunrise Hospital.

25 On page 54, what does this document look

1 like to you?

2 A. It appears to be a history and physical
3 note from admission on 12/26/2019.

4 Q. And where did the patient present?

5 A. It appears Sunrise Hospital and Medical
6 Center.

7 Q. If you can just read into the record from
8 this page, what is the reason for admission?

9 A. "Left lower back pain."

10 Q. If you can read into the record the next
11 section, History of Present Illness?

12 A. "This is a pleasant, obese male who
13 presents to the E.R. complaining of worsening left
14 low back pain. Per the patient, he has been having
15 issues with inability to walk for last two months,
16 and today the pain got worse to the point that he
17 called his orthopedic surgeon, who told him to go to
18 the E.R. The patient also complained of mild
19 numbness and tingling in the legs."

20 Q. Okay. If we could turn to Bates-stamped
21 59.

22 Dr. Goz, what does this document look like
23 to you?

24 A. That looks like an MRI report from an MRI
25 of the lumbar spine performed on 12/27/2019.

1 Q. And if we can turn to page 60. Can you
2 read into the record the section called
3 "Impression," the first impression.

4 A. "The canal narrow at T11-12 with likely
5 cord edema at this level. Recommend
6 contrast-enhanced thoracic spine MRI."

7 Q. Based on your experience, why would a
8 thoracic spine MRI be recommended here?

9 A. A contrast-enhanced MRI provides some
10 additional detail in terms of whether there is any
11 inflammatory tissue present, it can be useful in the
12 setting of an infection or tumor. It can also help
13 delineate a little bit more in terms of the nature
14 of the cord edema that is noted.

15 Q. Okay. Now if we can turn to page 61, the
16 next page.

17 What does this document like to you?

18 A. MRI spine with and without contrast, this
19 is the thoracic spine performed on 12/30/2019.

20 Q. Backing up here, please, what is the
21 thoracic spine?

22 A. It's the mid portion of your back.

23 Q. What does a MRI do in this circumstance?

24 A. It's an imaging modality that's useful for
25 visualizing soft tissues.

1 In this case, specifically neurologic
2 structures that we use to look for stenosis or
3 narrowing of the spinal canal, any sort of damage or
4 compression of neurologic structures.

5 Q. If we could turn to the next page 62. If
6 you could read into the record the Impression.

7 A. "Mild T7-T8, mild T9-T10, mild T11-T12.
8 Severe T10-T11. Central canal stenosis without
9 normal cord signal at T10-T11 and possibly T7-T8."

10 HEARING OFFICER BURCHAM: Hey, Doctor,
11 this is the Hearing Officer, you need to, when
12 you're reading things, slow down. I heard the court
13 reporter going really fast.

14 So when you're reading a document, you
15 need to read it with a slower cadence so that we
16 don't miss anything. Okay?

17 THE WITNESS: Sounds great.

18 HEARING OFFICER BURCHAM: Thank you.

19 THE REPORTER: Thank you, Hearing Officer.

20 BY MR. SHOGREN:

21 Q. Okay. I just wanted to break down this
22 impression a little bit.

23 So, first of all, what is the reference
24 to, like, a T10-T11, what are those numbers?

25 A. They are the numbering of the thoracic

1 spine vertebra, the bones of the thoracic spine.

2 Q. So what number range is in the thoracic
3 spine?

4 A. From 1 to 12.

5 Q. And what is stenosis?

6 A. A narrowing of the nerve tunnel.

7 Q. And central canal stenosis, what is that
8 specifically?

9 A. Narrowing of the central tunnel where the
10 spinal cord resides.

11 Q. And what does the narrowing consist of?

12 A. It can vary. It can be a disc that's
13 bulging out, it can be thickening of the ligaments,
14 it can be bones spurs.

15 "Stenosis" is not a specific term to any
16 one particular pathology.

17 Q. And in your experience, have you treated
18 patients with stenosis?

19 A. I have.

20 Q. How many patients would you say you
21 treated with this condition?

22 A. Hundreds.

23 Q. And then on this Impression, there's
24 reference to an abnormal core signal. Could you
25 explain what that means?

1 A. That is evidence of bruising or damage of
2 the spinal cord, commonly referred to as
3 "myomalacia," basically evidence of damage to the
4 spinal cord.

5 Q. And there's also reference here to "severe
6 T10-T11 central canal stenosis," what makes it
7 severe?

8 A. The degree of narrowing. Typically severe
9 stenosis deforms the spinal cord without any fluid
10 remaining around it.

11 Q. And how is central canal stenosis usually
12 treated?

13 A. It depends on the patient's symptoms.

14 Q. And what are some typical symptoms of
15 stenosis?

16 A. It can range from completely asymptomatic
17 to severe neurologic deficits with weakness,
18 decreased sensation, balance issues. And in most of
19 the cases, bowel and bladder control issues.

20 Q. Are there any symptoms specific to, like,
21 a thoracic stenosis?

22 A. Generally, more diffused lower extremity
23 weakness can be accompanied by numbness, can be
24 accompanied by growing numbness, can be accompanied
25 by bowel and bladder control issues.

1 The severity is different from case by
2 case.

3 Q. In your experience, generally what happens
4 if thoracic spine stenosis is not treated?

5 A. If severe, symptomatic thoracic central
6 stenosis is not treated, that can lead to permanent
7 neurologic deficits.

8 Q. Can you expound on what that means, the
9 deficits?

10 A. Meaning that -- let's say someone has
11 severe stenosis but they don't have cord signal
12 change -- which I think is here -- and they don't
13 have any symptoms, in that case, it may be
14 appropriate to not treat the stenosis if there's no
15 symptoms associated with it.

16 However, in the case where there is severe
17 central stenosis and cord signal change indicating
18 some degree of damage to the spinal cord and
19 symptoms, which may include things like decreased
20 sensation, motor deficits, bowel and bladder control
21 issues, all the things that are previously named,
22 those may become permanent or some subsection of
23 that may become permanent if left untreated.

24 Q. In your opinion, how soon does stenosis in
25 this circumstances need to be treated after

1 recovery?

2 A. I think there's a bit of leeway in the
3 sense that there's not a clear answer to that in
4 terms of standard of care. In general, it should be
5 treated in a timely fashion.

6 And from literature on spinal cord injury,
7 or often traumatic spinal cord injury is associated
8 with some degree of pressure on the spinal cord, we
9 aim for within 48 hours. We know that people within
10 48 hours of a decompression do better than folks
11 that have a decompression more than 48 hours after
12 spinal cord injury.

13 That being said, you know, those things
14 are being applied to these settings and we don't
15 have a clear answer for timing, we just know that
16 probably sooner is better than later. The specific
17 timing of each case is up to the discretion of the
18 treating surgeon.

19 Q. Okay. I'm going to now turn to page 56 of
20 Exhibit 3.

21 Doctor, what does this document looks like
22 to you?

23 A. That looks like an operative report by
24 Dr. Schneier. Date of procedure is 12/31/2019.

25 Q. And what is the -- if you can read into

1 the record the Preoperative Diagnosis?

2 A. "Thoracic myelomalacia myelopathy with
3 spinal stenosis, T10-T11."

4 Q. If you can explain -- I don't think you
5 have before -- myelomalacia myelopathy, what that
6 is?

7 A. Myelomalacia is referring to increased
8 inflammation and edema or sort of increased fluid in
9 the spinal cord or increased inflammation, more
10 accurately, that correlates with the finding of the
11 increased signal noted on the MRI, or they may have
12 referred to it as "edema."

13 Myelopathy is a clinical condition that
14 basically describes spinal cord dysfunction.

15 Q. According to preoperative diagnosis, what
16 part of the body is this occurring?

17 A. T10-T11.

18 Q. If you look at the Procedure section,
19 could you read that into the record?

20 A. "Thoracic laminectomy T10-T11 for cord
21 decompression and use of intraoperative neuro
22 monitoring, use of intraoperative fluoroscopy with
23 pedicle screw fixation, T10-T11, with onlay lateral
24 transfer of fusion with allograft autographed bone
25 fusion."

1 Q. If you can break that down a little bit.
2 What is a thoracic laminectomy?

3 A. That is referring to removing the lamina,
4 which is a bony proportion of the spinal canal, to
5 take the pressure off the spinal cord.

6 Q. Is this a common procedure in your
7 experience?

8 A. Yes.

9 Q. Is this a common procedure to treat the
10 preoperative diagnosis as described here?

11 A. It is.

12 Q. And moving on here, there's mention of a
13 "pedicle screw fixation," could you explain what
14 that is?

15 A. Use of screws and rods to perform a
16 fusion.

17 Q. Is it common for this to accompany the
18 laminectomy?

19 A. Yes.

20 Q. And what is the purpose of the fusion?

21 A. If a surgeon believes that the required
22 decompression, or laminectomy, would be so wide that
23 it may destabilize the spine, then that surgeon,
24 commonly, will perform a fusion at the same time as
25 the laminectomy.

1 It allows the surgeon to perform a wider
2 decompression of the spinal canal.

3 Q. And to be clear, can you explain what
4 decompression means?

5 A. Removing bones, ligaments that are leading
6 to the stenosis and thereby widening the nerve
7 tunnel.

8 Q. Okay. And in this report there's
9 mentioned of the T10-T11, we've established that is
10 the area of the spine; is that correct?

11 A. That's correct.

12 Q. So as part of the preoperative diagnosis,
13 how is the area determined?

14 A. Tell me more about what you're asking.

15 Q. How does a spinal surgeon determine what
16 area needs to be worked on?

17 A. Based on a combination of the patient's
18 clinical symptoms and the MRI or advanced imaging
19 findings.

20 Q. In your opinion, is the operative report
21 in agreement with the MRI previously reviewed from
22 12/30 --

23 A. Yes.

24 Q. -- on December 30th?

25 A. Yes.

1 MS. THOMAS: Objection to form -- I'm
2 sorry. What date did you say?

3 MR. SHOGREN: December 30th, 2019.

4 HEARING OFFICER BURCHAM: Counsel, why
5 don't you try that -- start over again. There was
6 an objection and then there was a lot of silence.

7 Can you ask the question or have the court
8 reporter read it back?

9 MR. SHOGREN: I'm sorry you're cutting
10 out. I apologize. It's probably on my end. We're
11 you asking me to restate the question?

12 HEARING OFFICER BURCHAM: Yes. Or have
13 the court reporter read it back.

14 MR. SHOGREN: I was asking: The
15 preoperative diagnosis from Dr. Schneier's operative
16 report, is that an agreement with the MRI impression
17 from December 30, 2019?

18 HEARING OFFICER BURCHAM: Go ahead,
19 Doctor.

20 THE WITNESS: Yes, it is.

21 BY MR. SHOGREN:

22 Q. Okay. Now if we can turn to Exhibit 3,
23 Bates-stamped 24.

24 Dr. Goz, what does this document look like
25 to you?

1 A. It looks like a note from the emergency
2 department, and the note is dated 1/22/2020.

3 Q. And how many pages does this document
4 appear to consist of?

5 A. It says "page 1 of 13" at the bottom
6 there, so I'm assuming 13.

7 Q. To be clear, who are these records for?

8 A. Can you clarify that question for me?

9 Q. Are these records for Patient A?

10 A. Yes.

11 Q. If you can read into the record the
12 section titled "HPI Note"?

13 A. "A 49-year-old male presented to the E.D.
14 complaining of left hip pain for nine days. Patient
15 recently had back surgery on 12/31/2019, and left
16 hip surgery on 1/9/2020. Reports back pain and
17 diaphoresis. Patient has had difficulty walking.
18 Patient is unable to straighten his left leg due to
19 spasms. Patient denies other symptoms at this
20 time."

21 Q. If you could turn to page 31. If you
22 could read into record under the section Hospital
23 Reports, the third paragraph, starting with "Patient
24 underwent"?

25 A. "Patient underwent T10-T11 laminectomy

1 cord decompression, pedicle screws fixation on light
2 fusion on 12/31/2019. Patient complained of left
3 lower extremity pain. Neurosurgery evaluated the
4 patient on 1/2/2020. Recommended baclofen for
5 muscle spasm and Decadron on tapering doses.
6 Neurosurgery cleared the patient for skilled nursing
7 facility. Okay to shower and get incision wet, pat
8 dry. Patient continued to complain of left hip
9 pain. X-ray done, and it showed posterior superior
10 dislocation of the femoral head. Patient has had
11 left hip total arthroplasty done under
12 Dr. Silverberg on 6/28/2018."

13 Q. Dr. Goz, thank you. That's all to read
14 into record there. Thank you.

15 Now if we can turn to page 35. Could you
16 just briefly read what the Clinical Impression on
17 the top of this page?

18 A. "Primary impression, back pain. Secondary
19 impression, focal neurologic deficit, post-op pain,
20 seroma."

21 Q. Can you explain what "seroma" means?

22 A. A collection of postoperative -- typically
23 postoperative fluid.

24 Q. Now can you turn to page 52 of Exhibit 3.
25 Dr. Goz, what does this document appear to be?

1 A. This appears to be a report of the CT
2 thoracic spine without contrast, dated 1/22/2020.

3 Q. And it's a CT for Patient A?

4 A. Correct.

5 Q. What is the difference between, like, a CT
6 thoracic spine and the MRI thoracic spine?

7 A. From a clinical standpoint, a CT is better
8 at showing bony structures, whereas an MRI is better
9 at showing soft tissues such as nerves.

10 Q. Okay. If you can read into the record
11 from this page, the History section.

12 A. "History: Bilateral lower extremity
13 spasticity, increased back pain after surgery,
14 recent spinal surgery at 12/31/2019, tenderness to
15 palpitation at approximately T6-T7."

16 Q. And if could you read into the record the
17 Comparison section.

18 A. "Comparison: MRI of the thoracic spine
19 dated 12/30/2019, intraoperative fluoroscopic spot
20 images of the lower thoracic spine dated
21 12/31/2019."

22 Q. If you can read into the record at the
23 bottom, the Impression section?

24 A. "Interval laminectomy at T9 and T10 with a
25 unilateral left-sided pedicle screw and rod

1 construct, the left T9 screw reaches the medial."

2 Q. If you can continue on the bottom of the
3 page and continue reading?

4 A. "Medial cortex of the left T9 pedicle,
5 approximately 50 percent of the width of the screw
6 projects into the lateral aspect of the central
7 canal at T9. Partially visualized, small
8 simple-appearing postoperative fluid collection
9 favor a small seroma."

10 Q. So going back to page 52, can you explain
11 what "interval laminectomy" means?

12 A. That relative to the comparison study, a
13 laminectomy or decompression was performed.

14 Q. According to this impression, where were
15 the laminectomies performed?

16 A. T9-T10.

17 Q. In this record, is there any mention of
18 the a laminectomy being performed at the T10-T11?

19 A. There is not.

20 Q. In your opinion, does this CT report
21 differ from Dr. Schneier's postoperative analysis
22 from December 31, 2019?

23 A. It does.

24 Q. In your opinion, how does it differ?

25 A. Dr. Schneier's operative report indicated

1 a T10-T11 laminectomy, whereas this report indicates
2 the laminectomy was performed at T9-T10.

3 Q. And, generally, how does -- a professional
4 that interprets the CT, how do they determine where
5 the laminectomy is?

6 A. It's fairly evident on the CT as an area
7 of bone that has been removed.

8 Q. In your opinion, it's fairly easy to
9 determined based off of a CT or MRI where the
10 laminectomy was done?

11 A. Yes.

12 Q. Dr. Goz, if can you turn to Exhibit 2.
13 Dr. Goz, are you familiar with this
14 document?

15 A. Yes.

16 Q. Were you provided this document in your
17 review of the standards?

18 A. I was.

19 Q. And what does this document appear to be?

20 A. It appears to be Dr. Schneier's response
21 to the Board.

22 Q. If you can turn to page 20.

23 If you can read into the record this
24 section -- although there's mention of the patient's
25 name, if you can just replace the patient's name

1 with "Patient A," and read that into the record?

2 A. "I, Michael Schneier, M.D., have reviewed
3 the response to the allegations made against me, to
4 confirm that the response is a true and accurate
5 representation of the care provided to Patient A,
6 and adopt the responses as though fully set forth by
7 my own hand."

8 Q. Now if we can go back to page 13 of
9 Exhibit 2.

10 If you can just read into the record
11 starting with the third paragraph, but there is also
12 mention of the patient's name, please replace with
13 "Patient A" whenever he is referred to.

14 A. "Patient A returned to the hospital on
15 January 22, 2020. An E.D. physician, Norland
16 Maltez, describes bilateral lower extremity
17 spasticity, left greater than the right, with normal
18 muscle strength and sensation. He noted that it is
19 possible pedicle screw breach and that Dr. Schneier
20 was contacted. Dr. Schneier prepared his
21 consultation report on the morning of January 23,
22 2020.

23 "In that report, he noted that Patient A
24 was status post-thoracic laminectomy and pedicle
25 screw replacement, T9-T10, with laminectomy

1 extending into the T10-T11 disc space.

2 "The patient now complained of left lower
3 extremity pain with a restriction in the extension.
4 The patient has no sensory deficits, no motor
5 deficits, and normal bowel and bladder control.

6 "Dr. Schneier noted that he reviewed the
7 CT scan, found no CSF extravasation, and the thecal
8 sac was not impinged. He planned to take Patient A
9 to surgery, remove the screws, and get a further MRI
10 without the" --

11 Q. Thank you, Doctor. That's all for that
12 section.

13 Now if you can turn back to the Exhibit 3,
14 page 49. What does this document look like to you?

15 A. This is an operative report of procedure
16 performed on -- let's see. Actually, the date of
17 the procedure is missing. The surgeon is Dr.
18 Schneier.

19 Q. If we can to to page 51 in this exhibit.
20 What does this document appear to be?

21 A. This appears to be brief operative note,
22 from an operative report dated 1/23/2020.

23 Q. And what is the surgery date and time
24 listed as?

25 A. 1/23/2020, 12:15.

1 Q. If you can turn back to page 49 and read
2 into the record what the preoperative diagnosis is?

3 A. "Question of T9 medial pedicle screw or
4 medial breach of the T9 pedicle with the pedicle
5 screw."

6 Q. And what is the procedure listed as?

7 A. Removal of T9-T10 pedicle screw, screw
8 lock implant.

9 Q. And if you explain what the "T9-T10
10 pedicle screw" means?

11 A. The screws that were previously implanted,
12 as well as the rods, were taken out.

13 Q. Is it a common procedure in your
14 experience?

15 A. It is.

16 Q. If you can read into the record the
17 Finding section.

18 A. "Medial wall pedicle intact with ball-tip
19 palpation T9, T10. No CSF leak noted with
20 valsalva."

21 Q. Can explain what the procedure was on this
22 page?

23 A. So Dr. Schneier removed the previously
24 placed pedicle screws. He felt the tract of the
25 pedicle screws -- meaning the hole that they were

1 placed in -- and in the findings, he notes that the
2 medial wall -- meaning the wall of the -- it's the
3 bony structure that's right next to the spinal cord
4 is basically the barrier between the bony pedicle,
5 which is where the screw should be placed, and the
6 canal, which we do not want to place the screw into
7 because at risks spinal cord injury -- he notes that
8 it was intact when he felt it with a ball-tip probe,
9 implying that the screw was not too medial, as the
10 CT scan implied.

11 Q. At this point on January 23, 2020, did Dr.
12 Schneier, in your opinion, depart from the standard
13 of care in regard to Patient A?

14 A. Yes, I believe so.

15 Q. Can you explain why?

16 A. At this point, the patient seems to be not
17 doing well, continues to have symptoms of
18 myelopathy, spinal cord dysfunction. One of those
19 symptoms, as I mentioned previous, is sort of issues
20 with lower extremities that can be motor deficits,
21 such as weakness, can be spasticity or increased
22 muscle tone.

23 And this was worked up with a CAT scan,
24 and that CAT scan indicated that there may be a
25 wrong-level surgery that was performed. And,

1 ostensibly, if the decompression was performed at
2 the wrong level, the appropriate intervention would
3 be to extend that laminectomy or to do a
4 decompression at the correct level where the area of
5 the stenosis is.

6 But instead of doing that, a removal of
7 hardware was performed.

8 Q. Can you explain what "extending the
9 laminectomy" means?

10 A. Meaning, if the stenosis or the
11 significant compression of the spinal cord is at
12 what we're calling the T10-T11 level and the
13 decompression is performed T9-T10, the appropriate
14 solution would be to extend the decompression
15 inferiorly, taking the rest of the T10 lamina and
16 the superior aspect of the T11 lamina in order to
17 address the area of stenosis.

18 Q. At this point I want to go back to
19 Exhibit 2, and just for the record, Dr. Goz, what
20 does this exhibit consist of?

21 A. This is a letter to Ms. LaRue.

22 Q. If could you read the second paragraph --
23 the first sentence of the second paragraph on
24 page 14? Sorry. "On February 4."

25 A. "On February 4, 2020, an MRI interpreted

1 by Dr. Julian Hardman describe postoperative changes
2 from laminectomy at T9 and T10 with the removal of
3 hardware, and severe stenosis" -- excuse me --
4 "severe canal stenosis at T10-T11, secondary to disc
5 protrusion and scar tissue from laminectomy at T10.
6 It must be noted that" --

7 Q. Thank you, Doctor, just the first --

8 A. Sorry.

9 Q. Continue to read the next paragraph, third
10 paragraph of the page.

11 A. The one starting with "Dr. Schneier's"?

12 Q. Yes.

13 A. "Dr. Schneier's progress note on
14 February 4, 2020, records that the patient was being
15 evaluated for inpatient rehabilitation, but had to
16 be able to perform three hours per day to meet
17 criteria.

18 "He noted that a thoracic MRI done that
19 day did not show signal edema, like the initial
20 12/31 MRI did. There was no evidence of
21 post-laminectomy spondylolisthesis or a CSF leak.
22 There was five out of five strength in all major
23 muscle groups at the lower extremities, but Patient
24 A continued to hold his left leg flex at the knee
25 and claimed he was unable to perform knee

1 extension."

2 Q. Can you read into the record the next
3 paragraph?

4 A. "A discharge summary was prepared on
5 February 10, 2020 by Doctor Saleem Assad, who noted
6 that Patient A continued to report back spasms and
7 remained weak. He was awaiting placement at a
8 skilled nursing facility which occurred on
9 February 16, 2020."

10 Q. In your opinion, based off of
11 Dr. Schneier's representations to the Board, as of
12 February 4, 2022, did Dr. Schneier depart from the
13 standard of care regarding Patient A?

14 A. I believe he did.

15 Q. Can you explain why?

16 A. At this point, there are multiple imaging
17 studies that indicate a wrong-level surgery was
18 performed and there's continued severe canal
19 stenosis that appears to be symptomatic, and Dr.
20 Schneier did not address the continued stenosis.

21 Q. Okay. If we can now turn to IC's Exhibit
22 5, page 66.

23 Dr. Goz, what does this exhibit appear to
24 be?

25 A. This appears to be part of a note for a

1 neurological consultation.

2 Q. Is there a date on this record?

3 A. April 30, 2020.

4 Q. Could you read the first Impression on
5 page 66?

6 A. "Weakness in the lower extremities
7 associated with tightness and spasm in the distal
8 legs and feet in a patient diagnosed with thoracic
9 myelomalacia, status post T10-T11 laminectomy,
10 December 2019, with a revision in January of 2020 at
11 Sunrise Hospital by Dr. Schneier. Limited
12 database."

13 Q. Okay. If you can read into the record the
14 Impression on page 66?

15 A. "Repeat MRI of the thoracic spine with and
16 without contrast after thoracic surgery and a
17 revision states, per verbatim, 'Persistent cord
18 compression to an AP diameter of 5 millimeters at
19 T10-T11, persistent abnormal T2 hyperintensity in
20 the cord. Decompression is similar in severity to
21 the prior MRI on February 4, 2020. Ventral CSF is
22 effaced by fluid, probable postoperative blood
23 product. Dorsal CSF appears effaced by enhancing
24 granulation tissue.' The patient denies loss of
25 bladder control or saddle anesthesia."

1 Q. Okay. And if we can turn to page 74, of
2 Exhibit 5.

3 Dr. Goz, what is this document appear to
4 be?

5 A. This appears to be an MRI report from an
6 MRI of the thoracic spine dated 5/13/2020.

7 Q. What is the Impression listed on this
8 document?

9 A. "Severe spondylotic degenerative changes
10 with severe central spinal stenosis at T10-T11, and
11 moderate central stenosis at T9-T10. AP diameter at
12 the T10-T11 level is 6 millimeters."

13 Q. Can you explain the severe -- and how do
14 you pronounce that?

15 A. Spondylotic degenerative changes.

16 Q. What does that mean?

17 A. Severe -- degenerative changes are wear
18 and tear or arthritis-related changes.

19 Q. Now, lastly, Dr. Goz, if you could turn to
20 Exhibit 8, page 95?

21 MS. THOMAS: I'm sorry. What was that?

22 MR. SHOGREN: Bates-stamped page 95 of
23 Exhibit 8, previously admitted.

24 BY MR. SHOGREN:

25 Q. And, Dr. Goz, on this page, 95, what does

1 this document look like to you?

2 A. This appears to be an operative report by
3 Dr. Khavkin dated June 6, 2020.

4 Q. And what is the date of surgery listed?

5 A. June 5, 2020.

6 Q. What is the preoperative diagnosis?

7 A. Spinal cord compression, thoracic
8 stenosis.

9 Q. And if you could just read into the record
10 the first three sentences of the Indication section?

11 A. "Patient is a 49-year-old gentleman who
12 presents with progressively worsening weakness and
13 inability to walk. The patient is thought to have a
14 severe spinal cord compression at the T10-T11 level.
15 The patient was told previously that this level was
16 addressed by another surgeon at his previous
17 surgery, but, unfortunately, the surgery that he had
18 was performed at the level above, and they were --
19 blank -- the patient's pathology, which resulted in
20 significant and worsening of his condition."

21 Q. Okay. If you could turn to page 97.

22 What does this document appear to be?

23 A. This is a note from Dr. Khavkin, and the
24 note is dated -- I want to say this -- this is dated
25 8/26/2020.

1 Q. What does the History of Presenting
2 Illness state?

3 A. "Patient presents for a follow-up. He
4 reports significant improvement of his symptoms, and
5 he says that his leg strength has gotten
6 significantly better. He is now able to stand on
7 its own, which he was not able to do prior to the
8 surgery."

9 Q. And what does the next sentence state?

10 A. "And his main complaint is the spasms in
11 the lower extremities."

12 Q. Okay. And so, Dr. Goz, after reviewing
13 records here on this case, would you opine that Dr.
14 Schneier committed malpractice?

15 A. I would.

16 MS. THOMAS: Objection. Calls for a legal
17 conclusion.

18 HEARING OFFICER BURCHAM: Overruled.

19 BY MR. SHOGREN:

20 Q. Can you explain why you believe this?

21 A. It is the delay in both identifying the
22 complication of the surgery and the delay in
23 appropriately addressing that complication that I
24 believe fell below the standard of care.

25 I want to be clear that I don't think that

1 a single episode of wrong-level surgery, if
2 identified in a timely fashion and addressed,
3 constitutes malpractice. But failing to identify
4 the wrong level of surgery that was performed and
5 the continued severe stenosis at T10-T11, which then
6 led to a delay in the appropriate decompression is
7 what, in my opinion, falls below the standard of
8 care.

9 Q. And in your opinion, when should Dr.
10 Schneier have identified this?

11 A. It's hard for me to give you an exact --
12 an exact time frame, but I think with this clinical
13 picture, ideally, it would have been identified, at
14 the very least, when that postoperative CT scan
15 identified a likely wrong-level surgery.

16 Q. And what CT scan are you referring to?

17 A. That was the CT scan that was performed --
18 it was probably on January 22, 2020, it was that
19 readmission after the initial surgery.

20 Q. In your opinion, after the January 22 --
21 sorry -- January 23rd surgery, were there any other
22 times Dr. Schneier should have addressed the
23 patient's stenosis?

24 A. I believe there were at least two other
25 MRIs that were performed that identified continued

1 severe stenosis at the T10-T11 level, and those were
2 opportunities to then address the continued
3 stenosis.

4 Q. And in your opinion, were Dr. Schneier's
5 records -- were they complete?

6 A. Yes, I think the records are appropriate.

7 MR. SHOGREN: I have no further questions.

8 HEARING OFFICER BURCHAM: Cross-exam?

9 MS. THOMAS: We're about an hour past the
10 point that we wanted to take a break. Can we do a
11 ten-minute break?

12 HEARING OFFICER BURCHAM: Yeah, we can. I
13 kind of assumed that the break we took to, you know,
14 figure out the technical stuff, that's why I didn't
15 stop, but absolutely.

16 Let's take -- what do you want to take,
17 Ms. Thomas, five minutes, ten minutes?

18 MS. THOMAS: Sure. Why don't we split it
19 and go seven.

20 HEARING OFFICER BURCHAM: Great. 11:32
21 and 30 seconds. All right. Off the record.

22 (Recess 11:25 A.M. to 11:33 A.M.)

23 HEARING OFFICER BURCHAM: We're back on
24 the record, and let's head off, Ms. Thomas, with
25 cross-exam.

1 CROSS-EXAMINATION

2 BY MS. THOMAS:

3 Q. Dr. Goz, were you present earlier when we
4 were asking questions of Ms. LaRue?

5 A. No.

6 Q. Okay. She indicated that she provided you
7 the records that you reviewed in this case. Is that
8 true?

9 A. Yes.

10 Q. Okay. Will you please list for me
11 everything you received?

12 A. All right. Allegation; response, which I
13 believe the response is Dr. Schneier's response to
14 the allegation; Apex Medical Center records; API
15 Physical Therapy records; Clinical Neurology and
16 Associates records; Desert Radiologist records; Dr.
17 Khavkin's records; Harmon Hospital records; Horizon
18 Health and Rehab Center records; Machuca Family at
19 Jones records; Nevada Pain Center records; Silver
20 State Orthopedics records; Spring Valley records;
21 UMC records; Sunrise Hospital records; Morrison
22 Hospital records; and I believe -- give me one
23 second, yep, and and a number of imaging studies.

24 Do you want me list the imaging studies?
25 There's a lot of them.

1 Q. Sure.

2 A. CT thoracic spine, 6/6/2020; X-ray chest,
3 6/5/2020; ultrasound guided intraoperative,
4 6/5/2020; X-ray spine, one view, 6/5/2020; MRI
5 thoracic spine, 6/4/2020; IR vertebroplasty,
6 6/4/2020; X-ray, chest, 6/4/2020; MRI at lumbar
7 spine, 6/1/2020; X-ray, chest, 1/17/2019; MRI,
8 lumbar spine, 1/16/2019; ultrasound, lower extremity
9 venous duplex bilateral, 1/15/2019; X-ray, pelvis,
10 one or two views, 1/15/2019; CT, spine lumbar,
11 1/15/2019; CT, abdomen, 5/13/2019; X-ray, hip,
12 3/11/2020; X-ray, left hip, 3/11/2020; abdomen, AP
13 only, 3/11/2020; X-ray, thoracic, 3/11/2020; X-ray,
14 lumbar, 3/11/2020; MRI, thoracic spine, 2/15/2020;
15 MRI, thoracic spine, 2/4/2020; MRI, joint left
16 without contrast, 1/29/2020; left knee X-ray,
17 1/25/2020. Thoracic spine X-rays, 1/23/2020; X-ray,
18 left hip, 1/23/2020; X-ray, left hip, 1/22/2020; CT,
19 Thoracic spine, 1/22/2020; AP, chest, 1/22/2020; AP
20 1/10/2020; CT, pelvis, 1/8/2020; X-ray, left hip,
21 1/7/2020; X-ray, left hip, 1/5/2020; abdomen, AP
22 only, 1/4/2020; X-ray, left hip, 1/3/2020; AP,
23 portable, 1/3/2020; MRI, lumbar spine, 12/31/2019;
24 MRI, thoracic spine, 12/30/2019; MRI, lumbar spine,
25 12/27/2019; X-ray, hip, 12/26/2019; lumbar spine

1 X-ray, 10/8/2019; X-ray, hip -- same one, apologize
2 -- left foot X-ray 6/5/2019; LS AP, 2/27/2019; and
3 X-ray, hip -- no, sorry -- X-ray, chest, 10/23/2019;
4 X-ray, right knee, 10/21/2019, X-ray, left knee,
5 10/21/2019; and X-ray, bilateral hip 10/21/2019.

6 Q. Was the only person that provided you
7 records or documents in this case Ms. LaRue?

8 A. I can't say for certain.

9 Q. And why is that?

10 A. Because I don't recall.

11 Q. So did you receive records on the more
12 than one occasion?

13 A. I'm not sure. Because this review was a
14 little while ago, I don't remember the exact
15 mechanics of who gave me the records.

16 I know that Ms. LaRue was a person that
17 gave me records. I don't recall whether there were
18 other folks that also provided records to me. I
19 can't give you those details, to the best of my
20 recollection.

21 Q. Did all records and documents you received
22 come from somebody at the Medical Board?

23 A. Yes.

24 Q. Ms. LaRue testified that she provided you
25 with the community complaint that initiated the

1 investigation in this action. You didn't list that
2 as one of the documents.

3 MR. SHOGREN: Objection. Misstating -- I
4 don't believe Ms. LaRue testified to that.

5 MS. THOMAS: She absolutely did, and the
6 hearing officer told me to canvass this issue with
7 the witness instead of continuing to pursue it with
8 Ms. LaRue.

9 HEARING OFFICER BURCHAM: You mentioned
10 "community" --

11 MR. SHOGREN: I --

12 HEARING OFFICER BURCHAM: Hang on.

13 You mentioned "community complaint," I
14 think was the phrase that you used, which I don't
15 recall that phrase being used in any previous
16 testimony or even questions.

17 MS. THOMAS: When I say "community
18 complaint" -- I do not know the identification of
19 the complainant, whether it is a patient or a
20 provider -- I mean that it came from the community,
21 that it was not generated by the Board. It's a term
22 of art, formal complaint that initiated these formal
23 proceedings.

24 HEARING OFFICER BURCHAM: Okay. And your
25 specific question is what?

1 MS. THOMAS: That she testified to
2 providing this document to Dr. Goz as part of the
3 records that he received for his review, and I
4 wanted to know why he didn't mention that when I
5 asked him to identify everything he had been
6 provided for his review.

7 HEARING OFFICER BURCHAM: So that's a --
8 you ask -- the specific question is: Why he did not
9 mention in his list of materials provided from the
10 Board that document or documents?

11 MS. THOMAS: Correct.

12 HEARING OFFICER BURCHAM: Mr. Shogren, on
13 that specific question, without getting into the
14 details of anything, do you have an objection to
15 that question?

16 MR. SHOGREN: I don't believe that Ms.
17 LaRue testified that she provided a complaint.

18 HEARING OFFICER BURCHAM: Okay. I'm going
19 to allow, to the extent that the witness understands
20 the question, without going into any details, any
21 substance, any identifying information, or anything
22 else on that document, if he knows, number one, what
23 the document is, yes or no, and number two, why that
24 wasn't listed. Okay?

25 THE WITNESS: I'm not sure what you're

1 referring to when you say "community complaint."

2 BY MS. THOMAS:

3 Q. Any complaint regarding Dr. Schneider's
4 care?

5 A. If you were to bring up a document, I'd be
6 happy to tell you if I have seen it as part of my
7 review.

8 Q. Do you have a document complaining about
9 Dr. Schneider's care in the materials you received
10 for review?

11 A. As part of the allegation response
12 document, the original letter that is sent to Dr.
13 Schneider by the Nevada State Board of Medical
14 Examiners is included in that document.

15 Q. And do you have a document from a patient
16 or outside health care provider complaining about
17 Dr. Schneider's care in this case?

18 A. I'm not sure. You'd have to show me the
19 document and I could tell you if I have seen it or
20 not.

21 Q. I'd like you to check your job file and
22 tell me what you have.

23 A. There are thousands of pages. I can't
24 effectively do that at the moment.

25 Q. I need you to do that in order to provide

1 Dr. Schneier with a full and fair, meaningful
2 opportunity to be heard today.

3 A. So you want me to repeat -- or review the
4 entire file?

5 MR. SHOGREN: I'm going to object.

6 HEARING OFFICER BURCHAM: Mr. Shogren --

7 MR. SHOGREN: I believe Ms. Thomas asked
8 and Dr. Goz specified what records he looked at.

9 MS. THOMAS: He cannot confirm --

10 HEARING OFFICER BURCHAM: Ms. Thomas,
11 you're asking the doctor whether or not in whatever
12 material -- which sounds fairly extensive -- that he
13 has received that it included the community
14 complaint? Whatever that term, however we define
15 that term.

16 MS. THOMAS: A complaint from a patient or
17 on a patient's behalf or from a medical provider on
18 a form provided by the Board, or similar to the
19 same, for filing or lodging of a complaint about
20 care provided by Dr. Schneier.

21 HEARING OFFICER BURCHAM: Mr. Shogren,
22 your position is? Just on that narrow question of
23 whether that was provided.

24 MR. SHOGREN: Well, I'm saying I think Dr.
25 Goz answered what records he has been provided

1 thoroughly. He listed everything.

2 HEARING OFFICER BURCHAM: And Ms.

3 Thomas --

4 MS. THOMAS: My response --

5 HEARING OFFICER BURCHAM: Hang on a
6 second. I just want to understand the parameters of
7 the discussion here.

8 The witness has indicated that there's,
9 perhaps, thousands of pages of material.

10 MS. THOMAS: I understand that. However,
11 Ms. LaRue testified that the complaint was provided
12 to Dr. Goz. I went -- or attempted to go down the
13 path of asking questions about that, you asked me to
14 table those questions and resume them with Dr. Goz,
15 and I agreed.

16 HEARING OFFICER BURCHAM: And you have
17 certainly done that, and we've gone down that path
18 to an extent.

19 The position of the IC, as I understand
20 it, regarding any of that material that would be
21 contained in the community complaint, quote/unquote
22 community complaint, would be subject to the
23 confidentiality provisions of the rules.

24 Is that correct, Mr. Shogren?

25 MR. SHOGREN: Yes.

1 HEARING OFFICER BURCHAM: Yes?

2 MR. SHOGREN: That is correct.

3 MS. THOMAS: And our position is that by
4 providing that document to someone who is not a
5 member of the IC and who is hired specifically to
6 offer opinions that Dr. Schneier committed
7 malpractice and violated the standard of care, is
8 not an employee of the Medical Board, that
9 protection and that privilege has been waived.

10 You cannot disseminate the document to a
11 third party and then attempt to preclude
12 dissemination to Dr. Schneier, you can't
13 collectively assert privilege or confidentiality.

14 HEARING OFFICER BURCHAM: Mr. Shogren, it
15 sounds like counsel is making some sort of a waiver
16 argument. Do you have a position on that?

17 MR. SHOGREN: Sorry. You were cutting out
18 there. I did not hear --

19 HEARING OFFICER BURCHAM: It sounds like
20 Ms. Thomas is making an argument that the
21 confidential nature of the -- of whatever this
22 complaint is, was, essentially, waived by giving it
23 to Dr. Goz.

24 Am I stating that generally correct, Ms.
25 Thomas?

1 MS. THOMAS: Yes.

2 HEARING OFFICER BURCHAM: And,
3 Mr. Shogren, waiver, if it had been provided.

4 MR. SHOGREN: All documents and other
5 information that's part of the investigative file
6 that's not disclosed in the prehearing disclosure is
7 confidential.

8 HEARING OFFICER BURCHAM: All right.
9 Here's what we're going to do: We're not going to
10 delay these proceedings having Mr. -- or having the
11 doctor go through everything, especially based upon
12 what Mr. Shogren just indicated.

13 I don't believe that that material that's
14 being referenced was not in any of the prehearing
15 disclosures. I am cognizant of the private and
16 confidential nature of these investigations.

17 As a result of that, I am going to sustain
18 an objection to the extent -- to the extent I
19 understand it after our discussion regarding this
20 particular -- what's been termed a "community
21 complaint," and whether or not it is in Dr. Goz's
22 file, and more importantly, whether or not he ever
23 reviewed it.

24 For the record, he has testified
25 extensively about the materials that he -- medical

1 materials that he did receive, and, therefore, the
2 objection, to the extent that I understand it, is
3 going to be sustained.

4 Ms. Thomas, please carry on with your
5 cross.

6 MS. THOMAS: For the record, we would like
7 to strike the testimony of Dr. Goz. Anything
8 reviewed by an expert must be disclosed to the other
9 side out of fairness.

10 I understand you have overruled my
11 objection, but we are preserving that for the
12 record.

13 And we would request that, during a break,
14 we be provided, via email, a copy of any document
15 sent to Dr. Goz that have not been disclosed by the
16 Medical Board.

17 HEARING OFFICER BURCHAM: Okay. Your
18 comments are noted on the record. Please continue.

19 BY MS. THOMAS:

20 Q. Did you prepare more than one report in
21 this case?

22 A. No. I just prepared one report.

23 Q. Did you revise that report?

24 A. I have not revised the report.

25 Q. What is the report dated?

1 A. Let me take a look.

2 (Witness reviewed document.)

3 THE WITNESS: I do not believe it's dated.

4 BY MS. THOMAS:

5 Q. When did you provide it to the Board?

6 A. It would be in -- around late April of
7 2023.

8 Q. How many pages?

9 A. Three pages.

10 Q. Did you have any conversations with anyone
11 from the Medical Board prior to drafting or
12 finalizing your report?

13 A. Besides the initial conversation engaging
14 me as an expert or as a reviewer, aside from that
15 initial conversation, no additional conversations
16 took place.

17 MS. THOMAS: I would ask that the witness
18 transmit the report to me via email so that we could
19 go over it.

20 HEARING OFFICER BURCHAM: Mr. Shogren?

21 MR. SHOGREN: I object to that request.

22 HEARING OFFICER BURCHAM: Based upon? For
23 the record, based upon, please. Basis for the
24 objection for the record?

25 MR. SHOGREN: Anything that's part of the

1 investigative file in this case that wasn't
2 disclosed by the IC for prehearing disclosure is
3 confidential.

4 MS. THOMAS: The IC generated documents.
5 This is a document setting forth the opinions of
6 this expert that was not directed or influenced by
7 the Board in any way, and, therefore, for purposes
8 of providing Dr. Schneier a meaningful opportunity
9 to be heard today, this evidence must be disclosed
10 or this witness should be stricken.

11 MR. SHOGREN: As I stated, it's part of
12 the investigative file, this is a well-tread issue,
13 this has been addressed, there's multiple cases in
14 Second Judicial District Court about the
15 confidentiality of the investigative file, and it's
16 been found in the Boards's favor that any documents
17 that are not part of the prehearing disclosures are
18 confidential.

19 HEARING OFFICER BURCHAM: I'm going to
20 sustain the objection.

21 Ms. Thomas, the issue is preserved for the
22 record, I think, adequately. Can we move on?

23 MS. THOMAS: Yes.

24 BY MS. THOMAS:

25 Q. Dr. Goz, please read your report onto the

1 record.

2 MR. SHOGREN: I object to that question.

3 HEARING OFFICER BURCHAM: Sustained.

4 BY MS. THOMAS:

5 Q. Are there opinions contained in your
6 report that you have not provided today?

7 A. No. The report reflects the opinions that
8 I discussed today.

9 Q. Have you provided any opinions today that
10 are not in your report?

11 A. I don't believe so. The general meaning
12 and the general interpretation are consistent.

13 Q. Have you referenced your report during
14 your testimony today?

15 A. Yes.

16 Q. More than once?

17 A. Yes.

18 Q. Did you rely on your report to testify
19 today?

20 A. Can you define the difference between
21 "rely" and "reference"?

22 Q. Would you have been able to testify
23 without looking at the contents of your report?

24 A. Would I have been able to give a
25 testimony?

1 Q. Would you have been able to answer all of
2 Mr. Shogren's questions without looking at your
3 report?

4 A. I would have been able to provide an
5 answer, sure.

6 HEARING OFFICER BURCHAM: You broke up.
7 Did the court reporter get that? It was broken.

8 THE REPORTER: "Provide an answer" was all
9 I heard.

10 HEARING OFFICER BURCHAM: Doc, could you
11 go back and give an answer if you -- we didn't hear
12 it.

13 THE WITNESS: Yes. I said I would have
14 been able to provide answers to Mr. Shogren's
15 questions, absolutely.

16 THE REPORTER: "I would have been able to
17 answers." Thank you.

18 THE WITNESS: I would have, yes.

19 BY MS. THOMAS:

20 Q. How many times did you look at your report
21 during Mr. Shogren's questioning?

22 A. I'm not sure. I didn't keep count.

23 Q. More than five?

24 A. I genuinely don't know.

25 Q. You can't say whether it was more than

1 five?

2 A. I can't because I wasn't keeping count.

3 Q. Have you been licensed anywhere else
4 besides Nevada and California?

5 A. Yes.

6 Q. Where?

7 A. During training, I was licensed in Utah,
8 New Jersey, Pennsylvania. I think that's it. I had
9 a Colorado license for a minute.

10 Q. Why do you no longer retain those
11 licenses?

12 A. Utah, New Jersey, Pennsylvania were for
13 training, residency, and fellowship, so those are
14 complete, I had no reason to keep them. Colorado
15 was when I thought I may be joining a practice in
16 Colorado and ended up not.

17 Q. How long have you been licensed and
18 qualified to perform spine surgery by yourself?

19 A. Can you unpack that question a little bit
20 for me?

21 Q. Sure. What part is confusing?

22 A. You asked about licensing and
23 qualification, and I think those are the different.

24 Q. How long have you been performing spine
25 surgery without supervision?

1 A. Approximately five years.

2 Q. Do you recall the date that you began?

3 A. Approximately September of 2020.

4 Q. How are you qualified to offer opinions on
5 the standard of care for a spine surgery performed
6 in December, 2019, prior to your qualification to
7 independently perform the same?

8 A. My training and experience as a spine
9 surgeon gives me the expertise necessary to offer
10 opinions, regardless of when the surgery occurred.

11 If I reference a surgery, current -- you
12 know, if I reference the surgery that was done a
13 number of years back, even before I finished my
14 training, I still, at the time that I'm referencing
15 all the materials, have that expertise.

16 Q. But you were not able to and/or performing
17 those procedures independently?

18 A. I was asked to be an expert when this
19 surgery was done, I was asked to be an expert a
20 number of years after that.

21 Q. So do you believe that you can serve as an
22 expert regarding the standard of care for a
23 procedure that was performed at the time that you
24 were not qualified to perform that procedure?

25 A. Correct. Because at the time that I

1 offered my expert opinion, I was well qualified to
2 do so.

3 Q. So you believe that expertise is
4 determined at that time the opinion is offered, but
5 not at the time that the procedure was performed?

6 A. Correct. In 2019, I would have not been a
7 good expert because I was training. But in 2023, I
8 was a well-qualified expert.

9 Q. And you would agree that the standard of
10 care changes over time, for example, based on
11 changes or in capability or technology; correct?

12 A. The standard of care does evolve over
13 time, sure.

14 Q. So do you concede that it may be possible
15 that a different standard of care applied in
16 December of 2019, at the time of Dr. Schneier's
17 surgery than at the time of your 2023 opinion?

18 A. My opinion is that Dr. Schneier's care
19 fell below the standard of care for the time frame
20 when Patient A was being cared for.

21 Q. Based on the standard applicable in 2023?

22 A. Based on my expertise as a spine surgeon.

23 Q. In 2023?

24 A. As the sum total of all of my education,
25 training, and the patient care that I have

1 delivered.

2 Q. But your opinions are based on -- I'm
3 sorry. Strike that.

4 So do you believe you had the expertise to
5 offer these opinions in December, 2019?

6 A. I believe that in 2023, I had the
7 expertise to offer opinions on care delivered in
8 2019.

9 Q. Based on the 2023 standard; correct?

10 A. No. Based on my expertise and training as
11 a spine surgeon.

12 Q. How long have you served as an expert for
13 the Board?

14 A. A number of years. My CV may have when I
15 started. I don't remember the exact date.

16 Q. I don't see it on there. Would you please
17 look at -- take a look at your CV and let me know if
18 you can find it?

19 A. It was at some point in 2022 that I
20 started -- nope, wait -- 2021, I believe.

21 Yes, either in 2021 or 2022 is when I
22 started serving as a reviewer for the Board.

23 Q. So somewhere between three months into
24 your licensure in Nevada, up until a year and a
25 half. Is that about right?

1 A. Pretty broad range, but somewhere in
2 there.

3 Q. How is it that you began reviewing cases
4 for the Board?

5 A. I believe I was contacted by someone from
6 the Board's office staff to see if I was interested.

7 Q. Have you ever received a patient complaint
8 that the Board asked you to provide information in
9 response to?

10 A. I apologize. Can you repeat that question
11 for me?

12 Q. So in Exhibit 2, the Board's Exhibit 2,
13 there is a response from Dr. Schneier to a Board
14 request for information regarding a patient -- a
15 complaint regarding a patient's care.

16 Do you recall looking at that exhibit?

17 A. Yes.

18 Q. Have you ever been asked to provide a
19 similar response to allegations of improper care?

20 A. Yes.

21 Q. By the Nevada Medical Board?

22 A. Yes, ma'am.

23 Q. How many occasions?

24 A. One occasion that I can recall.

25 Q. How long ago was that?

1 A. Approximately a year.

2 Q. A year ago?

3 A. Yes, about that.

4 Q. Was a formal complaint filed in that case?

5 A. I do not know.

6 Q. Did you receive similar complaints in any
7 other jurisdiction where you were licensed?

8 A. No.

9 Q. Earlier you testified to reviewing about
10 five or six cases on behalf of the Board; correct?

11 A. That sounds about right, maybe a little
12 more. But, yes, somewhere in that ballpark.

13 Q. Have you reviewed any cases for the Board
14 since you received a patient care complaint?

15 A. Yes.

16 Q. Have you ever offered an opinion for the
17 Board that the provider met the standard of care?

18 A. Yes.

19 Q. How many cases out of the five or six
20 cases that they've reviewed?

21 A. On every other occasion.

22 Q. Every other occasion?

23 A. Yes, ma'am.

24 Q. Did any of those other cases involve
25 similar allegations to those in this case?

1 A. No, ma'am.

2 Q. Have you ever been accused of performing a
3 wrong-site surgery?

4 A. No.

5 Q. How are you compensated on this case?

6 A. I believe the rate is, maybe, \$150 an hour
7 for the review part. I'm not sure if this part of
8 it, the deposition, is compensated or not.

9 Q. How much have you been paid so far?

10 A. I don't know. I will have to look. I
11 don't remember how long the review took or what my
12 billing was.

13 Q. We can wait.

14 HEARING OFFICER BURCHAM: Doctor, do you
15 have that information at hand? And if so, how long
16 would it take you to get it?

17 THE WITNESS: I do -- maybe I do. Give me
18 a second.

19 To answer your question, I was compensated
20 \$3,000 for the 20 hours of work for this case.

21 BY MS. THOMAS:

22 Q. Do you expect to submit additional billing
23 after today?

24 A. I honestly don't know. I don't know if
25 this part of it is compensated or not.

1 Q. How much time did you spend reviewing this
2 case prior to drafting your 2023 report?

3 A. I don't know. It's over 20 hours. At the
4 time, I was under the impression that I was only
5 compensated for the first 20 hours and that I
6 wouldn't be compensated after that, and so I would
7 just bill for the first 20 and I wouldn't bill for
8 the rest of it.

9 The answer is more than 20, but I don't
10 know how much total.

11 Q. The fact that you would not be compensated
12 beyond 20 hours did not impact your review of the
13 totality of the information you were provided, did
14 it?

15 A. Correct, it did not. It impacted my
16 recordkeeping because I would keep track of the
17 first 20 hours and then continue working until the
18 job was done.

19 Q. Walk me through your review in this case.
20 You have been designated as conducting a medical
21 review of this case. What did that entail?

22 A. It entailed reviewing all the documents
23 provided, reviewing all of the imaging provided,
24 synthesizing the material, and answering the
25 questions proposed to me in sort of the letter from

1 the Board that requested my services.

2 Q. What questions have you been asked?

3 A. The important one was whether the standard
4 of care has been breached or not.

5 Q. What other questions were there?

6 A. I don't know if I have the original
7 letter. Let me see if it's readily available.

8 MR. SHOGREN: I'm objecting to this
9 because it's confidential, the letter to Dr. Goz.

10 HEARING OFFICER BURCHAM: That is the
11 indication in the ruling that I've made on the
12 evidence in this. That objection is sustained.

13 I don't want it to be, again, back-doored
14 through these kind of questions.

15 MS. THOMAS: Again for the record, this
16 witness has testified that his medical review
17 included answers from those questions, and he
18 already began to answer the question without an
19 objection until there was a belated objection made.

20 HEARING OFFICER BURCHAM: Yeah, the
21 objection wasn't weighed by any timeliness issues,
22 so the objections stands. And it's sustained.

23 BY MS. THOMAS:

24 Q. Please identify everyone with whom you
25 have shared your written report in this case.

1 A. I sent the written report to whoever was
2 my contact at the Board at that time. I
3 subsequently -- actually, I did not send it to Mr.
4 Shogren, just Ms. LaRue. Whoever was my contact at
5 the Board at the time.

6 Q. And no one else?

7 A. No.

8 Q. Did you interview anyone?

9 A. No, ma'am.

10 Q. Were you interviewed by anyone?

11 A. Tell me more about that question. What do
12 you mean?

13 Q. Do you know what an interview is?

14 A. Yes. But I am not sure how an interview
15 would be part of my process as a medical reviewer
16 for this case.

17 Q. That wasn't my question.

18 My question was: Were you interviewed by
19 anyone?

20 A. Like ever, have I ever been interviewed by
21 anyone? I'm not sure what you're asking.

22 Q. Regarding this case?

23 A. I had a call with Mr. Shogren about this
24 case.

25 Q. Were you provided with complete records

1 for your review or only excerpts?

2 A. I don't know how to answer that because
3 you kind of don't know the completeness of records
4 until some record turns up that you were missing.

5 I listed the records that I was provided,
6 and I read through all of those. I can give numbers
7 of pages of each document that I found. I can't
8 really testify to the completeness of those records.

9 Q. Have you reviewed Dr. Schneier's
10 prehearing statement and all of the disclosed culled
11 exhibits?

12 A. Yes.

13 Q. Did you review the imaging that was
14 disclosed by Dr. Schneier?

15 A. I reviewed the imaging that was provided
16 to me and that I listed during the beginning of our
17 deposition.

18 Q. So that would have been imaging from the
19 Medical Board?

20 A. All the images that I listed I reviewed.

21 Q. Have you printed any records or materials
22 that were disclosed as exhibits?

23 A. I have not personally printed anything,
24 no.

25 Q. Is there any information you requested to

1 to review that was not originally provided to you?

2 A. No.

3 Q. Did you personally review the imaging for
4 the date of service and scan performed that you
5 testified about earlier?

6 A. Yes.

7 Q. So, specifically, you reviewed the 12/27
8 MRI?

9 A. Can you be more specific?

10 Q. Are you aware of -- well, strike that.
11 -- 12/27/19 MRI lumbar spine?

12 A. Yes, I reviewed that.

13 Q. And you reviewed the imaging itself, not
14 just the report?

15 A. Correct.

16 Q. Did you review the 12/30/2019 MRI
17 thoracic?

18 A. Yes, ma'am.

19 Q. The MRI itself and not just the report?

20 A. Correct.

21 Q. Did you review the 1/22/20 CT thoracic?

22 A. Yes.

23 Q. And again, not just the report, but the
24 imaging itself?

25 A. Yes, ma'am.

1 Q. Did you review the 6/4/2020 MRI thoracic?

2 A. Yes, ma'am.

3 Q. The imaging itself and not just the
4 report?

5 A. Correct.

6 Q. Did you review the 6/4/2020 kyphoplasty?

7 A. Yes.

8 Q. The imaging itself or just the report?

9 A. Imaging itself.

10 Q. Are you a neuroradiologist?

11 A. No, ma'am.

12 Q. Do you have any training in
13 neuroradiology?

14 A. I would say that there's a fair amount of
15 overlap in training between neuroradiology and spine
16 surgery.

17 Q. Do you feel qualified to review and
18 interpret imaging?

19 A. Yes. The core competency for a spine
20 surgeon.

21 Q. And did you rely on your interpretation of
22 the images I just listed with you, or did you rely
23 on the interpretation in the accompanying report
24 prepared by the radiologist?

25 A. I used both.

1 Q. Did you find them to be consistent, or did
2 you disagree with any of the interpretations?

3 A. It's a little bit nuanced, is what I would
4 tell you. But I didn't have -- I didn't have
5 significant disagreements with the interpretation of
6 the radiologist.

7 Q. So what do you mean that it's nuanced?

8 A. Meaning that I would -- I would interpret
9 the imaging in the context of the radiology report
10 and even if the descriptors that I use, you know,
11 personally in my own interpretation were slightly
12 different than the descriptors used by the
13 radiologist, I would really look for key
14 discrepancies.

15 For example, if a radiologist identifies a
16 level as T10-T11, and said that even after a
17 laminectomy was done that there was continued
18 stenosis at the T10-T11 level, and maybe they talk
19 about granulation tissue as a contributing factor,
20 and in my opinion, you know, maybe the granulation
21 tissue was a slightly less of a significant factor
22 but it was more of the degenerative change, that is
23 a very small nuance. It might be a little bit of a
24 discrepancy, but it wouldn't necessarily change the
25 major take-home points.

1 You kind of have to take my -- or what I
2 do is I take my interpretation, I look at maybe
3 discrepancies with the radiologist, and then I
4 synthesize both together when I offer my opinions
5 and report.

6 Q. Is that what you do when you treat your
7 own patients?

8 A. Tell me more. What do you mean by -- what
9 do you mean by what you just said?

10 Q. Do you follow that same process when
11 treating your own patients?

12 A. When treating my own patients, I also use
13 the radiology interpretation in addition to my own
14 interpretation in order to come up with the best
15 course of care.

16 Q. And is your interpretation based on what
17 you see once you begin or get -- begin the operation
18 on the patient?

19 A. I believe we're talking about two
20 different things now.

21 Q. Tell me more about that. What do you
22 mean?

23 A. Your prior questions were about my process
24 of interpreting imaging and now you're asking me
25 about what I see during the operation, those are

1 separate processes.

2 Q. In what way?

3 A. One is in surgery, and the other one is my
4 thought process in interpreting imaging studies.

5 Q. Do you have a personal practice to always
6 review your patient's film?

7 A. Context dependent, but reviewing films is
8 a key part of treating patients.

9 Q. What's the difference between an
10 orthopedic spine surgeon and a neurosurgeon?

11 A. The residency completed.

12 Q. How do those differ?

13 A. Neurosurgery residency involves
14 seven years that involves spine surgery, as well as
15 other parts of neurosurgery, cranial cases, et
16 cetera.

17 Orthopedic surgery residency involves
18 spine surgery in addition to other parts of
19 orthopedics, such as knee, hip replacement, you
20 know, fracture care, et cetera.

21 It is now fairly standard for spine
22 surgeons coming from the orthopedic track to do a
23 one-year fellowship in spine-specific, which is what
24 I did.

25 Q. Do you collaborate with neurosurgeons?

1 A. I do.

2 Q. Do you have any conflicts with
3 Dr. Schneier?

4 A. I don't know Dr. Schneier.

5 Q. Have you ever treated or shared patients
6 with Dr. Khavkin?

7 A. Not that I'm aware of.

8 Q. Have you ever treated or shared patients
9 with Dr. Germin?

10 A. Again, not that I'm aware of.

11 Q. Have you ever treated or shared patients
12 with Dr. Schneier?

13 A. Didn't you just ask me that? Oh, no, it
14 was Khavkin.

15 Not that I'm aware of. I don't know of
16 any shared patients. We practice in the same space
17 and we might have some, but I'm not aware of it.

18 Q. Did you -- I'm sorry. Strike that.

19 Have you ever held privileges at Sunrise
20 Hospital?

21 A. No.

22 Q. Have you ever held privileges at Spring
23 Valley Hospital?

24 A. No.

25 Q. Have you ever held privileges at any

1 hospitals in Southern Nevada?

2 A. No.

3 Q. Did you hold privileges at any hospital in
4 Nevada in December, 2019?

5 A. No.

6 Q. Earlier, Mr. Shogren asked you how many
7 laminectomies you performed and you stated that you
8 weren't sure. Can you estimate?

9 A. I can't.

10 Q. How -- what percentage of your
11 laminectomies have been performed in the thoracic
12 spine?

13 A. There are more there in the lumbar spine
14 or the cervical spine, for sure. I can't give you a
15 percentage.

16 Q. You indicated that you performed 200 to
17 250 spine surgeries. Is that accurate?

18 A. Per year.

19 Q. Per year?

20 A. Yes.

21 Q. When's the last time you perform a
22 thoracic laminectomy?

23 A. I would have to look at my case log, but
24 definitely within -- I would say within the last
25 six months for sure. I don't know how recent.

1 Q. When's the last time you performed a
2 thoracic laminectomy at T10-11?

3 A. That's a very specific question. I would
4 definitely have to look at my case log.

5 Q. Within the last year?

6 A. T10-11 is a specific level, so I don't
7 know.

8 Q. Is it your custom to use operative
9 microscopes for decompression of coarctation of
10 compression of the cord?

11 A. What do you mean? I need to find out more
12 for that one.

13 Q. Do you know what an operative microscope
14 is?

15 A. There are many types of operative
16 microscopes, and I have used some of them.

17 Q. Have you used any type of operative
18 microscope for decompression of coarctation of
19 compression of the cord?

20 A. Yes, I've used many different types of
21 microscope for decompression of the spinal cord.

22 Q. Is that your typical custom and practice
23 for performing a decompression?

24 A. Is what my custom and practice?

25 Q. The use of an operative microscope.

1 A. My typical is the use of what are called
2 "surgical loops," which is a type of microscope.
3 You know, the microscope that you wear on the
4 glasses instead of the big ones that you wheel in.

5 I've used both. I prefer loops in my
6 practice.

7 Q. How many surgeries have you performed
8 without image guidance?

9 A. What do you mean by "image guidance"?

10 Q. Do you not understand the question?

11 A. I do not.

12 Q. How many surgeries have you performed
13 without fluoroscopy?

14 A. A very low number. Just about every
15 surgery we do involves fluoroscopy for some basis.

16 Q. How many have you performed without a
17 robot?

18 A. Without a robot? It's pretty rare.

19 Q. You know, the average age demographic of
20 the patients upon whom you perform thoracic
21 laminectomies?

22 A. I don't.

23 Q. What about the breakdown and procedures
24 performed on men versus women?

25 A. You know, I don't know off the top of my

1 head.

2 Q. Would you agree that it is somewhat
3 unusual to have problems with the spinal cord at T10
4 to T11?

5 A. Context dependent.

6 Q. Please expand on that.

7 A. Like is it rare in the scope of my entire
8 clinical practice? Is it rare in emergent cases?
9 Is it rare in the scope of thoracic myelopathy
10 cases? You know, those are all different issues.

11 Q. Is it rare in the scope of your entire
12 practice?

13 A. Yes, it's a very small component of my
14 practice.

15 Q. And you'd agree that the ribs act somewhat
16 as a stabilizer for the thoracic spine; correct?

17 A. Sure.

18 Q. Would you agree that as a result, it's not
19 natural, for lack of a better word, to acquire
20 stenosis in the thoracic spine, even in the aging
21 population?

22 A. It naturally occurs, I wouldn't say
23 frequently, but it naturally occurs occasionally.

24 Q. Do you agree that this patient had an
25 exceptionally rare presentation of pathology?

1 A. No.

2 Q. Why not?

3 A. Thoracic myelopathy happens. Thoracic
4 stenosis happens. While it doesn't happen as common
5 lumbar stenosis, it still happens.

6 Any practicing spine surgeon is probably
7 going to see thoracic myelopathy, you know, some
8 number of times every year.

9 Q. In your own practice, you get a patient's
10 history in order to understand the conditions that
11 the patient comes to the table with because the age
12 in your assessment and recommended intervention;
13 correct?

14 A. Yes.

15 Q. You'd agree -- or you're aware that this
16 patient had bilateral hip replacements in 2018 and
17 2019 prior to his surgery with Dr. Schneier?

18 A. While I don't recall the date, yes, the
19 patient had bilateral hip replacements.

20 Q. And you're aware that he had complaints of
21 extreme pain and could not extend his legs to lay
22 flat for the MRI secondary to his displaced hip
23 prostheses; correct?

24 A. That's a little bit of a compound
25 question.

1 Q. Are you unable to answer it as a result?

2 A. I can't answer it accurately.

3 Q. Are you aware that the patient was unable
4 to extend his leg to lie flat for the MRI?

5 A. Yes.

6 Q. Are you aware that that was due to a
7 displaced hip prosthesis?

8 A. Hard to say what the cause was. I can't
9 really opine on that.

10 Q. Within two months prior to seeing
11 Dr. Schneier, the patient had a documented history
12 of increased lower extremity weakness, back pain,
13 and falls; correct?

14 A. I would have to reference the, you know,
15 review materials for that, but that sounds accurate.

16 Q. So you don't dispute that?

17 A. I don't dispute it. I don't know about
18 the details on whether it was two months or longer
19 or shorter, but it sounds accurate.

20 Q. Is it the norm for a 49-year-old male to
21 have spinal stenosis throughout his cervical,
22 thoracic, and lumbar spine?

23 A. When you say "norm," do you mean like do
24 the majority of people that age have it?

25 Q. Correct.

1 A. No, the majority of people that age don't
2 have that condition.

3 Q. So you would agree that this was a rare
4 case?

5 A. It depends on how you define "rare."

6 Q. How do you define rare?

7 A. I would say that this is a well-described
8 condition, certainly is less common than other
9 conditions we frequently treat, but it is still a
10 condition that's encountered probably, you know,
11 every year during a spine surgeon's practice.

12 Q. And then two months prior to seeing
13 Dr. Schneier, you're aware that the patient left two
14 separate rehabilitation centers against medical
15 advice after one day; correct?

16 A. I'm not acutely aware of that.

17 Q. Do you deny the accuracy of that
18 statement?

19 A. I don't deny it.

20 Q. And you're aware that he was ambulating
21 with a walker about five to six weeks before seeing
22 Dr. Schneier; correct?

23 A. Again, not acutely aware of that.

24 Q. And not denying it?

25 A. Correct.

1 Q. Are you aware that he has a history of
2 substance abuse?

3 A. I am not.

4 Q. You didn't see that in the records that
5 you reviewed?

6 A. I may have seen it, but I'm not currently,
7 years after my review, aware of that fact.

8 Q. And in the records you reviewed, are you
9 aware that the patient had a positive drug screening
10 for cocaine at the time of his presentation for the
11 care at issue in this case?

12 A. I --

13 MR. SHOGREN: I'm going to object to that
14 as irrelevant.

15 HEARING OFFICER BURCHAM: The objection
16 was based upon the relevancy?

17 MR. SHOGREN: Correct.

18 MS. THOMAS: And the response is that it's
19 within the records that the provider who was taking
20 his history and physical felt was relevant to his
21 presenting condition and the care provided in the
22 case.

23 I wanted to know if the witness had seen
24 that information.

25 HEARING OFFICER BURCHAM: The question is

1 allowed. Witness can answer.

2 THE WITNESS: While I'm sure I have seen
3 it in the record, I'm not currently -- again, a
4 couple of years after the review -- acutely aware of
5 that.

6 Q. Are you aware that the patient had a
7 history of opioid dependence?

8 A. Again, I was likely aware of that at the
9 time that I composed my report, but I'm not acutely
10 aware of that today.

11 Q. The patient was taken by ambulance for 10
12 out of 10 low back pain on December 26, 2019, to
13 Sunrise Hospital; correct?

14 A. Yes, ma'am.

15 Q. Having reviewed the history and physical
16 for multiple practitioners, can you describe the
17 long tract findings on exam?

18 A. Are you asking in general what are long
19 term -- long tract findings?

20 Q. No. I'm asking you, based on your review
21 of the history and physical performed by multiple
22 practitioners related to this patient, can you tell
23 me what the long tract findings were on exam?

24 A. You're asking me specifically to recall
25 the exam on the patient's admission that occurred in

1 2019?

2 Q. Yes.

3 A. I don't recall those documents off the top
4 of my head.

5 Q. You're aware that the patient reported an
6 inability to walk for two months prior; correct?

7 A. Again, I'm sure I was aware of it at the
8 time that my report was compiled, but not acutely
9 aware of that now.

10 Q. You don't disagree with the statement, do
11 you?

12 A. I do not disagree, no.

13 Q. And you're aware that this patient's hip
14 prosthesis was found to be disarticulated; correct?

15 A. Yes.

16 Q. You're aware the patient had a history of
17 osteoarthritis; correct?

18 A. Yes.

19 Q. And you testified earlier that you
20 personally reviewed the imaging from the MRI of the
21 lumbar spine taken on December 27, 2019; correct?

22 A. MRI of lumbar spine, December 27, 2019,
23 give me one second to see if that one was an
24 included study.

25 MRI, lumbar spine, yes.

1 MS. THOMAS: I am going to go ahead and
2 share my screen.

3 MR. SHOGREN: Sorry to interrupt,
4 Mr. Burcham. I know Dr. Goz said he had something
5 at one o'clock to attend to.

6 I don't know if you need to get to that.

7 THE WITNESS: We can -- if we're getting
8 close, we can finish up, just in the interest of
9 everyone's time.

10 HEARING OFFICER BURCHAM: Ms. Thomas,
11 let's continue on. I don't know how far, you know,
12 how much time you have.

13 Doctor, if you have to run to whatever
14 else you have to run to, is that the rest of the
15 day?

16 THE WITNESS: Yes. I think let's keep on
17 trucking and finish the questioning. I think that
18 would be fair to everyone.

19 HEARING OFFICER BURCHAM: I agree.

20 MS. THOMAS: I appreciate that, thank you.

21 HEARING OFFICER BURCHAM: I agree. Let's
22 do that. Hang on. The court reporter --

23 THE REPORTER: Except the court reporter
24 is not a statue, I'm not a machine, so --

25 HEARING OFFICER BURCHAM: Yeah. Let's go

1 off the record.

2 (Off-the-record discussion.)

3 HEARING OFFICER BURCHAM: Let's go back
4 on.

5 BY MS. THOMAS:

6 Q. Can you see my screen?

7 A. Yes.

8 Q. Do you need me to make it bigger? Is that
9 a yes or no?

10 A. I think we're okay.

11 Q. Okay. Do you see the red arrow on the
12 screen?

13 A. Yes, ma'am.

14 Q. What level is depicted by the red arrow?

15 A. It depends.

16 Q. On what?

17 A. It depends on how you count.

18 Q. On how you count. Okay.

19 What do you count this level to be?

20 A. So this is where the tricky thing with
21 spine surgery is, is that depending on the context,
22 you can count from the first multiple disc, you can
23 count down from T2, you can count from the thoracic
24 spine.

25 But the important thing is that when

1 you're looking to address pathology, especially in
2 the thoracic spine, that you independently look at
3 the imaging and how you count, and you
4 cross-reference multiple imaging modalities and you
5 end up arriving at the same answer.

6 Q. Dr. Goz, my question is what level is
7 depicted by the red arrow?

8 A. It can be referred as either as L5 or S1,
9 depending on how you count. I can't from this image
10 alone give you a concrete. It really is
11 context-dependent as sort of why we're labeling it.

12 Q. So you agree that a radiologist did
13 interpret this film as a standalone film on
14 December 22, 2019; correct?

15 A. No.

16 Q. Please turn to Exhibit 3 at page NSBME
17 059.

18 A. You got to bring it up for me. I don't
19 have it.

20 Q. What are the documents that you do have in
21 front of you?

22 A. I don't have any documents in front of me.
23 I have your -- I have the respondent's culled
24 exhibits, that's about it.

25 Q. I will pull the exhibits up. Please turn

1 to Exhibit B, pages 13 to 14.

2 A. There's a lot of -- I see page 1 here.
3 What are your page numbers?

4 Q. How about this: Exhibit A SHMC 2428
5 through 2429.

6 A. Thank you. These jump around, these skip
7 around a lot.

8 Q. So I will represent to you that the report
9 for this exam says "None available," next to
10 "comparison."

11 A. Yes. That's not relevant.

12 Q. Well, I asked you how -- or if you were
13 aware that the radiologist interpreted this film
14 without additional information, as you suggested,
15 would be required for you to answer my questions?

16 A. I don't know if you used the term "image"
17 or "film," but an MRI includes multiple series in
18 addition to a localizer film or a localizer series
19 that includes, typically, the entire slide. And
20 that's actually what helps the radiologist sort of
21 determine how they label the level.

22 They don't go off of that picture that you
23 showed me.

24 Q. Are you aware that this scan did not
25 include a localizer image?

1 A. I am not aware of that. Typically a
2 localizer is run.

3 Q. I will represent to you that one was not
4 used on the scan and that the radiologist was still
5 able to interpret the exam.

6 However, I'm asking you --

7 A. I'm literally -- go ahead.

8 Q. I'm asking you, based on your knowledge,
9 training, experience and stated expertise, what you
10 would label the vertebrae depicted by the red arrow?

11 A. So there is a localizer that I'm looking
12 at, so it did contain that.

13 Q. The 12/27/2019 scan?

14 A. Yes. It doesn't go up to the cervical
15 spine, but it includes key sagittal imaging.

16 Q. Okay. Based on that information, what is
17 the vertebrae depicted next to the red arrow?

18 A. It can be referred to by multiple
19 different numbering.

20 Q. How do you refer to it?

21 A. It really depends on what I'm looking for.
22 So it can be referred to L5 or F1 or S2, but the L5
23 or F1 would be the most common.

24 Q. And in this case, you are alleging that
25 Dr. Schneider operated at the incorrect level;

1 correct?

2 A. Yes.

3 Q. So wouldn't it be important for you to
4 determine what -- with certainty, what level a
5 vertebrae is?

6 A. A better way to frame this, in my opinion,
7 is that it would be most important to localize an
8 area of high stenosis and operate on the area of
9 severe or high stenosis, high degree of stenosis.

10 So whether you call the area of severe
11 stenosis T9-T10 and you operate in that area, or you
12 call it T10-T11, you operate on that area. That's
13 the most important part.

14 But if you call an area of severe stenosis
15 T10-T11 and you operate at T9-T10 and the area of
16 severe stenosis remains, that's when you have a
17 problem.

18 Q. So you operate on the pathology, not the
19 ambiguous or differing interpretations within an MRI
20 report; correct?

21 A. You operate on the pathology, and you have
22 to take special attention to what the radiologist --
23 how the radiologist numbered the vertebrae in their
24 report, where the pathology is, and whether what
25 you're calling T10-T11 is the same thing as what the

1 radiologist called T10-T11. That's sort of a key
2 issue with thoracic decompression.

3 Q. Okay. So your testimony is that the red
4 arrow depicts F1, L5, or S2; correct?

5 A. Potentially. Again, it's really not that
6 important. The important part is not the number, it
7 is where the pathology is and if you can accurately
8 identify where the pathology is in the operating
9 room.

10 And I'll tell you, when I went through
11 that, sort of what I did is cross-reference the
12 thoracic spine with the lumbar spine imaging.
13 You're kind of showing me one picture and you're not
14 showing you the axial to then cross-reference to
15 this image, and I need to see the thoracic spine and
16 the lumbar spine imaging.

17 And then after I can cross-reference all
18 of them, can I accurately give you what number that
19 should be referring to.

20 Q. Okay. What number would the vertebrae
21 next to the green arrow on this image?

22 A. Again, I really would have to
23 cross-reference both the radiology reports, the
24 thoracic spine and MRI spine, multiple series, in
25 order to be able to give you an accurate answer that

1 also coincides with the radiology report.

2 Q. So you don't know what level is adjacent
3 to the green arrow; correct?

4 A. More importantly, I would say that there
5 are a number --

6 Q. Dr. Goz, I'm happy to let you go on that
7 tangent, but I want you to answer my question. My
8 question is important to me, so please answer my
9 question and then you can finish with the side
10 statement.

11 A. It's not a side statement; it is an answer
12 to question. I'd be happy to if you let me answer.

13 HEARING OFFICER BURCHAM: Continue,
14 Doctor. There was a question asked, maybe it's been
15 lost in the translation, I don't know.

16 That question needs -- Counsel Thomas, ask
17 it again specifically.

18 BY MS. THOMAS:

19 Q. What level is depicted next to or by the
20 green arrow?

21 A. So in order to answer that accurately, I
22 would need to cross-reference multiple studies and
23 reports.

24 Q. What did the radiologist interpreting this
25 film read that level as?

1 A. I would have the cross-reference their and
2 multiple studies to provide that answer.

3 Q. I provided you with the base number for
4 the report. You stated that you have the
5 respondents exhibits in front of you.

6 A. We actually could not track that report
7 down, if you recall, so I don't have it in front of
8 me.

9 I would have to actually, in the imaging
10 software, cross-reference multiple studies and the
11 reports to give you an accurate answer.

12 Q. Do you have Exhibit B in your binder?

13 A. I have tab B, and all of the pages on tab
14 B are labeled as "page 1" and then "page 2"
15 afterwards. They are not numbered, you know, within
16 the tab.

17 Q. Would you please count 13 pages in?

18 A. Okay. And what am I looking for?

19 Q. The radiologist's interpretation of what
20 levels are depicted by the red and green arrows.

21 A. Now I have one additional piece of the
22 puzzle, but I still need to be able to scroll
23 through multiple images and series with the thoracic
24 lumbar MRI in order to be able to give you that
25 answer.

1 Q. Okay. The report found at T11 to T12,
2 there is severe spinal canal narrowing, secondary to
3 disc bulge, facet/ligamentum flavum hypertrophic
4 changes with mild T2 hyperintensity of the cord
5 suggesting edema.

6 Where is that on this view in relation to
7 the green arrow?

8 A. I'm speculating, because I need multiple
9 series that are cross-referenced to give you an
10 accurate depiction, but it is likely that -- not the
11 direct disc involved, probably one above that, but,
12 again, I'd have to cross-reference multiple series
13 for both the thoracic and the MRI of the lumbar
14 spine to give you an accurate answer.

15 Q. If I understand you correctly, the level
16 above the green arrow you are designating as T12?

17 A. No, ma'am. I would tell you that it's a
18 more nuanced issue than that requiring
19 cross-referencing multiple studies in order to get a
20 consistent, I guess, numbering scheme.

21 Q. Where's the cord edema depicted on this
22 image in relation to the green arrow?

23 A. I would have to be able to scroll through
24 that image to give you an accurate answer. It does
25 appear to be -- I see some cord edema, potentially

1 the one level up. I have to scroll back and forth,
2 I have to look at, ideally, their images, and I
3 actually have a more complete set of data to be able
4 to give you an accurate answer as an expert.

5 Q. So is it fair to say, then, that that
6 analysis was not something that you conducted in
7 forming your opinions in this case?

8 A. No, ma'am, that is not fair to say.

9 Q. So you have done this analysis in forming
10 your opinions in this case?

11 A. Meaning -- what analysis are you referring
12 to?

13 Q. The questions that I've been asking you,
14 Dr. Goz, related to the location of the edema and
15 the corresponding vertebral levels.

16 A. I have looked at the location of the edema
17 on the MRI images as part of my analysis of the
18 case, yes.

19 Q. Do you see cord edema or canal narrowing
20 on this film?

21 A. I see a potential for cord edema, but in
22 order for me to give you a answer with confidence, I
23 would have to have access to the full study, which
24 is what I had when I formed my opinions for this
25 case.

1 Q. You agree that T11 and T12 are shown on
2 this film; correct?

3 A. Yes.

4 Q. Where are those in relation to the green
5 arrow?

6 A. I will reference you back to my prior
7 answers, which is I would have to have access to
8 multiple series, and I would have to cross-reference
9 both the thoracic and lumbar spine MRI in the
10 reports to give you that answer.

11 Q. And as a result of the cord edema found on
12 this film, Dr. Schneider was asked to consult on
13 this patient; correct?

14 A. You asked me why Dr. Schneier was
15 consulted?

16 Q. I'm asking you if you agree that as a
17 result of the cord edema found on this film,
18 Dr. Schneier was asked to provide a consult on this
19 patient?

20 A. I think you would have to ask whoever
21 consulted him.

22 Q. That's not information that you reviewed
23 in the records?

24 A. No. As far as the core cause for the
25 consult, I cannot recall -- I can't recall the exact

1 cause of consult or reason for consult that was in
2 the note. I'm not sure if it's cord edema, if it's
3 leg weakness, or back pain.

4 I would have to review those documents.
5 It could be any one of those things that would lead
6 to a consult by -- by a spine surgery.

7 Q. And Dr. Schneier first saw the patient on
8 December 28, 2019; correct?

9 A. That sounds plausible.

10 Q. And at the time of his consult, the
11 patient had already had X-rays of his hip and pelvis
12 and the lumbar MRI; correct?

13 A. That also sounds likely.

14 Q. And you would agree that the records
15 demonstrate that Dr. Schneier reviewed the MRI
16 lumbar with this patient; correct?

17 A. That is one of the studies that he
18 reviewed.

19 Q. And Dr. Schneier ordered further MRI
20 imaging of the thoracic spine; correct?

21 A. Yes, that sounds plausible.

22 Q. And that imaging was performed two days
23 later on December 30, 2019; correct?

24 A. Yes.

25 MS. THOMAS: And for the record, the

1 imaging we just looked at is a modified version of
2 Exhibit C at 001.

3 HEARING OFFICER BURCHAM: Counsel, when
4 you say "modified," can you define modified?

5 The reason I ask that is that I am
6 colorblind and you guys have been talking about red
7 and green, and I want to make sure on the arrows
8 that are on there that I understand which is which.

9 MS. THOMAS: Absolutely.

10 HEARING OFFICER BURCHAM: The red arrow is
11 the one at the bottom of the image. Is that
12 correct?

13 MS. THOMAS: Yes, that is correct.

14 HEARING OFFICER BURCHAM: Okay.

15 MS. THOMAS: And the green arrow is on
16 top. I will orient any further reference to arrows
17 in addition to stating their color just so that
18 you're able to participate.

19 HEARING OFFICER BURCHAM: I appreciate
20 that. I was going to bring that up just to make
21 sure so you're aware. Thank you.

22 MS. THOMAS: Okay. Thank you for letting
23 me know. I apologize. I would have done it sooner.

24 HEARING OFFICER BURCHAM: Not your fault.
25

1 BY MS. THOMAS:

2 Q. Now I'm going to show you Exhibit C, which
3 is combined imaging studies of this patient, at 004.
4 Do you see that on the screen?

5 A. Yes.

6 Q. This is a scout image from the MRI
7 thoracic.

8 What is a scout image?

9 A. It's an image used to help localize a sort
10 of a rough picture to help count or label the level.

11 Q. Do you see the red arrow pointing at the X
12 on the screen?

13 A. I do.

14 Q. What spinal level does the X depict?

15 A. If we use the method of counting down from
16 T1, that would be T1.

17 Q. What is the lowest level of the spine --
18 I'm sorry. The lowest level of the thoracic spine
19 shown on this image?

20 A. You can see part of T11.

21 Q. Is that covered by the text "I 268"?

22 A. Yes.

23 Q. I have now put page 005 on the screen.
24 This is an image from the thoracic spine MRI.

25 Are you able to identify the vertebral

1 level that the red arrow is pointing to?

2 A. No. Because to do that -- this is what I
3 did during my review -- you have to basically use
4 your prior scout image, get an axial image to scroll
5 down to certain discs lower down, and then
6 cross-reference that axial image that you've used
7 your scout image to count where the axial image is
8 to localize to this.

9 Q. So you're not able to tell us what
10 vertebral level that is based on the information
11 you're looking at right now?

12 A. Correct.

13 Q. Do you see cord edema or canal narrowing
14 on this film?

15 A. Again, there's likely canal narrowing, but
16 you can't make an assessment by looking at one
17 picture. That's not -- that's really not a safe way
18 to make an assessment.

19 Q. But you looked in all the pictures in
20 forming your opinions in this case; correct?

21 A. Correct.

22 Q. Are you able to provide that information
23 based on the review you did in forming your opinions
24 in this case?

25 A. Provide what information?

1 Q. The information I just asked you for,
2 whether you see cord edema or canal narrowing on
3 this film?

4 A. You're showing me one picture, and so my
5 review of multiple images does not help me
6 accurately assess the one picture you're showing.

7 There's likely cord edema slightly --
8 maybe slightly above that arrow in the spinal cord.
9 There might not be. There's multiple pictures. I
10 don't know which picture you chose to show me.

11 Q. So you're not sure but you think there
12 might be cord edema at how many levels above the red
13 arrow?

14 A. It looks like there's pretty severe
15 stenosis one level below, and there's questionable
16 edema above.

17 But I can't really assess that without
18 being able to scroll through multiple series of
19 axial construction.

20 Q. Okay. So you can't rule it out but you
21 can't rule it in, based on --

22 A. Exactly. It always takes more than one
23 view to provide an accurate diagnosis.

24 HEARING OFFICER BURCHAM: Counsel, the
25 court reporter needs to take a break. It's one

1 minute before a quarter after.

2 You started to ask another question, you
3 can ask that, but at the end of this, whenever you
4 switch subjects -- and hopefully at the end of this
5 subject -- we got to take a break.

6 MS. THOMAS: Okay. So the end of this
7 subject is probably a couple more questions long.
8 How long of a break do we need to take?

9 THE REPORTER: I'm fine with a half an
10 hour.

11 HEARING OFFICER BURCHAM: Need 30 minutes.

12 MS. THOMAS: Okay. Why don't we do that.

13 THE WITNESS: If we're doing that, can I
14 continue at a different point in the day? I have
15 patients.

16 HEARING OFFICER BURCHAM: Let's go off the
17 record to discuss this.

18 (Off-the-record discussion.)

19 HEARING OFFICER BURCHAM: We're back on
20 the record. We're going to take a short lunch
21 break, 30 minutes. Dr. Goz has graciously agreed to
22 move his schedule around a little bit so we can
23 get -- complete his testimony.

24 We'll stand adjourned until 1:50.

25 (Recess 1:19 P.M. to 1:50 P.M.)

1 HEARING OFFICER BURCHAM: Let's go back on
2 the record.

3 Ms. Thomas, please continue.

4 BY MS. THOMAS:

5 Q. Dr. Goz, did you have any conversations
6 during our break with anyone related to this case?

7 A. No.

8 Q. Okay. Let's see here. Before we went on
9 break, I was sharing my screen with you. I want to
10 put that back up.

11 Are you able to see the image on the
12 screen?

13 A. Yes.

14 Q. And I don't recall the last question I
15 asked you. Is the court reporter able to read that
16 back?

17 (Record read.)

18 BY MS. THOMAS:

19 Q. Did you review the imaging while we were
20 on break?

21 A. No, ma'am.

22 Q. Do you see any anterior ventral
23 osteophytes on this film in the thoracic spine?

24 A. You have to be a little bit more
25 descriptive than that. Osteophytes anterior to the

1 spinal cord? Osteophytes on the anterior vertebral
2 bodies? What are you referring to?

3 Q. The vertebral bodies.

4 A. There are osteophytes anterior to some of
5 the vertebral bodies, yes.

6 Q. And in relation to the red arrow, are
7 those above or below or both?

8 A. The ones I'm seeing that are most
9 prominent are below.

10 Q. Okay. How many -- how many levels below
11 is the longest osteophyte?

12 A. I think for purposes of being explicit, we
13 should distinguish between levels and segments.

14 A level is generally the disc space,
15 T10-T11 level, as an example. And then if, for the
16 sake of argument, that arrow is noted to be T10, T10
17 would be a segment.

18 The two segments below the arrow, have the
19 largest osteophytes that I can tell from this
20 picture, but as I emphasized in my prior answers to
21 you, you can't really judge an MRI based on one
22 picture.

23 Q. Okay. And so your response regarding the
24 osteophytes is based on this picture and not Dr.
25 Lev's interpretation of this picture; correct?

1 A. Yes.

2 Q. And I believe -- I just want to clarify --
3 that you testified that you cannot say one way or
4 the other whether there is cord edema visualized on
5 this excerpt of Exhibit C at page 005?

6 A. The picture in front of me, so it's a
7 potential for edema at the level of the arrow and at
8 the disc just below the arrow. There's potential
9 cord edema higher up, but I can't rule it out
10 because I need, you know, the full MRI and all the
11 series involved with it in order to be able to give
12 you a conclusive answer.

13 Q. And you're now at your office; correct?

14 A. Yes.

15 Q. Okay. Can you please turn to Exhibit 3 at
16 NSBME 061?

17 A. I don't have the paperwork, so we'll have
18 to go with the screen sharing. I cannot find it, I
19 don't think.

20 Yes, I know where it is.

21 Q. Did you bring the other binder of records
22 with you to your office?

23 A. No. Can you screen share whatever you
24 want me to look at?

25 Q. Why didn't you bring the binder with you?

1 A. Did you instruct me to bring the binder
2 with me?

3 Q. Well, they were referring to it in your
4 testimony. Did I have to instruct you? Did you
5 think that you did not need it?

6 HEARING OFFICER BURCHAM: Argumentative.
7 Let's move on, please.

8 MS. FUENTES: If I may, are we able to see
9 the documents that are on screen sharing right now?
10 Can everybody see those?

11 THE WITNESS: Yes.

12 MS. FUENTES: Okay. Thank you.

13 MS. THOMAS: That's not the document I was
14 sharing.

15 MS. FUENTES: I'm sorry, Ms. Thomas. You
16 directed Doctor Goz to go to Exhibit 3, and I do not
17 recall the Bates stamp number. Was that correct or
18 did I get that wrong?

19 MS. THOMAS: I would appreciate if you
20 allowed me to control the screen. That was one of
21 our conditions for holding this via Zoom.

22 MS. FUENTES: Sure. I mean, if you have
23 the IC'S exhibits and you're able to project them --
24 I was just trying to assist in that. I wasn't sure
25 if you had them or not.

1 MS. THOMAS: I'll be able to complete my
2 examination in the manner that I choose, but I do
3 appreciate you offering your assistance.

4 Let's move on.

5 BY MS. THOMAS:

6 Q. Going back to page 001 of Exhibit C, are
7 you able to visualize the same osteophyte that you
8 just referenced on the thoracic MRI?

9 A. No way of knowing if it's the same
10 osteophyte without cross-referencing multiple
11 images.

12 Q. Do you disagree that there is edema in the
13 cord one level above the ventral osteophytes?

14 A. It looks that way in this image, but to be
15 sure, I would have to review the entire series.

16 Q. Do you disagree that there is cord edema
17 one level above the level with the red arrow?

18 A. I would have to really review the entire
19 study to be sure.

20 Q. How would you correlate this
21 intraoperatively?

22 A. Well, you have to consider how you're
23 numbering. Right? So for the sake of argument,
24 let's say that the level below the red arrow where
25 this stenosis on this single image appears to be --

1 let's say it appears to be on other images as well,
2 then you have to look at how your labeling. Let's
3 say we call it T10-T11.

4 If you're counting down from the top, one
5 thing you could do is you can then look at where the
6 rib is at. If you're going to count
7 intraoperatively, you need to double check -- you
8 know, if you're using ribs intraoperatively, then
9 you have to see if you can count the ribs on the
10 MRI.

11 If you're going to use one of the lumbar
12 disc spaces and count up, you will have to
13 cross-reference the lumbar MRI and the thoracic MRI.

14 And instead of blindly following the
15 numbers that the radiologist recommend, you have to
16 actually be able to reliably cross-reference the MRI
17 in whatever method you're going to use, and if you
18 can't identify a reliable marker that is present on
19 both the thoracic and the lumbar imaging, or if you
20 can't count down from the top of T2, then, as
21 happened in this case, you could always implant an
22 identifiable marker, such as doing a kyphoplasty
23 that is readily, you know, radial image -- repeat
24 imaging with that radial marker and go from there.

25 It really depends. And it depends on what

1 you can identify during the surgery and how you can
2 cross-reference the thoracic and the lumbar spine
3 MRIs as reliable.

4 Q. Would an osteophyte provide the landmark
5 to cross-reference?

6 A. No. It's a terrible landmark.

7 Q. Why?

8 A. Because there are a lot of osteophytes,
9 usually. You see one osteophyte here, if I were to
10 get a lumbar MRI, there could be multiple
11 osteophytes formed one level below in any particular
12 place. It's not a unique identifier.

13 In a perfect world, you would have a more
14 unique marker.

15 Q. Do you see multiple osteophytes on
16 page 001, the lumbar MRI at the level below?

17 A. Yes. That's a single cut, and you can
18 tell you're absolutely off center there, so you
19 would have to really -- you'd have to scrutinize
20 this pretty significantly.

21 And that's the reason why it's so easy to
22 do a wrong-level surgery in the thoracic spine. It
23 is tricky. You can't make these judgments based on
24 one image here and one image there.

25 Q. What about using the 12th rib?

1 A. If you can see the 12th rib reliably on a
2 coronal cut or an axial cut of your MRI, then you
3 can absolutely use that as a reference point. But
4 the caveat there as you can't blindly call the 12th
5 rib T12. You have to be able to see it on the MRI
6 relative to where the area of the severe stenosis
7 is.

8 Q. And earlier you testified that you
9 reviewed Dr. Schneier's operative report from
10 December 31, 2019; correct?

11 A. Yes.

12 Q. And his operative -- preoperative
13 diagnosis was thoracic myelomalacia myelopathy with
14 spinal stenosis, T10-T11; correct?

15 A. Correct.

16 Q. His postoperative diagnosis was the same;
17 correct?

18 A. Yes.

19 Q. And this is a condition where the spinal
20 cord in the thoracic region is compressed; correct?

21 A. Are you asking whether that is myelopathy?

22 Q. Whether thoracic myelomalacia myelopathy
23 with spinal stenosis is a condition where the spinal
24 cord is compressed in the thoracic region?

25 A. Yes. The stenosis part that is specific

1 to compression.

2 Q. And it can result in a range of symptoms
3 affecting movements and sensation and, essentially,
4 bowel and bladder control; correct?

5 A. Yes.

6 Q. And in this patient, there was a
7 constriction limiting the circulatory outflow from
8 the spinal cord that needed to be removed or
9 decompressed; correct?

10 A. It's not necessarily just a circulatory
11 issue.

12 Q. So what was the issue in this case, then?

13 A. Compression of the spinal cord, which can
14 both directly impact the neurologic structures as
15 well as the vascular supply of the spinal cord.

16 Q. So this makes surgical intervention at the
17 compressed level urgent versus elective; correct?

18 A. Yes.

19 Q. And the point of the surgery was to
20 address the pathology, the constriction; correct?

21 A. Yes.

22 Q. And the constriction was what was causing
23 the spinal cord edema; correct?

24 A. Presumably.

25 Q. After Dr. Schneier performed surgery on

1 this patient, he was later admitted to Spring Valley
2 Hospital on May 29th, 2020; correct?

3 A. Yes.

4 Q. And Dr. Khavkin later operated on the same
5 patient; correct?

6 A. Yes.

7 Q. And according to the operative report
8 found within the Board's Exhibit 8 at NSBME 095 to
9 096 and corresponding to Dr. Schneier's Exhibit E,
10 the operation took place on June 5, 2020; correct?

11 A. That sounds right.

12 Q. And prior to that surgery, imaging was
13 performed on the thoracic and lumbar spine; right?

14 A. Yes.

15 Q. And prior to that surgery, Dr. Khavkin
16 requested interventional radiology to perform a
17 placement of cement in the thoracic spine to
18 facilitate localization of the correct level in the
19 surgery; correct?

20 A. Yes.

21 Q. That procedure is also known as a
22 "kyphoplasty"; correct?

23 A. Yes.

24 Q. And according to the records, the
25 kyphoplasty was performed on June 4, 2020; correct?

1 A. That sounds accurate. I would have to
2 double check.

3 Q. Do you want to double check or will you
4 accept that representation?

5 A. It sounds plausible. That's fine.

6 Q. If a patient has a laminectomy defect that
7 you can see on imaging, why would you need a
8 kyphoplasty?

9 A. Sounds like a great question for Dr.
10 Khavkin.

11 Q. So do you agree that it would not be -- in
12 your personal practice you would agree that it would
13 not be necessary if you already had a laminectomy
14 defect?

15 A. I think you do whatever is needed to
16 prevent a second wrong-level surgery.

17 Q. Do you think a kyphoplasty is needed in
18 the setting of a laminectomy defect?

19 A. It's whatever works in your hand, and so I
20 think it is one of the many solutions to the problem
21 of wrong-level surgery.

22 Q. Okay. And as the expert for the Board in
23 this case, I'm asking you what your opinion is on
24 this, not what Dr. Khavkin may or may not have been
25 thinking.

1 Do you think a laminectomy -- I'm sorry.
2 Do you think a kyphoplasty is necessary in the
3 setting of a laminectomy defect?

4 A. I think it is a reasonable solution to the
5 problem at hand.

6 Q. So if the patient already had a
7 laminectomy at the level adjacent to the proposed
8 kyphoplasty, why would you need the kyphoplasty to
9 serve as a surgical landmark?

10 A. It provides even easier visualization via
11 flora. You know, the term "necessary" implies it's
12 the only solution. I would say it is sufficient,
13 it's a sufficient solution. It's one of the many
14 things you could do. It is not the only solution,
15 but it is a very reasonable solution that's within
16 the standard of care.

17 Q. Is that your personal practice to use
18 preoperative kyphoplasty for the sole purpose of
19 establishing an unambiguous landmark?

20 A. It depends on the case. It is not a
21 common technique, but it is certainly a technique
22 within my skill set.

23 Q. So being not common or uncommon, it is not
24 standard of care to perform a kyphoplasty?

25 A. I explicitly said it is within the

1 standard of care to perform a kyphoplasty in this
2 case.

3 Q. Right.

4 My question was not whether it fell below
5 the standard of care; my question is, is it the
6 standard of care to perform a kyphoplasty?

7 A. The standard of care within spine surgery
8 encompasses multiple techniques, and this is one of
9 the many techniques that is within the standard of
10 care for this case.

11 Q. So there are other options or other means
12 available such that a kyphoplasty is not the only
13 means that would meet the standard of care?

14 A. Correct.

15 Q. And in this case, Dr. Khavkin requested
16 the kyphoplasty solely for the purpose of landmark
17 creation; correct?

18 A. I wouldn't know. That is definitely
19 something you have to ask him. I think it could
20 serve the purpose of landmark creation. I'm not
21 sure if he had other purposes in mind.

22 Q. That was not something that you learned
23 from your review of the Spring Valley Hospital
24 records?

25 A. No, I did not learn other purposes that

1 Dr. Khavkin may have had for the kyphoplasty.

2 Q. Okay. And as we sit here now, you don't
3 have any opinions that there was any other purpose
4 for the kyphoplasty; correct?

5 A. I don't know.

6 Q. Would you rely on the records in that
7 regard?

8 A. No. My statement is I don't know if there
9 are other purposes for the kyphoplasty in this case.

10 Q. That information is contained within the
11 record. Do you disagree?

12 A. I -- like I said, my statement is I don't
13 know other purposes. If there is another purpose
14 among the records, I don't currently recall.

15 Q. The primary purpose of a kyphoplasty is to
16 treat vertebral compression fractures; correct?

17 A. That is it's most common use, yes.

18 Q. Where was Dr. Schneier's operation in
19 reference to the level of the kyphoplasty?

20 A. You would have to show me a picture of the
21 kyphoplasty. Probably if there was a CT scan, I
22 would need to see that. I don't remember where he
23 put the kyphoplasty.

24 Q. Is that an opinion that you offered in
25 your report?

1 A. I knew where the kyphoplasty was at the
2 time I completed the report. I just don't know it
3 now.

4 Q. Do you need to refer to your report for
5 that information?

6 A. You can tell me, like, if that information
7 you actually need me to answer.

8 Q. I would like an answer to my question if
9 you're able to provide it.

10 A. Let's see if I can access my report from
11 here.

12 Q. Let me ask you this: Isn't it important
13 for you to know where Dr. Schneier's procedure was
14 performed in relation to the kyphoplasty in order to
15 offer opinions in this case?

16 A. Say that again?

17 Q. Isn't it important for you to know where
18 Dr. Schneier's operation was in reference to the
19 kyphoplasty in order to offer your opinions that he
20 performed a wrong-site surgery in this case?

21 A. No, it's not important.

22 Q. Why not?

23 A. Because the important bit from a clinical
24 perspective is that Dr. Schneier's surgery was one
25 level above the level he listed it as, making it an

1 wrong-level surgery.

2 Regardless of where the kyphoplasty was
3 placed, whether you went above, one below, you know,
4 at the top end or bottom end of the decompression,
5 wherever it was as a landmark, what's important is
6 the level that was initially operated was above the
7 level of the severe stenosis, and multiple images
8 afterwards demonstrated continued severe stenosis
9 despite the original surgery.

10 Q. I put Exhibit C at 006 on the screen. Do
11 you see that?

12 A. I was looking for my report. I guess
13 we've moved on.

14 Yes, I see Exhibit C.

15 Q. And just for the record and the benefit of
16 our Hearing Officer, there are two arrows on the
17 screen, one on the left and one on the right. The
18 one on the right is red. The one on the left is
19 yellow.

20 A. Yes.

21 Q. Do you see the red arrow on this image?

22 A. Yes.

23 Q. This is an image taken from the
24 January 22, 2020, CT thoracic spine. Would you
25 agree that the red arrow shows the site of Doctor

1 Schneider's laminectomy?

2 A. Yes.

3 Q. Do you see the yellow arrow on the image
4 on the left-hand side?

5 A. Yes.

6 Q. What is the arrow pointing to?

7 A. Osteophytes.

8 Q. Is that a landmark?

9 A. It is a relatively unreliable landmark.

10 Q. And why is it unreliable?

11 A. Because it's common to have multiple
12 osteophytes.

13 Q. Where are the other osteophytes on this
14 image?

15 A. There are small osteophytes just above the
16 screw. And above that, there osteophytes we see at
17 the cervical spine that we see at the very top.

18 There's a lot of osteophytes, and there
19 might be osteophytes further down. I don't know.

20 Q. And are any of those osteophytes even
21 remotely close to the size of the osteophytes next
22 to the yellow arrow?

23 A. The rest of them are small.

24 Q. Significantly smaller, you'd agree?

25 A. Yes.

1 Q. Are any of the other osteophytes within
2 the operative field?

3 A. What are you defining as the operative
4 field?

5 Q. Where the edema is within the cord.

6 A. Can you bring up your exhibit with the
7 edema in the cord, in the sagittal in the thoracic
8 spine that you have?

9 Q. Yes.

10 A. It looks like the most significant
11 stenosis is one level above the large osteophytes.

12 But like I said, the most reliable
13 landmark.

14 Q. And for the record, we have gone back to
15 Exhibit C at 005.

16 You are now able to visualize the edema in
17 the cord at the level above the osteophyte; correct?

18 A. Again, not the most robust conclusion
19 because in order to accurately assess where the
20 edema and the stenosis are the worst, you need
21 multiple series and multiple images throughout each
22 series with careful cross-referencing.

23 But certainly from this image, it looks
24 like below the arrow is an area of potentially
25 significant stenosis. The way to confirm that would

1 be with cross-referencing axial images, which are
2 not provided here.

3 Q. Earlier, I believe you testified that you
4 did not -- or, no, you did testify that you reviewed
5 the actual imaging for the kyphoplasty; correct?

6 A. Yes.

7 Q. And I will represent to you -- and for the
8 record, on the screen is Exhibit C at 007 -- this is
9 taken from the kyphoplasty.

10 Do you see the red arrow on the screen?

11 A. Yes.

12 Q. Would you agree that the arrow points to
13 and shows the vertebrate where the kyphoplasty was
14 performed on June 4, 2020?

15 A. Yes. Ideally, you would show me a
16 sagittal or a lateral image as well because it is
17 possible for that arrow to be actually pointing to
18 one level above or below the kyphoplasty, and you
19 need to cross-reference all images to be sure.

20 Q. And for the record, the kyphoplasty
21 material appears darker than the surrounding
22 vertebral structure; correct?

23 A. Yes.

24 Q. In your review of the records, do you know
25 that right after the kyphoplasty was performed, an

1 MRI of the thoracic spine was also performed to
2 confirm the kyphoplasty site; correct?

3 A. Yes.

4 Q. I've now put on the screen Exhibit C at
5 012. This is an image taken from the June 4, 2020,
6 thoracic MRI.

7 Do you see the red arrow on the screen?

8 A. Yes.

9 Q. Would you agree with me that the red arrow
10 is pointing at the vertebrae where the kyphoplasty
11 was performed?

12 A. Yes, it appears so. You're giving me,
13 like, the most washed-out image with a little bit of
14 the cement, but it's plausible that that's the
15 kyphoplasty.

16 Q. Yes. You can kind of see the
17 darker-colored material within that vertebrae;
18 correct?

19 A. Yes.

20 Q. And now I put on a darker image for you,
21 013, do you see the red arrow?

22 A. Yes.

23 Q. And you'd agree you're still able to see
24 the kyphoplasty in the vertebra next to this level;
25 correct?

1 A. Yes.

2 Q. Okay. I'm going to share a different
3 screen with you. I'm going to have to find it.

4 Okay. I shared with you from Dr.
5 Schneier's Exhibit E, as in elephant, it's the
6 Spring Valley Hospital Records at pages 952 and 953,
7 the reference points.

8 A. Yes.

9 Q. Oh, I'm sorry. That's the wrong reference
10 point.

11 A. Okay.

12 Q. Same exhibit, pages 949 through 951. This
13 is also at the IC's Exhibit 7, pages 91 through 92.

14 A. Okay.

15 Q. Can you read this or do you need me to
16 there it bigger.

17 A. I think I can do it.

18 Q. Okay. And so you'd agree that this is a
19 report for a kyphoplasty performed on June 4, 2020;
20 correct?

21 A. It appeal it's a vertebroplasty, not a
22 kyphoplasty.

23 Q. Are you aware of -- well, are you
24 disputing that there was more than one procedure
25 performed on the vertebrae on June 4, 2020?

1 A. No. I'm just pointing out that it's a
2 vertebroplasty, not a kyphoplasty, according to this
3 report.

4 Q. What is the difference?

5 A. Kyphoplasty involves inflating a balloon
6 in the vertebral body first.

7 Q. Okay. And what does it say under the
8 History section?

9 A. "Localization for surgery, other, please
10 specify."

11 Q. And the kyphoplasty is used to provide
12 treatment; correct?

13 A. This is a vertebroplasty.

14 Q. I understand. I'm asking you a question.
15 The kyphoplasty procedure is used to
16 provide treatment; correct?

17 A. Used to provide treatment at times, sure.

18 Q. That is why this radiologist did not use a
19 balloon; correct?

20 A. I don't know.

21 Q. Okay. Can you please read the line
22 starting at -- well, I'm sorry. Strike that.

23 You would agree that this report provides,
24 "The T11 vertebral body is identified by counting
25 cranial from the L5 vertebral body"; correct?

1 A. That's what that sentence states, yes.

2 Q. And you'd agree that the report further
3 provides, "A 10-gauge introducer needle was advanced
4 via a right transpedicular approach to the posterior
5 fourth of the T11 vertebral body"; correct?

6 A. Yes.

7 Q. And you'd agree that on page 951, the
8 report provides, "Impression: Status post T11
9 kyphoplasty"; correct?

10 A. Yes.

11 Q. And that this procedure was performed by
12 Dr. Hoque; correct?

13 A. Yes.

14 Q. And so you'd agree that Dr. Hoque
15 performed this procedure at T11; correct?

16 A. This kind of gets us back to the original
17 point of when you had an image with the red and the
18 green arrow and you asked me whether, you know, if I
19 can identify the number and I said, "It depends on
20 how you count."

21 Sometimes it's going to be T11, maybe in
22 another form of counting it's T12, maybe the last
23 form of counting is T10. The important part is
24 really where that cement is relative to the severe
25 stenosis.

1 The post-vertebroplasty MRI that
2 determines, really, the importance of the location.
3 It's its localization relative to the pathology
4 where this becomes important, not just the T11, et
5 cetera, number scheme.

6 Q. Right.

7 But given that you were unable to provide
8 me with your opinion based on your review of the
9 imaging that I showed you, what level you thought
10 was depicted by a certain arrow, would you agree
11 that Dr. Hoque was able to form an opinion, and that
12 he opined the level of the kyphoplasty was performed
13 at T11?

14 A. I know that is completely missing the
15 point.

16 Q. That's -- I understand that you might
17 think that I am missing the point, but I am asking
18 you a question, and I would really appreciate if you
19 would answer my question.

20 A. My answer is that the important part is
21 that the same vertebral body, given different
22 methods of counting, can be referred to as "T11" or
23 "T10" or "T12," and then important part in location
24 of that vertebral body in the cement is relative to
25 the pathology, not the number assigned to it.

1 MS. THOMAS: Move to strike that last
2 answer.

3 Madam Court Reporter, would you please
4 read back to my last question?

5 THE REPORTER: Yes. If you could just
6 give me one moment.

7 MS. THOMAS: Thank you.

8 THE REPORTER: You're welcome.

9 (Record read.)

10 HEARING OFFICER BURCHAM: Doctor, do you
11 understand the question that was asked?

12 THE WITNESS: So my answer was that it is
13 not that the radiologist was able to identify T11
14 correctly and I was not, it is that the vertebral
15 body that can be referred to as T11 in one report
16 may be referred to as T10 in a different report, and
17 it's the ambiguity of the numbering schemes that's
18 important.

19 So it's not that I can't identify a level
20 and the radiologist can; it's that there's ambiguity
21 to what one person calls "T11" and another person
22 calls "T10."

23 MS. THOMAS: All right. I put Exhibit C
24 back on the screen. I apologize. I want to use
25 something different.

1 I am sharing my screen with side-by-side
2 excerpts of Exhibit C. For the record, the
3 left-hand side is a image taken from the
4 December 30, 2019, thoracic MRI, and the image on
5 the right is from the thoracic MRI taken on June 4,
6 2020, after Dr. Hoque's kyphoplasty.

7 Are you able to see that or would you like
8 me to make a bigger, Doctor?

9 A. Can you make it a little bigger would be
10 great.

11 Q. How's that?

12 A. That looks good.

13 Q. Are you able to confirm that on the image
14 on the right-hand side from the June 4, 2020,
15 thoracic MRI shows the kyphoplasty next to the red
16 arrow?

17 A. Yes.

18 Q. I'm sorry. Did you say yes?

19 A. Yes, I did.

20 Q. Okay. And on the left-hand side from the
21 December 30, 2019, thoracic MRI, do you see the red
22 arrow --

23 MS. THOMAS: And for the record, for the
24 sake of the Hearing Officer, the arrow is a single
25 arrow on the left-hand side of the left screen.

1 There are two other arrows on the same -- on the
2 left-hand side, on the right part of the image. I
3 know that I just created a bad record.

4 Are you able to see three arrows, Mr.
5 Hearing Officer?

6 HEARING OFFICER BURCHAM: Yes, I can.

7 MS. THOMAS: Okay. So it's the one arrow
8 by itself on the image on the left-hand side, that
9 arrow is red. I'll start on the question over.

10 BY MS. THOMAS:

11 Q. Do you agree that the red arrow on the
12 left-hand side is pointing towards the same
13 vertebral level depicted by the red arrow on the
14 June 4th thoracic MRI?

15 A. Most likely. But to be 100 percent sure,
16 you need the localizer images.

17 Q. Do you see below the red arrow on the
18 left-hand film the osteophytes that we've been
19 discussing, the large osteophytes?

20 A. Yes.

21 Q. And on the June 4, 2020, thoracic MRI, are
22 you able to see the large osteophytes below the red
23 arrow?

24 A. Yes.

25 Q. So would you agree now that the red arrow

1 on each screen points to the site of where the
2 kyphoplasty is performed?

3 A. As I said before, most likely, but the
4 most reliable way to be sure is the localizer
5 images, because, as per my testimony earlier,
6 osteophytes are not the most reliable marker.

7 Q. Do you see the two white arrows the
8 December 30, 2019, MRI?

9 A. Yes.

10 Q. Would you agree that the white arrows
11 point to the edema within the spinal cord?

12 A. Definitely for the bottom one. The top
13 one, I'd have to see more images to be sure.

14 Q. Do you see the yellow arrows on the
15 June 4, 2020, MRI?

16 A. Yes.

17 Q. Would you agree that the yellow arrows
18 point to the spinal cord at the same level as
19 depicted by the white arrows on the December 30,
20 2019, MRI?

21 A. Yes.

22 Q. You'd agree that the spinal cord has
23 expanded in the area of the bottom yellow arrow from
24 the same area marked by the bottom white arrow on
25 the December 30, 2019, MRI; correct?

1 A. The images what?

2 Q. Expanded. The spinal cord has expanded.

3 A. We would really need an axial image of
4 both to be sure. And from my recollection, it went
5 from severe stenosis to continued severe stenosis.

6 Q. My question was: Can you see that the
7 spinal cord has expanded in the areas depicted by
8 the bottom arrows from the December 30, 2019, MRI to
9 the June 4, 2019, MRI?

10 A. And my answer is I can't conclusively say.

11 Q. So you can't say that it didn't either;
12 correct?

13 A. Correct.

14 Q. You'd agree that the edema in the cord
15 next to the white arrows is no longer present next
16 to the yellow arrows on the June 4, 2020, image;
17 correct?

18 A. You can't really make that comparison.

19 Q. You can't?

20 A. No, ma'am.

21 Q. I've put Exhibit E, Spring Valley Hospital
22 records, Schneider 953, back on the screen.

23 Do you see that document?

24 A. Exhibit E, Spring Valley Hospital Medical
25 Center. I'm seeing MRI thoracic spine report.

1 Q. Okay. And I understand that you are not
2 able to see the resolved edema within the cord based
3 on the imaging that I showed you.

4 But you would agree that the interpreting
5 radiologist in his June 4, 2020, report found that
6 "The spinal cord demonstrates normal signal
7 intensity"; correct?

8 A. I'm just looking for that specific -- yes,
9 I do see that.

10 Q. And that radiologist, Dr. Singh, reviewed
11 all of the imaging, not just but excerpts that I put
12 up on the screen; correct?

13 A. I apologize. Can you ask that question
14 again?

15 Q. Yes.

16 So as the interpreting radiologist,
17 Dr. Singh, reviewed the totality of the images that
18 were produced in the June 4, 2020, MRI of the
19 thoracic spine; correct?

20 A. Presumably. I don't really know what he
21 reviewed.

22 Q. Well, you're not suggesting or you don't
23 hold an opinion in this case that he didn't review
24 the entirety of the imaging; correct?

25 A. I have no opinion on what imaging he

1 reviewed.

2 Q. Okay. And you have no opinion on whether
3 his interpretation of that imaging was correct or
4 incorrect; correct? Or is that accurate?

5 A. Correct.

6 Q. And normal signal intensity in the cord
7 demonstrates an absence of edema; correct?

8 A. Correct.

9 Q. So Dr. Singh's dictation is consistent
10 with what can be visualized next to the yellow
11 arrows on the June 4, 2020, image; correct?

12 A. Dr. Singh's dictation is consistent
13 with -- what about the arrows?

14 Q. What can be visualized next to the arrows
15 on the June 4, 2020, image.

16 A. Could you be more specific in terms of
17 what you're asking?

18 Q. The absence of cord edema?

19 A. Correct. Dr. -- is it Dr. Singh? The
20 radiologist report indicates a lack of edema.

21 Q. Do you have any criticisms of the June,
22 2020, surgery performed on this patient by Dr.
23 Khavkin?

24 A. I do not.

25 Q. And you'd agree that there are records

1 showing that Dr. Khavkin offered the patient
2 additional spine decompression after his June,
3 2020th -- I'm sorry -- June, 2020, surgery; correct?

4 A. I don't recall.

5 Q. It's not uncommon in patients with
6 congenital spinal stenosis to have multiple
7 surgeries spanning many years; correct?

8 A. Correct.

9 Q. And you don't disagree that the patient's
10 neurological examination was normal, as documented
11 by Dr. Khavkin and Dr. Valencia, throughout mid to
12 late 2020 and through 2021; correct?

13 A. I will look at the notes. I don't know if
14 it was completely normal, if there were -- was
15 sustained neurologic deficits.

16 Q. Do you want to go ahead and look at your
17 notes, or are you not offering an opinion in that
18 regard?

19 A. Not offering an opinion.

20 Q. So the absence of an abnormal neurological
21 examination would suggest that there were no
22 permanent neurological deficits; correct?

23 A. I can't opine on the impact of delaying
24 surgery and delaying appropriate intervention had on
25 this patient.

1 Q. Did you review the entirety of the records
2 contained within Dr. Schneier's prehearing statement
3 and culled exhibits in the binder that you received?

4 A. No.

5 MS. THOMAS: I would move to admit Exhibit
6 C, the combined imaging studies of the patient as
7 marked, and the excerpt of Exhibit C, 005 and 013,
8 the side-by-side from December 31, 2019, and June 4,
9 2020.

10 HEARING OFFICER BURCHAM: Mr. Shogren?

11 MR. SHOGREN: That would be admitted as a
12 separate exhibit?

13 MS. THOMAS: I am fine admitting them in
14 place of the actual disks contained in Exhibit C.
15 Otherwise, I'm happy to renumber them.

16 MR. SHOGREN: I have no objection.

17 HEARING OFFICER BURCHAM: All right.
18 They're going to be admitted, then.

19 (Respondent's Exhibit C was
20 admitted.)

21 HEARING OFFICER BURCHAM: However, I'm
22 going to need to make sure that I know how to access
23 this stuff on disks, or if we're not doing the
24 disks, if we're doing something else. Counsel is
25 going to have to figure that out so that we have

1 something.

2 The witness has testified extensively
3 regarding those images with the various add-on,
4 colored arrows, that sort of thing, so I just have
5 to make sure that we have those that we can
6 access -- that I can access.

7 MS. THOMAS: Yes. I can email those over
8 to you and the court reporter. I have no further
9 questions of this witness.

10 If we need to take a break in between now
11 and the next witness or after Mr. Shogren completes
12 any follow-up questions he has, I'm happy to email
13 those over, if you want to provide your email
14 address to send them to, and also to ensure that the
15 court reporter gets them.

16 HEARING OFFICER BURCHAM: That's the most
17 important part. The second part is that'll be an
18 official record. Let's hold that.

19 Mr. Shogren, how much time do you have do
20 you think?

21 MR. SHOGREN: I'll try to be brief. I
22 don't know how long.

23 HEARING OFFICER BURCHAM: Yes, let's try
24 to be brief so we can take an afternoon break.
25 Thank you.

1 REDIRECT EXAMINATION

2 BY MR. SHOGREN:

3 Q. Dr. Goz, I just have a couple of further
4 questions.

5 When did you graduate medical school?

6 A. I believe 2014.

7 Q. When did you become licensed in Nevada?

8 A. In 2020.

9 Q. As a spinal surgeon in your experience,
10 would you say you're familiar with the standard of
11 care to which spinal surgeons are held?

12 A. Yes.

13 Q. Would you say you're familiar with what
14 the standard of care would have been in 2019?

15 A. Yes.

16 MS. THOMAS: Late objection. That's calls
17 for speculation.

18 HEARING OFFICER BURCHAM: Overruled.

19 BY MR. SHOGREN:

20 Q. In your opinion, has the standard care for
21 spinal surgeons changed between 2019 and 2020?

22 A. No.

23 MS. THOMAS: Objection. Calls for
24 speculation.

25 HEARING OFFICER BURCHAM: Overruled.

1 THE WITNESS: I answered no.

2 MR. SHOGREN: I didn't hear if Mr. Burcham
3 ruled on that objection.

4 HEARING OFFICER BURCHAM: I did. I
5 overruled.

6 MR. SHOGREN: Okay.

7 BY MR. SHOGREN:

8 Q. Dr. Goz, when you received records from
9 the Board regarding Patient A and Dr. Schneier,
10 roughly how many pages did you review?

11 A. I don't know. I can give you a quick
12 estimate.

13 Probably somewhere between be 4,000 and
14 5,000, I would assume. Not assume, but I would
15 estimate between 4- and 5,000.

16 Q. And were all those pages relevant in your
17 determining whether or not a Dr. Schneier departed
18 from the standard care?

19 A. They were not all pertinent records, no.

20 Q. Based on your review of the records, can
21 you say when Dr. Schneier's care of the patient
22 ended?

23 A. That is hard to say, but I would -- I
24 think it's fair to say when Dr. Khavkin took over
25 care is when Dr. Schneier's responsibility ended.

1 Q. And in your review of the records, did
2 Dr. Schneier, was he involved with the Dr. Khavkin's
3 surgery?

4 A. Not that I could tell.

5 MR. SHOGREN: No further questions.

6 HEARING OFFICER BURCHAM: Thank you,
7 Doctor.

8 THE WITNESS: Thank you, guys.

9 HEARING OFFICER BURCHAM: Okay. We will
10 --

11 MR. SHOGREN: Thank you, Dr. Goz.

12 HEARING OFFICER BURCHAM: We will take our
13 afternoon break, ten minutes. We're off the record.

14 (Recess from 2:54 P.M. to 3:04
15 P.M.)

16 HEARING OFFICER BURCHAM: Back on the
17 record. All right. Mr. Shogren, you had some
18 comment you wanted to make or no?

19 MR. SHOGREN: That was my comment about
20 the time.

21 HEARING OFFICER BURCHAM: Time. Okay, so
22 what we're doing is we're just working with that.

23 Ms. Thomas -- well, excuse me.

24 Mr. Shogren, any other witnesses on your
25 end of things?

1 MR. SHOGREN: No other witnesses.

2 HEARING OFFICER BURCHAM: Okay.

3 Ms. Thomas, do you want to make an opening
4 or you want to --

5 MS. THOMAS: We'll just move forward, and
6 I can do a closing.

7 HEARING OFFICER BURCHAM: Good idea.
8 Okay. Go ahead, ball's in your court.

9 MS. THOMAS: All right. We are calling as
10 our first witness Dr. Raj Agarwal.

11 HEARING OFFICER BURCHAM: Doctor, would
12 you please state your full name for the record, and
13 then I'm going to have the court reporter swear you
14 in.

15 THE WITNESS: Okay. My first name is
16 Rajneesh, R-A-J-N-E-E-S-H, and last name is Agarwal,
17 A-G-R-A-W-A-L.

18 (The oath was administered.)

19 DIRECT EXAMINATION

20 BY MS. THOMAS:

21 Q. Good afternoon, Dr. Agarwal. Could you
22 please provide us with a quick summary of your
23 background, your education, training, experience?

24 A. I'm a neuroradiologist. I do diagnostic
25 neuroradiologist as well as interventional

1 neuroradiology.

2 I did my medical school at Northwestern
3 University in Chicago. I did my fellowship in both
4 interventional and diagnostic neuroradiology at
5 Henry Ford Hospital.

6 I came to Las Vegas right after my
7 fellowship in 1998, and I've been in practice with
8 Desert Radiology since then, 27 years.

9 Q. And you're a board-certified
10 neuroradiologist; correct?

11 A. Correct.

12 Q. You've been asked to review some films in
13 this case?

14 A. Yes.

15 Q. Differentiating for a moment between films
16 and radiology reports, what specific films have you
17 reviewed?

18 A. So I've looked at the MRI of the lumbar
19 spine from December 27, 2019, Sunrise Hospital; MRI
20 kyphoplasty spine, December 30, 2019, Sunrise
21 Hospital; the intraoperative thoracic spine report
22 from December 31, 2019; CT scan of the thoracic
23 spine, January 22, 2020; intraoperative film report
24 January 22, 2020; MRI thoracic spine February 4,
25 2020; MRI thoracic spine, February 15, 2020; MRI

1 lumbar spine, June 4, 2020; MRI thoracic spine,
2 June 4, 2020; and CT scan thoracic spine, June 5,
3 2020.

4 Q. And in performing your review, did you
5 notice any anomalies in this patient's spine?

6 A. Yes, I did.

7 Q. And what were they?

8 A. Yes. So this patient has what's called a
9 "segmentation anomaly." What means it is that some
10 of the vertebral bodies and disc spaces are fused,
11 and the most common site is -- we see at the lumbar
12 sacral junction of the L5, S1, which is not that
13 uncommon, where you will see either the S1 segment,
14 which looks like a lumbar vertebral body, but we
15 call it "lumbarized," the L5 vertebral body can look
16 like the sacrum, we call it "sacralized." In this
17 case, what was a little bit unusual was that the L5
18 vertebral body was completely sacralized.

19 So by that, what I mean is that the L5
20 vertebral body and S1 vertebral body had no disc
21 space so it was completely bony fused, that's a
22 congenital anomaly, and because of that, when you're
23 numbering, it becomes very difficult because the L5
24 level looks exactly like the S1 level.

25 Q. Did this anomaly have any effect or impact

1 on the interpretation of this patient's radiological
2 studies?

3 A. Yes. And if you look at all the reports,
4 depending upon where the scout film was taken, the
5 numbering is different between all radiologists and
6 neuroradiologists.

7 So, for example, if you are reading a
8 study and you use the lumbar sculpture -- which we
9 do all the time -- to count, then you will get a
10 different level, versus if you use the cervical
11 spine to count, you get a different levels.

12 One example is if you use the lumbar spine
13 to count, the anatomic or embryologic L5 vertebral
14 body looks like the S1 level. And so the L1
15 vertebral body will have small ribs, so that's why
16 there's a difference -- that's why there's what we
17 call "anatomic ambiguity."

18 Q. And I'm going to share my screen. Give me
19 just a moment here.

20 I put on the screen Exhibit C, the
21 combined imaging studies of the patients that have
22 been marked. I'm looking at 001. Can you see it
23 that?

24 A. Yes.

25 Q. And this is the -- this is taken from the

1 December 27, 2019, lumbar MRI.

2 You just testified that this is a study
3 you've reviewed in forming your opinions?

4 A. That's correct.

5 Q. The corresponding reports for what is on
6 the screen can be found at Exhibit B, pages 13
7 through 15. I'll hand that to you for your
8 convenience.

9 A. Yes.

10 Q. Please take a look at that report and let
11 me know when you finish reading it.

12 A. Yes.

13 Q. Okay. And moving back to Exhibit C at
14 0012, you see the green arrows and red arrows on the
15 screen?

16 A. Yes, I do.

17 Q. And for the record, and the red arrows are
18 at the bottom of the screen and the green arrow is
19 at the top.

20 Based on the corresponding report by Brock
21 Bleazard, M.D., what vertebral level is he reading
22 for the vertebra depicted next to the red arrow?

23 A. He's reading that as one.

24 Q. And based on Dr. Bleazard's corresponding
25 reports, what vertebral level is he attributing to

1 the vertebrae depicted next to the green arrow on
2 this image?

3 A. That would be the L1.

4 Q. So that would make two levels above the
5 green arrow T12 and T11, respectively, according to
6 Dr. Bleazard's read?

7 A. That is correct.

8 Q. And for the record, 002 that I just placed
9 on the screen is another image taken from the same
10 lumbar MRI.

11 Would you agree that the red arrow is at
12 S1 and the green arrow is at L1, according to Dr.
13 Bleazard's interpretation?

14 A. That is correct.

15 Q. Same thing with the Exhibit 3, this is
16 another image taken from this lumbar MRI. I'm
17 sorry, not Exhibit 3. Exhibit C at 003.

18 The red arrow is at S1 and the green arrow
19 is at L1, according to Dr. Bleazard's
20 interpretation; correct?

21 A. That is correct.

22 Q. I believe you already testified about the
23 impact that such a manner of counting and vertebral
24 designation have with regard to this patient?

25 A. That is correct.

1 Q. Would the patient's bilateral hypoplastic
2 ribs present another anatomical anomaly in addition
3 to his L5 developmental segmentation anomaly?

4 A. Yes.

5 So these anomalies usually go hand in
6 hand, and so because we are reading the completely
7 sacralized L5 vertebral body S1, the L1 vertebral
8 body ends up having small ribs.

9 Q. And both of these anomalies of the sites
10 present at birth?

11 A. No. This is -- this is -- so, yes, this
12 occurred from birth. This patient had at birth.

13 Q. Is this patient's variant spinal anatomy
14 out of the ordinary?

15 A. What's unusual about this case is the
16 complete sacralization of L5. We also get some
17 partial, but it's clear in this case, when the
18 radiologists who read it at the time they were
19 reading the study, they completely assumed just
20 looking at the lumbar spine films, that the S1 level
21 was S1. Usually we have some clues.

22 They didn't even comment on the report
23 because they thought that was the S1.

24 Q. And going back to Exhibit 3 at 003, are
25 there any other findings of significance on this

1 image?

2 A. Yes. For me as a neuroradiologist, you
3 look for -- when you have ambiguity, you look for
4 other clues to give you hints for these patients.

5 Fortunately, this patient, you know, Dr.
6 Bleazard had one large osteophyte at the T12 of L1
7 level, based on this counting, that you could use as
8 a clue. Now, if he had a lot of osteophytes,
9 multiple big osteophytes, then you can't use it.

10 But in this case, this patient only had
11 one large osteophyte, so that's a clue. The
12 hypoplastic T12 ribs are clues at the L1.

13 Q. And where is the large osteophytes on this
14 image, Exhibit C at 003?

15 A. If we are counting at the L1, the
16 osteophyte is just above it right there.

17 Q. So the green arrow at the top goes to L1,
18 and then where is the osteophyte in relation to
19 that?

20 A. So that was -- the green arrow is the one
21 with the osteophyte, so it would to be T12-L1,
22 counting from the lumbar spine.

23 Q. So is it this black, almost half circle to
24 the left above the green arrow?

25 A. That's correct, yes.

1 Osteophyte is just a large bone spur and
2 it's bone, so it looks dark on an MRI.

3 Q. Can an osteophyte like this be a useful
4 landmark?

5 A. So in this patient, yes.

6 Q. Where is the osteophyte on this view in
7 relation to the severe spinal stenosis with cord
8 edema?

9 A. You can see it. This is a midline scan,
10 and so midline sagittal images where we most see the
11 spinal cord, the center, and as neuroradiologist,
12 that's where we use degree of -- spinal stenosis
13 cannot occur circumferentially, but the midline cut
14 is the most important cut, because if the spinal
15 cord is compressed, it will always be compressed in
16 the midline also.

17 And so you can see it just above the one
18 level. If we're calling this T12 a "one," then the
19 severe spinal stenosis is at T11-T12, one level
20 above.

21 Q. And so the last partial vertebrae that can
22 be visualized on Exhibit C at 003, is that what
23 you're counting is T11?

24 A. That is correct.

25 Q. And then the one below it is T12?

1 A. Correct.

2 Q. And then the one next to the green arrow
3 is L1, according to Dr. Bleazard's read of this
4 12/27/19 MRI?

5 A. That is correct. And that's why -- he saw
6 that severe stenosis, and that's why he recommended
7 more evaluation.

8 Q. So is it a correct statement that,
9 regardless of how the vertebrae are numbered, there
10 is severe spinal stenosis with cord edema at the
11 level above the large anterior osteophytes?

12 A. That is correct.

13 Q. I'm going to put on the screen Exhibit C
14 at 004. This is an image taken from the patients
15 December 30, 2019, thoracic MRI.

16 This is a study that you reviewed
17 informing your opinions, correct?

18 A. That is correct.

19 Q. And 004, this image is called a "scout
20 film"?

21 A. That is correct.

22 Q. Do you see the right arrow on the screen?

23 A. Yes, I do.

24 Q. It is pointing at a vertebra that has an X
25 over it. Would you agree?

1 A. That is correct.

2 Q. Would you agree that the X is placed over
3 T1?

4 A. That is correct.

5 Q. Do you see at the bottom of the screen
6 where it says "I 268" in the middle?

7 A. Yes.

8 Q. Based on this image and the placement of
9 the X over T1, is the vertebra that the I 268 is on
10 top of T11?

11 A. That is correct.

12 Q. So would you agree that the scout film
13 does not show the entirety of the thoracic spine?

14 A. That is correct.

15 But, yes, the scout film's purpose is
16 purely for numbering.

17 Q. And now moving to Exhibit C at 005. This
18 is taken from the same December 30, 2019, MRI
19 thoracic?

20 A. That is correct.

21 Q. The corresponding report for what is on
22 the screen can be found at Exhibit C, pages 16 to
23 17, which I've just handed you.

24 Would you take a look at that report and
25 let me know when you finished reading it.

1 (Witness reviewed document.)

2 THE WITNESS: Yes, I have.

3 BY MS. THOMAS:

4 Q. And moving back to Exhibit C at 005, based
5 on the corresponding reports by Raisa Lev, M.D., are
6 there differences in interpreting the level of
7 pathology in this patient from Dr. Bleazard's report
8 we discussed?

9 A. Yes, that is correct. Dr. Lev is purely
10 counting from the cervical spine, and so she comes
11 up to the conclusion that the severe stenosis is at
12 T10-T11.

13 When you count from the lumbar spine, it's
14 the same level as T11-T12.

15 Q. And does she designate the large
16 osteophytes at a different level than Dr. Bleazard?

17 A. That is correct.

18 Q. Where is that osteophytes according to her
19 interpretation?

20 A. So, again, just looking at the report, the
21 degree of the stenosis she describing is at this
22 level and the large osteophyte is one level above,
23 and so that is how you know that the findings of the
24 lumbar spine and the thoracic spine, even though
25 they both read at different levels, are the same

1 level.

2 Q. Dr. Bleazard's report placed the same
3 osteophyte at T12-L1?

4 A. That is correct.

5 Q. Do you see the red arrows on the screen?

6 A. Yes.

7 Q. Based on the corresponding report by Dr.
8 Lev, what vertebral level is she reading for the
9 vertebra depicted next to the red arrow?

10 A. T10.

11 Q. Dr. Bleazard's interpretation was that
12 this -- for this level next to the red arrow was
13 what?

14 A. T11.

15 Q. Do you have an opinion on these
16 differences in Dr. Bleazard's report and Dr. Lev's
17 interpretations are the same level taken three days
18 apart?

19 A. So the degree of stenosis and core
20 compression is the same -- it's the same -- they
21 both talking about the same area, they are just
22 labeling them differently based on different scout
23 films they used.

24 Q. Was Dr. Lev counting downward from the
25 cervical spine when counting the patient's vertebra?

1 A. That is correct.

2 Q. And you heard earlier and now based on our
3 discussion of the differences between Dr. Lev and
4 Dr. Bleazard's interpretation, would you agree that
5 there seems to be ambiguity in assigning vertebral
6 levels on this patient?

7 A. That is correct.

8 Q. Would you agree that there is abnormal T2
9 hyperintensity within the cord at the level above
10 the red arrow?

11 A. It is at the level and above the level,
12 that is correct.

13 Q. I'm going to share a different screen with
14 you.

15 A. Okay.

16 Q. I have shared with you what's been
17 identified and admitted as Exhibit C, 005 and 013,
18 side-by-side thoracic. The image on the left is
19 from the December 30, 2019, scan, and the image on
20 the right is from the June 4, 2020 scan. I will
21 make this bigger for you. I just wanted to orient
22 you the differences.

23 Would you agree that the red arrow on the
24 image to the left is at the same level as the red
25 arrow on the image to the right?

1 A. That is correct.

2 Q. Do you see the two white arrows on the
3 left image?

4 A. Yes.

5 Q. Would you agree that those areas point to
6 edema within the spinal cord?

7 A. That is correct.

8 Q. The image on the right is taken from the
9 patient's June 4, 2020, thoracic MRI.

10 As previously discussed, this was a scan
11 that you reviewed in forming your opinion?

12 A. That is correct.

13 Q. Do you see the yellow arrows on the image
14 on the right?

15 A. Yes.

16 Q. Would you agree that the yellow arrows are
17 placed at the same level as the white arrows on the
18 left image?

19 A. Yes.

20 Q. Do you have any opinions on whether there
21 are any differences in what the yellow arrows depict
22 from the image on the left?

23 A. Yes. There is two things, and I've looked
24 at the whole studies, the whole -- the whole exam.

25 The edema, the swelling, in the June,

1 2020, had completely resolved. It was very obvious
2 on the prior exam. And the second is that the
3 spinal stenosis that we have seen previously with
4 the cord edema on top of the spinal stenosis, that
5 spinal canal is, you know, decompressed.

6 Q. So does this June 4, 2020, thoracic MRI
7 confirm resolution of the spinal cord edema?

8 A. Yes.

9 Q. This MRI of the thoracic spine was taken
10 prior to Dr. Khavkin's surgery on June 5, 2020;
11 correct?

12 A. That is correct.

13 Q. So what does this all mean?

14 A. So the -- despite the ambiguous numbering
15 system, the surgery was done at the level that was
16 the tightest, the spinal stenosis, by Dr. Schneier.
17 And there was decompression of the spinal canal and
18 there was resolution of the spinal edema, based on
19 imaging.

20 Q. And I'm going to share with you again the
21 Exhibit C of the combined imaging studies for this
22 patient at page 006.

23 Have you reviewed the January 22, 2020, CT
24 of the thoracic spine?

25 A. Yes, I have.

1 Q. And does this scan demonstrate to you
2 whether the appropriate level was decompressed?

3 A. Yes.

4 And again, you know, you can look at it
5 now -- of course, I had all the imaging so I could
6 count from multiple levels. But for the sake of
7 simplicity on this exam, you can see that there are
8 no large osteophytes except at this area, large
9 area, and we know that the level of stenosis was a
10 level above it.

11 You can see that the entire bone, what's
12 called a "wide splenectomy," so the entire posterior
13 bone has been taken out to decompress the spinal
14 canal. This is your vertebral body behind where the
15 maximum stenosis is, and the disc space and attached
16 bone.

17 Q. The yellow arrow on the left side of this
18 image, what does that point to?

19 A. That's the osteophyte.

20 Q. And the red arrow on the right side of the
21 image, what does that point to?

22 A. The laminectomy site.

23 THE REPORTER: Doctor, can I get
24 clarification from you, please? This is the court
25 reporter. When you responded, did you say "osteo

1 site" or "osteophyte"?

2 THE WITNESS: Osteophyte, P-H-Y-T-E.

3 THE REPORTER: Okay. Thank you.

4 BY MS. THOMAS:

5 Q. So based on the December 31, 2019,
6 operative report, the January 22, 2020, CT thoracic,
7 and the June 4, 2020, thoracic, are you able to
8 state whether Dr. Schneier performed the
9 decompression at the correct level of the most
10 serious pathology?

11 A. Yes. The most serious pathology that the
12 patient presented with December, 2019, that was the
13 area that Dr. Schneier operated on.

14 Q. Did the June 4, 2020, MRI of the thoracic
15 spine show resolution of the cord edema previously
16 noted on Dr. Lev's December 30, 2019, MRI thoracic
17 report?

18 A. Yes, it did.

19 Q. Do you believe that Dr. Schneier's
20 December 31, 2019, surgery provided a positive
21 response?

22 A. Based on the imaging, yes.

23 Q. And it's true that the pathology that
24 required immediate urgent intervention was one level
25 above the large anterior endplate osteophytes?

1 A. That is correct. That was one of the
2 landmarks.

3 Q. While multiple radiologists over multiple
4 dates, locations, and spine segments imaged came up
5 with different and inconsistent vertebra counts, the
6 landmark that remains unchanged is the large
7 anterior endplate osteophyte; correct?

8 A. That is correct.

9 Q. I've put the Exhibit C, 005 and 013,
10 side-by-side image back on the screen.

11 Do you see that?

12 A. Yes.

13 Q. On the image to the right taken from the
14 June 4, 2020, MRI of the thoracic spine, do you see
15 the site of the kyphoplasty?

16 A. Yes.

17 Q. Where is it in relation to the arrows of
18 the screen?

19 A. The kyphoplasty is right there next to the
20 red arrow.

21 Q. And in front of you there is the Board
22 exhibit book, it's a spiral binder, it's
23 spiral-bound. Please turn to Exhibit 7, page 91.

24 Do you see that Dr. Hoque performed the
25 kyphoplasty at T11?

1 A. That is correct.

2 MR. SHOGREN: I object. Technically
3 Exhibit 7 wasn't admitted into evidence.

4 MS. THOMAS: I apologize if I say
5 "admitted." I thought I referenced just that it was
6 your Exhibit 7.

7 HEARING OFFICER BURCHAM: Seven has not
8 yet been admitted.

9 MS. THOMAS: Would you prefer to use
10 Exhibit E that has been admitted from Dr.
11 Schneier's, or do you have an issue with me asking
12 him questions about this document?

13 HEARING OFFICER BURCHAM: Are you asking
14 Mr. Shogren that?

15 MS. THOMAS: Yes.

16 MR. SHOGREN: I just wanted to make a
17 record, point out, I understand that Exhibit E or
18 Exhibit 7 are the same records.

19 HEARING OFFICER BURCHAM: I tell you what,
20 7 is admitted, since, I believe, it already exists
21 elsewhere.

22 MS. THOMAS: Yes.

23 HEARING OFFICER BURCHAM: So you can use
24 whichever one you want to use.

25 (IC's Exhibit 7 was admitted.)

1 MS. THOMAS: Thank you. And just for the
2 record, referring to a document that is also located
3 at Exhibit E, page Schneier 000949 through 000951.

4 BY MS. THOMAS:

5 Q. I believe you've already answered my
6 question that Dr. Hoque's report indicates that he
7 performed the kyphoplasty at the T11 vertebral body?

8 A. That is correct. And he uses the lumbar
9 spine to count.

10 Q. You sat through the testimony of Dr. Goz
11 today, do you have any comments or opinions based on
12 the testimony he provided?

13 A. Yes. I think -- and again, I mean, I
14 don't know Dr. Goz, and I don't know how much
15 imaging he was using.

16 Neuroradiology is something I do every
17 day. I consult with neurosurgeons, spine surgeons
18 on a daily basis. I think that he was looking at
19 the reports, but not -- or maybe not looking at the
20 images at the same time, because this patient does
21 have a segmentation problem where the numbering can
22 be an issue. And so that's why you have to really
23 look at it carefully when you're counting from above
24 and below to see the area that's operated on.

25 For me, regardless of what number we give

1 this area, the question is: What is surgery done on
2 the area of the severest stenosis that the patient
3 presented?

4 And that is, you know, I would say, yes,
5 the answer is yes, and that's based on two facts.
6 One is imaging showing that the spinal canal
7 expanded in this area, and the other reason is the
8 spinal edema has resolved. And spinal edema
9 resolution -- so edema is just swelling, so that
10 means that the injury that was there in the spinal
11 cord has gone away because the cause of the injury
12 has been taken away.

13 This patient clearly has a lot of disease,
14 a lot of other reasons to have pain, though I can't
15 explain that, but the stenosis has resolved and the
16 swelling in the spinal cord has resolved. If you
17 count from lumbar spine and cervical spine, the area
18 of surgery is the correct level.

19 Q. With regard to the opinions that you have
20 offered today, are all of those opinions expressed
21 to a reasonable degree of medical probability and
22 medical certainty?

23 A. Yes.

24 MS. THOMAS: I have no further questions
25 at this time.

1 HEARING OFFICER BURCHAM: Cross-exam?

2 CROSS-EXAMINATION

3 BY MR. SHOGREN:

4 Q. Good afternoon, Doctor.

5 A. Yes. Good afternoon.

6 Q. I have you performed any expert witness
7 work before?

8 A. I have.

9 Q. How many cases have you performed?

10 A. Probably about 30 to 40. Not malpractice;
11 personal injury, and have been on a patent case.

12 Q. I'm sorry. Could you repeat that last
13 part?

14 A. Also was involved -- was an expert witness
15 on a patent case, patent infringement law.

16 Q. Have you done any expert witness work
17 testifying in a case like this before?

18 A. I don't believe so, no.

19 Q. Have you ever met Dr. Schneier in person?

20 A. Yes.

21 Q. And how well do you know Dr. Schneier?

22 A. I mean, being in Las Vegas for 27 years, I
23 know every neurosurgeon, spine surgeon. I've worked
24 or helped someone out all the time.

25 Dr. Schneier, I don't -- I probably talked

1 to him once a year, maybe. He used to be -- I don't
2 know how long ago, over 10 years ago -- at Spring
3 Valley Hospital when I would see him more often.
4 Over the last few years, he moved to other
5 hospitals, so maybe once a year. And it's usually
6 always -- never socially so I'm not friends, like
7 social friends with him, it's always been regarding
8 some patient care.

9 Q. Have you worked with Dr. Schneier
10 professionally in any capacity?

11 A. Yes, when he used to work at Spring Valley
12 a long time ago.

13 Q. And are you being paid to testify today?

14 A. I haven't been paid yet, but I will be. I
15 will charge for it.

16 Q. How much do you charge per hour?

17 A. I'll -- probably \$500 an hour.

18 Q. Dr. Agarwal, are you a surgeon?

19 A. I'm on what's called a
20 "neurointerventional surgeon." I do do treatments
21 of complex vascular anomalies of the brain and
22 spine. For example, I treat strokes, I treat brain
23 aneurysms, I treat spinal cord tumors, I do a lot of
24 kyphoplasties.

25 It's kind of a new field called

1 "neurointerventional surgery."

2 Q. Have you performed any thoracic
3 laminectomies?

4 A. No, I've never done a thoracic
5 laminectomy.

6 Q. Have you personally treated patients with
7 stenosis?

8 A. Just for pain management.

9 Q. Have you treated a patient under similar
10 circumstances as Dr. Patient A treated Patient A --
11 Dr. Schneier treated Patient A?

12 MS. THOMAS: Objection. Form, vague,
13 ambiguous.

14 HEARING OFFICER BURCHAM: What was the
15 question?

16 MR. SHOGREN: I mangled the question. I
17 apologize.

18 HEARING OFFICER BURCHAM: Can you restate
19 it?

20 MR. SHOGREN: Sure.

21 BY MR. SHOGREN:

22 Q. Have you treated a patient under similar
23 circumstances as Patient A was treated by Dr.
24 Schneier?

25 MS. THOMAS: Same objection.

1 HEARING OFFICER BURCHAM: Overruled.

2 If he can answer it.

3 THE WITNESS: I don't do laminectomies, if
4 that's what you mean.

5 BY MR. SHOGREN:

6 Q. So you believe you can opine on whether
7 Dr. Schneier met the standard of care in his
8 treatment of Patient A?

9 A. As a neuroradiologist, I can opine if he
10 did the surgery at the correct level or not. That's
11 my job. As a neuroimager, as a neuroradiologist, I
12 do this every day where I talk to the surgeons about
13 what level the problem is.

14 So from just a neuroimaging standpoint, if
15 you ask me, is the level of surgery done at the area
16 of the severe spinal stenosis, I can opine on that.

17 Q. And were you personally involved in the
18 treatment of Patient A at any time?

19 A. And I never met this patient. I've never
20 treated this patient.

21 Q. I wanted to clarify, do you have the IC's
22 exhibits in front of you, the exhibit binder?

23 A. Yes.

24 Q. Please turn to the bottom -- the page
25 markings here at the bottom right corner, there's a

1 page, page 74.

2 A. Yes.

3 Q. Is this your document?

4 A. Yes, this is my report.

5 Q. This is regarding Patient A?

6 A. That is correct.

7 Q. You have personally treated Patient A?

8 A. No, just --

9 MS. THOMAS: Objection. Misstates
10 evidence.

11 THE WITNESS: This is MRI of the spine,
12 MRI of the thoracic spine. I read the report and
13 MRI. I did not treat this patient. I never met
14 this patient.

15 BY MR. SHOGREN:

16 Q. You said you were involved in the care of
17 Patient A at some point?

18 MS. THOMAS: Objection. Misstates
19 evidence.

20 THE WITNESS: I read hundreds of MRIs a
21 day. It came through my path, yes.

22 BY MR. SHOGREN:

23 Q. So what would you call this document?
24 What is your relationship with Patient A in this
25 document?

1 A. This is an MRI of the thoracic report
2 that -- Dr. Germin sent the patient for an MRI and I
3 read the MRI.

4 And if you look at my report, there is
5 no -- so we don't have access to Sunrise, so I knew
6 nothing else about the patient except the history
7 that was given. No other imaging or anything was
8 provided at that time.

9 Q. Is it correct in this document that you
10 stated Patient A has severe central spinal stenosis
11 at T10-T11?

12 A. That is correct.

13 Q. Doctor, if I can refer you to respondent's
14 exhibits, Exhibit B.

15 MS. THOMAS: What page number?

16 MR. SHOGREN: There's no page numbers that
17 I can see.

18 BY MR. SHOGREN:

19 Q. I wanted to refer to the thoracic spine
20 MRI from December 30, 2019.

21 A. Okay. Yes.

22 Q. You've reviewed this report before?

23 A. Yes.

24 Q. Do you agreed with the Impression that is
25 stated on the second page?

1 A. Yes.

2 Q. Okay. Now, Doctor, did you review the MRI
3 from January 2, 2020?

4 A. Yes.

5 Q. Patient A --

6 A. Did you mean the CT scan?

7 Q. The CT, yes.

8 A. Yes.

9 Q. Do you agree with the Impression from this
10 report?

11 A. No.

12 Q. Why don't you agree with it?

13 A. I believe on the report he mentions a
14 T9-T10 laminectomy. The laminectomy is actually at
15 -- it's a wide laminectomy, T10-T11, that extended
16 to the T9 level. So it don't describe it.

17 If you look at the sagittal image, there's
18 actually levels on that film. It's partially above,
19 and so the laminectomy is at the T10-T11.

20 Q. And did you review an MRI of the thoracic
21 spine from -- the report from February 4, 2020?

22 A. Sorry. I'm looking through here.

23 MS. THOMAS: Do you have a Bates number?

24 MR. SHOGREN: No. It's a couple pages
25 after the last one I referenced.

1 MS. THOMAS: Is it in the Board's
2 exhibits?

3 MR. SHOGREN: This one, I don't believe
4 that it is.

5 MS. THOMAS: Would you like me to put
6 Exhibit B on the screen or -- I don't know if you
7 can take control of it if I share it.

8 MR. SHOGREN: I'm trying to look at the
9 February 4, 2020, MRI.

10 BY MR. SHOGREN:

11 Q. Doctor, you did review an MRI from
12 February 4, 2020?

13 A. I did. I don't have the report in front
14 of me, but I did review it.

15 Q. Do you recall if you agreed with the
16 report or not?

17 A. Can you tell me what the impression said?
18 I'll go -- I believe I did, but I -- I think I did.

19 Q. I can read the Impression. Number 1,
20 "Post-operative changes from laminectomy at T9 and
21 T10. There has been interval removal of the spinal
22 hardware."

23 A. Yes.

24 Q. Do you agree to with that impression?

25 A. Do I agree? I don't agree with the

1 laminectomy site, that the laminectomy was T9-T10
2 and T10-T11, or if it was more T10-T11 and partial
3 T9.

4 Q. And then the second numbered Impression
5 is, "There is severe canal stenosis at T10-T11,
6 secondary disc protrusion of scar tissue from the
7 laminectomy at T10."

8 A. Again, you know, I don't have it in front
9 of me, but, yes, you may have -- it was postop, so
10 there could be swelling in the scar tissue. I don't
11 have in front of me.

12 Q. Do you agree that that patient had
13 continued stenosis, severe stenosis between December
14 and February -- December of 2019 and February of
15 2020?

16 A. Not at the level of the spinal surgery.
17 Can I clarify some of the reports to you?

18 Q. Yes.

19 A. Okay. You know, we're going many
20 different hospitals, many different radiologists,
21 and so I want to try to be clear here.

22 This patient has a congenital anomaly that
23 is unusual, that's why have thrown a lot of the
24 doctors who are looking at it, and they don't have
25 the whole history, and so they don't -- so they're

1 reading it incorrectly.

2 So when you look at my report that I read,
3 I read it, it was done at an outpatient facility
4 where for all thoracic spine, we use a lumbar spine
5 scout. We don't use a cervical spine scout. All
6 magnets are different, that's how we've established
7 the magnet, and that was actually used at the
8 request of the spine surgeon because they like to
9 also count down from the lumbar spine.

10 So when I looked at the MRI of the
11 thoracic spine at eastern, the level that I'm
12 counting calling the stenosis is actually one level
13 above where the severe stenosis was.

14 The other -- you can look at my report,
15 there is artifacts so evaluation of a signal in the
16 cord is difficult, and that's because our eastern
17 magnet or the eastern MRI is the oldest MRI so the
18 resolution is lower. And so I can't even -- I don't
19 even see a sign of surgery, or I could even tell the
20 surgery was done because the resolution. And I
21 didn't have any history on the patient at that
22 point. The area of stenosis was a level above.

23 Now, if you look at the patient, this
24 patient has got congenital spinal stenosis and have
25 got significant stenosis throughout the lumbar spine

1 and the thoracic spine.

2 So -- but what tells us is the whole
3 kyphoplasty or vertebroplasty MRI that is done
4 before Dr. Khavkin's surgery, that's done at Spring
5 Valley Hospital. Spring Valley Hospital has a
6 three-step magnet, which is the most powerful magnet
7 and the most resolution, so you see the most and
8 best on that magnet, especially if the patient has
9 moved. If the patient is in pain, they're moving,
10 things get very blurry for us. It becomes important
11 we have the whole picture.

12 So on that MRI, the two things we see
13 clearly is, one, the stenosis, one level above where
14 the osteophyte was which is where the stenosis was,
15 is gone. But more importantly, the swelling has
16 gone.

17 And actually the area that I read as
18 stenosis, just three, two months, a month before
19 that, does not look that bad, and so that's based on
20 the type of magnet and the imaging resolution.

21 So if you look at the -- I believe it was
22 the June 4 kyphoplasty, the June 4, 2020 MRI, and
23 look at the preoperative MRI, that tells you that
24 the stenosis is resolved and the edema has resolved.

25 But there's a lot -- in between, depending

1 on all of us reading different, there's a lot of
2 confusion as to where the levels are, and so that's
3 why it's hard to tell.

4 The other thing I would tell you is that
5 the laminectomy, some can be difficult to see on an
6 MRI because MRI is not very good for both. CT scan
7 is where you see the laminectomy the best.

8 Q. One last question: In your opinion, would
9 you have done anything different than what Dr.
10 Schneier did with Patient A regarding treatment and
11 care?

12 MS. THOMAS: Objection. This witness is
13 not a neurosurgeon.

14 Are you asking him to opine on a
15 neurosurgery that he doesn't perform?

16 MR. SHOGREN: If he can't opine on that, I
17 will withdraw my question.

18 HEARING OFFICER BURCHAM: I'm not sure
19 whether you're waiting for me to say something. If
20 he has an opinion within the scope of his expertise,
21 he can give it to us, but it's pretty clear he's not
22 a neurosurgeon, not an orthopedic surgeon.

23 So within the scope of his expertise, if
24 he has an answer to that, I'd like to hear it, if
25 you want the question. You can withdraw the

1 question, of course.

2 MR. SHOGREN: I withdraw my question. I
3 have no further questions.

4 HEARING OFFICER BURCHAM: Okay. Redirect?

5 MS. THOMAS: I just have a couple
6 follow-ups.

7 HEARING OFFICER BURCHAM: Go ahead.

8 REDIRECT EXAMINATION

9 BY MS. THOMAS:

10 Q. To clear up any confusion about earlier
11 testimony, isn't it true that radiologists that
12 solely review imaging are not providing treatment to
13 a patient?

14 A. That is correct.

15 Q. Isn't it true that all of the cord edema
16 for which the urgent operation was required on
17 December 31, 2019, had resolved by June 4, 2020?

18 A. That is correct.

19 Q. And as a neuroradiologist, you review
20 films and images, just like those taken in this
21 case, to help determine what level has the most
22 serious pathology; correct?

23 A. That is correct.

24 Q. And it is your opinion to a reasonable
25 degree of medical probability and medical certainty

1 that Dr. Schneier treated the urgent pathology and
2 that there was improvement, as demonstrated on the
3 June 4, 2020, MRI at the thoracic spine?

4 A. That is correct.

5 Q. Thank you.

6 MS. THOMAS: I've got nothing further.

7 HEARING OFFICER BURCHAM: Thank you,
8 Doctor. Appreciate your time and your input. Thank
9 you.

10 Witnesses is excused.

11 Ms. Thomas, next witness?

12 MS. THOMAS: Are we good on time? I'm
13 sorry. Can we go off the record?

14 HEARING OFFICER BURCHAM: Off the record.

15 (Off-the-record discussion.)

16 HEARING OFFICER BURCHAM: All right, Ms.
17 Thomas, carry on.

18 MS. THOMAS: All right. I am ready to
19 call Dr. Schneier.

20 HEARING OFFICER BURCHAM: All right.
21 Doctor, would you please state your name for the
22 record, and then the court reporter will swear you
23 in.

24 THE WITNESS: Ira Michael Schneier,
25 S-C-H-N-E-I-E-R. Colloquially, Michael.

1 MS. THOMAS: All right. In an effort to
2 try to speed things up, I'm going to go ahead and
3 show Dr. Schneier what's been admitted as Exhibit Q,
4 his curriculum vitae.

5 DIRECT EXAMINATION

6 BY MS. THOMAS:

7 Q. Doctor Schneier, does your curriculum
8 vitae accurately set forth your education?

9 A. Yes.

10 Q. And is there anything that's not on your
11 curriculum vitae, any activities that have occurred
12 since then that are worth noting?

13 A. In conjunction with the trauma center at
14 Sunrise Hospital, I am going to be a principal
15 investigator on confluence injury in spinal cord
16 injury with vertebral artery injury, high cervical
17 spine injury, and I was apprised last week that is
18 now going to be a multi-site, national study as
19 well.

20 Q. And could you just give us briefly the
21 highlights of your education, training, and
22 experience?

23 A. NYU Medical School, graduated in 1989.
24 Fellowship in -- sorry. Neurosurgical residency
25 training at Einstein medical college. Won some

1 research awards in New York State, New York City
2 environment. Then did a fellowship at University of
3 New Mexico. Then when the chairman went on to
4 become the chairman at the Cleveland Clinic, I was
5 the director of trauma and spine services at the
6 University of New Mexico for several years.

7 Q. And isn't it true that this surgery
8 performed prior to image-guided capability at
9 Sunrise Hospital, that spine surgeons would count
10 from the lowest rib and then identify the level of
11 interest by fluoroscopy when counting vertebrae?

12 A. Yes.

13 Q. Isn't it true that spine surgeons can also
14 use lumbar sacral segmentation as a landmark when
15 counting vertebrae?

16 A. Yes.

17 Q. In your fellowship in New Mexico at a
18 multi-site trauma center, both of these methods
19 would be appropriate for localization for level?

20 A. Yes.

21 Q. But you also have a clinical acumen that
22 you use intraoperatively and that you used in this
23 case?

24 A. Yes, ma'am.

25 Q. You used the anterior osteophytes?

1 A. Yes.

2 Q. In this case, do you find -- in this
3 patient's case, do you find the normal level above
4 the pathology and work down?

5 A. Yes.

6 Q. And "normal" meaning where the spinal cord
7 has normal diameter?

8 A. In this case, yes.

9 Q. This has all been under a microscope?

10 A. It's my aptitude utilized after the
11 microscope, yes.

12 Q. So as you're following the spinal cord, at
13 some point does it go from normal to abnormal?

14 A. Yes, in this case.

15 Q. In this patient, what did you identify as
16 abnormal during this process?

17 A. In my office report, I did note the
18 findings, but from recollection, the patient had a
19 severe constriction -- compression of the spinal
20 cord from an atypical calcified ligament and facet,
21 which is a joint -- facet, F-A-C-E-T -- facet joint
22 encroaching and compressing the spinal canal and the
23 spinal cord.

24 Q. And this was relatively unusual enough for
25 you to send it to pathology?

1 A. Yes.

2 Q. What did you do next?

3 A. Under -- just for the record, an accurate
4 microscope has at least 300, if not greater,
5 magnification. Loop magnification, which the
6 Board's expert, has three and a half magnification,
7 so there's a differential.

8 But following the compression of the cord,
9 a microsurgical technique was utilized to morselize
10 the bony spurs or invaginated overgrowth of atypical
11 calcified ligaments and joints that was compressing
12 the spinal cord from its normative anatomic phase to
13 a two-dimensional compressed structure.

14 And once released from that, I followed
15 that distally to ensure that there was no further
16 compression or constraint on the spinal cord or
17 through the cerebrospinal fluid flow. I could see
18 the pulsations of the spinal cord. And also
19 introduced various instruments below the level of
20 laminectomy to ensure that there was no other points
21 above and below the decompression that showed
22 evidence of constriction and constraint to the
23 severe cerebrospinal fluid flow or cord compression.

24 Q. And after releasing the cord, did you
25 visually see any differences?

1 A. The cord expands. And just for the
2 record, with expansion of the cord and especially in
3 cases of spinal cord edema, there's always a risk of
4 intramedullary or intraparenchymal hemorrhage, but I
5 could see the cord expand and pulsate, which would
6 be a sort of clinical sign against any evidence of
7 hemorrhage.

8 Q. In this case, within the exhibits and
9 listening to the testimony today, there's been
10 several inconsistent imaging reads by the
11 radiologists involved in the patients pre- and
12 post-operative imaging.

13 Would you agree?

14 A. Correct.

15 Q. According to some of them, you performed
16 this procedure at T10 to T11.

17 You'd agree?

18 A. Correct.

19 Q. There are some counting from the cervical
20 spine downward that suggests the procedure was
21 performed at T9 to T 10?

22 A. Correct.

23 Q. Earlier I was -- when I was asking Dr. Goz
24 and Dr. Agarwal questions, you saw me show them the
25 before-and-after imaging?

1 A. Correct.

2 Q. And would you agree that the imaging
3 showed improvement from December 31, 2019, to
4 June 4, 2020?

5 A. I think we're all in agreement on that.

6 Q. And it improved because you treated the
7 patient's pathology?

8 A. Correct.

9 Q. So whether we go with your account, the
10 radiologist reading the lumbar imaging in
11 December of 2019, or even Dr. Hoque's count on
12 June 4, 2020, in performing the kyphoplasty, we can
13 see that there is multiple sources of evidence that
14 suggests that this procedure was performed at the
15 appropriate levels for relief of the spinal cord
16 edema, as read on December 27, 2019, and on the
17 June 4, 2020, kyphoplasty?

18 A. Yes.

19 Q. Is there any landmarks on this patient's
20 imaging that did not change regardless of the
21 vertebral counts that was used?

22 A. The ventral osteophyte one level below the
23 area of the coarctation of the cord, or edema of the
24 cord as noted by the radiologist, was a fixed
25 landmark that could be used as a reference point of

1 localization.

2 Q. And regardless of any vertebral counts
3 used, you operated at the level of the most emergent
4 pathology; correct?

5 A. Correct.

6 Q. And that was the constricted edematous
7 portion of the cord?

8 A. The answer to that is yes, but there was
9 also edema and constriction above the level --
10 whether labeled T10-T11, T11-T12, there was also
11 significant arthritic pathology similar to that
12 level of the edema in the cord.

13 Q. The purpose of the surgery was to
14 decompress the spinal cord?

15 A. To relieve the venous congestion clogging
16 the edema in the cord.

17 Q. As you've heard, there's an allegation by
18 the Board that your care of the patient resulted in
19 additional pain, discomfort, surgical procedures,
20 hospitalizations, and medical expenses. We're going
21 to break that down.

22 After your first surgery --

23 MR. SHOGREN: Objection. Misstates the
24 record (inaudible).

25 HEARING OFFICER BURCHAM: What?

1 MS. THOMAS: I'm sorry. I didn't hear
2 you, Hearing Officer.

3 HEARING OFFICER BURCHAM: The word was
4 "what." I couldn't hear anything nor could the
5 court reporter, from what Mr. Shogren said. I don't
6 know, I don't know what he said. We don't.

7 THE REPORTER: Mr. Shogren, what was your
8 objection, please?

9 MR. SHOGREN: I believe the way the
10 question was worded, it's misstating the allegations
11 in the Board's Complaint.

12 HEARING OFFICER BURCHAM: Yes, counsel
13 asked that question. Is there an objection?

14 MR. SHOGREN: Yes.

15 HEARING OFFICER BURCHAM: Are you
16 objecting to the question?

17 MR. SHOGREN: Yes.

18 HEARING OFFICER BURCHAM: Okay. On the
19 basis of what? The question was -- well, Ms.
20 Thompson, can you repeat what the question was that
21 elicited the objection?

22 MS. THOMAS: Absolutely. Sure. It's no
23 problem. I said: There is an allegation that your
24 care of the patient resulted in additional pain,
25 discomfort, additional surgical procedures,

1 hospitalizations, and medical expenses. Let's break
2 that down.

3 After your first surgery, the patient
4 returned around January 22, 2020; correct?

5 THE WITNESS: Yes.

6 MS. THOMAS: Sorry. He asked me to repeat
7 the question so he could rule on the objection, I
8 believe.

9 HEARING OFFICER BURCHAM: Well, I didn't
10 even hear what the objection was.

11 MR. SHOGREN: I think it's misstating --
12 the Complaint alleges that Dr. Schneier departed
13 from the standard of care, committed malpractice,
14 among other counts.

15 HEARING OFFICER BURCHAM: Ms. Thomas, are
16 you just reading the Complaint?

17 MS. THOMAS: So, for whatever reason, the
18 Board chose not to make the Complaint an exhibit to
19 their materials, and instead, as Exhibit 1 --

20 MR. SHOGREN: It's --

21 MS. THOMAS: Okay. Mr. Shogren, if I may
22 finish, I'll let you finish too. I think it's
23 difficult if we talk over each other for the court
24 reporter.

25 But for whatever reason, it was not made

1 an exhibit to these proceedings, and so I was going
2 off of the language in the Board's Exhibit 1, page
3 NSBME 001, paragraph 5: Your care of the patient
4 resulted in additional pain, discomfort, additional
5 surgical procedures, hospitalizations, and medical
6 expenses.

7 MR. SHOGREN: I would say that that's not
8 part of the Board's Complaint. That's not
9 specifically stated in the Board's Complaint against
10 Dr. Schneier.

11 HEARING OFFICER BURCHAM: It was stated in
12 other documents. Let's quickly go -- can you
13 quickly go through this, Ms. Thomas?

14 MS. THOMAS: Yes. So if Mr. Shogren's
15 position is that's not an allegation made against my
16 client, I'm happy to move on. I just don't want
17 that to be taken into consideration if that's not an
18 allegation that they are any longer making against
19 my client.

20 HEARING OFFICER BURCHAM: Comment,
21 Mr. Shogren?

22 MR. SHOGREN: At this point, I withdraw my
23 objection.

24 HEARING OFFICER BURCHAM: Okay. Carry on,
25 Mr. Thomas.

1 MS. THOMAS: Thank you.

2 BY MS. THOMAS:

3 Q. And you answered yes, that you saw the
4 patient somewhere around January 22, 2020.

5 After your initial care of this patient in
6 December, the patient had undergone a hip reduction
7 for displaced prosthesis; correct?

8 A. Correct.

9 Q. He had a revisit -- or revision surgery
10 related to his hip?

11 A. I think he had a closed reduction
12 initially -- this is surmised -- and then eventually
13 that failed and underwent a hip revision surgery.
14 He had two procedures.

15 Q. And he had a history of hip and knee
16 issues?

17 A. Correct.

18 Q. Did he have any bowel or bladder
19 incontinence when you saw him in January, 2020?

20 A. No.

21 Q. Any Lhermitte pain?

22 A. Lhermitte?

23 Q. Lhermitte-type pain?

24 A. L-H-E-R-M-I-T-T-E, no.

25 Q. Did he have distal motor movement in his

1 feet and toes?

2 A. Yes.

3 Q. This is consistent with healthy function
4 of the spinal cord?

5 A. It's distal conducting through the spinal
6 cord to the peripheral nerves, yes.

7 Q. He had continued restriction on his left
8 knee extension?

9 A. Yes.

10 Q. A problem that preexisted your treatment
11 of him?

12 A. Yes.

13 Q. There's an allegation that there was a
14 medial breach of a left T9 screw. Forgetting the
15 semantics regarding T9 or T10 for a moment, let's
16 focus on the medial breach of a pedicle screw
17 alleged to have projected 50 percent into the left
18 lateral aspect of the central canal.

19 Was there any evidence of CSF leak?

20 A. Yes.

21 Q. For the record, what is CSF?

22 A. Through the fluid, which is the
23 differential between arterial pressure metabolism
24 and venous pressure.

25 Q. And so the absence of a CSF leak is

1 significant because why?

2 A. If you had a 50 percent breach of the
3 canal, you would have had to have violated the
4 spinal canal, and cerebrospinal fluid would be
5 leaking out. That would be pathognomonic for spinal
6 cord injury, findings would be apparent. Not
7 radiology's finest moment in a very difficult case.

8 Q. So and you used neuro -- intraoperative
9 neuro monitoring during your second surgery;
10 correct?

11 A. Correct.

12 Q. And that intraoperative neuro monitoring
13 would have shown a breach if there had been one?

14 A. Correct.

15 Q. Did the intraoperative neuro monitoring
16 show a breach?

17 A. No.

18 Q. Did you use ball-tip palpation?

19 A. Ball-tip probe is a blunt instrument used
20 for palpation, yes.

21 Q. Is there any evidence of pedicle breach by
22 ball-tip palpation?

23 A. No.

24 Q. You also visualize the absence of a
25 pedicle breach intraoperatively?

1 A. Correct.

2 Q. There was never any evidence of CSF leak
3 and fluid leak on any CT scan?

4 A. Correct.

5 Q. Was the patient compliant with physical
6 therapy?

7 A. Not to my knowledge.

8 Q. Was the patient compliant with any patient
9 rehab?

10 A. Not to my knowledge.

11 Q. And due to reports of pain, he required
12 anesthesia for his MRIs, and you advocated for the
13 same, including with his orthopedic surgeon, for his
14 hip-related issues?

15 A. Correct.

16 Q. Your surgery relieved the spinal cord of
17 its constriction at that level?

18 A. Yes.

19 Q. The patient's ambulatory status was
20 limited by the constructure and his knee and
21 displaced orthotic implant; correct?

22 A. In my clinical opinion, it was the
23 dislodged orthotic implant that blocked -- it
24 limited -- it was painful to the patient and limited
25 his ambulatory status and left him unable to extend

1 the knee for quad, secondary to pain, not consistent
2 with long tract findings of a spinal cord
3 compression or injury.

4 Q. And there was improvement objectively
5 identifiable on the June 4, 2020, MRI, thoracic
6 spine?

7 A. We all agree on that, yes.

8 Q. You personally reviewed the medical
9 records related to his admission, including the
10 history and physical, prior to your operation?

11 A. Yes.

12 Q. You personally reviewed the consent form
13 in this case?

14 A. Yes.

15 Q. You personally reviewed the patient's
16 radiograph prior to operation?

17 A. Yes.

18 Q. You had a personal discussion with the
19 patient before he underwent anesthesia?

20 A. Yes.

21 Q. You personally marked the intended level?

22 A. Yes.

23 Q. You used intraoperative radiographs?

24 A. Fluoroscopy.

25 Q. And this patient improved -- the pathology

1 improved after your procedure?

2 A. Yes.

3 MS. THOMAS: I have no further questions.

4 I'm sorry. Strike that.

5 One more.

6 BY MS. THOMAS:

7 Q. And the procedures that you performed on
8 this patient met the standard of care to a
9 reasonable degree of medical probability and
10 certainty?

11 A. Unequivocally.

12 MS. THOMAS: No further questions.

13 HEARING OFFICER BURCHAM: Cross-exam?

14 MR. SHOGREN: I have a couple of quick
15 questions here.

16 CROSS-EXAMINATION

17 BY MR. SHOGREN:

18 Q. Do you recall how many times you saw the
19 patient?

20 A. In what circumstance?

21 Q. In your professional capacity?

22 A. I saw the patient several times. I last
23 saw him as an outpatient and had him admitted to the
24 hospital because I thought the patient was going
25 through acute, unmonitored narcotic withdrawal, and

1 I was concerned for his well-being.

2 Q. What date did that happen?

3 A. I don't have that in front of me.

4 Q. Do you remember when you last saw the
5 patient regarding the stenosis?

6 A. No.

7 Q. Did you see the patient after the
8 January 23, 2020, surgery?

9 A. I can't recall if did. I believe he had
10 gone to rehab. I don't know if I saw him after that
11 event.

12 Q. Do you recall what complaint the patient
13 presented with prior to your December, 2019,
14 surgery?

15 A. The outstanding complaint is pain and
16 inability to extend the knee.

17 Q. Do you recall a complaint the patient
18 presented to you prior to the January, 2020,
19 surgery?

20 A. I'm sorry. I didn't hear your question.

21 Q. You performed a surgery on Patient A on
22 January 23, 2020; correct?

23 A. Yes.

24 Q. Were you aware of what the patient's
25 complaints were prior to that surgery?

1 A. Again, it looked to me as the patient was
2 going through acute withdrawal without monitoring or
3 support, and was -- had discharged himself from a
4 facility and did not have supportive care and was
5 beginning to fail for ADL. I had him admitted to
6 Sunrise. He was ambulatory at the time of
7 presentation to the office, with bladder/bowel
8 function.

9 Q. In your experience, what are the typical
10 symptoms of spinal stenosis?

11 A. The typical scenario of spinal stenosis is
12 associated with what we call "neurogenic
13 presentation," where there is ambulatory intolerance
14 over distance, and it's usually associated with
15 lumbar spinal stenosis, not thoracic spinal
16 stenosis.

17 Q. Do you recall after the December 31, 2019,
18 surgery did the patient present any symptoms of
19 thoracic stenosis?

20 A. There is no classic description of
21 thoracic stenosis symptoms.

22 Q. Did the patient present symptoms after
23 December 31 of stenosis?

24 A. Vague, unclear -- the short answer is no.

25 Q. All right. Give me one second.

1 IC's Exhibit 2, page 13, the fourth
2 paragraph, which starts with "Dr. Schneier prepared
3 his complication report." "The patient is
4 complaining of left lower extremity pain."

5 A. Do you want to read forward?

6 MS. THOMAS: Is there a question?

7 BY MR. SHOGREN:

8 Q. Is that statement accurate that the
9 patient now complained left lower extremity pain?

10 A. I'm sorry. Was that left lower extremity
11 pain with the left quadricep pain, the left hip
12 dislocation?

13 Q. I was referring to the statement. Would
14 you say that's not -- is that a symptom of stenosis?

15 A. Not necessarily. Not pathognomonic.

16 Q. Can you repeat that last part, please?

17 A. Pathognomonic, P-A-T-H-O-G-N-O-M-O-N-I-C.
18 Not unique to or specific for.

19 Q. Would you agree after December 31, 2019,
20 the patient continued to have severe stenosis?

21 A. No.

22 Q. Do you think this contradicts various MRI
23 statements that you reviewed after --

24 A. Dr. Agarwal was trying to -- to educate us
25 that there are multiple sites with multiple

1 radiologists without comparison of studies that may
2 -- subjective to reads of studies that may or may
3 not be causative to any other prior study, so
4 "severe," "significant," "mild," "moderate" are all
5 subjective terms that I defer to the radiologist who
6 reads the report.

7 Q. In your opinion, what does severe spinal
8 stenosis entail?

9 MS. THOMAS: I just want to object that
10 this exceeds the scope of the direct examination,
11 the Board listed and chose not to call Dr. Schneier
12 in their case in chief, and so should be limited to
13 a proper and limited cross-examination.

14 HEARING OFFICER BURCHAM: I think this is
15 within that scope. Overruled.

16 Witness can answer.

17 THE WITNESS: Yes. If you can repeat
18 that?

19 THE REPORTER: If I heard it correctly,
20 Doctor, the question was: In your opinion, what
21 does severe spinal stenosis entail?

22 Is that correct, Mr. Shogren?

23 MR. SHOGREN: Yes.

24 THE WITNESS: An arthritic condition.

25 MR. SHOGREN: No further questions.

1 HEARING OFFICER BURCHAM: Redirect?

2 MS. THOMAS: Nothing further.

3 HEARING OFFICER BURCHAM: Doctor, you are
4 relieved from your witness duties, but obviously
5 free to stay.

6 Ms. Thomas, anything further on your end
7 of things?

8 MS. THOMAS: No further witnesses for us.
9 We rest.

10 HEARING OFFICER BURCHAM: Any rebuttal at
11 all, Mr. Shogren?

12 MR. SHOGREN: No rebuttal.

13 HEARING OFFICER BURCHAM: All right. I
14 know Ms. Thomas would like to make a closing.
15 Mr. Shogren, you as well.

16 Are you ready to proceed, do you want to
17 take two minutes to gather your thoughts, or are you
18 ready to go?

19 MR. SHOGREN: I'm ready to go.

20 MS. THOMAS: Okay. Go ahead and I'll be
21 ready.

22 MR. SHOGREN: Okay. I'll try to keep this
23 brief and given the time right now being a little
24 later in the day.

25

1 CLOSING STATEMENT

2 BY MR. SHOGREN:

3 On behalf of the Investigative Committee,
4 I'd like to thank everyone involved in today's
5 hearing, Hearing Officer Burcham, Ms. Court
6 reporter, Dr. Schneier, counsel for your good work
7 and your presentation. I would also like to thank
8 all the witnesses for their time and consideration.
9 I think everyone made modifications to their
10 schedules to be here today, so I do thank all of
11 them.

12 As I mentioned in my opening statement,
13 we're here to present evidence so the Board can
14 determine if Dr. Schneier violated the Medical
15 Practice Act.

16 You heard today, the IC presented
17 testimony from their expert witness, Dr. Goz, who
18 reviewed this case. He reviewed thousands of pages
19 of documents regarding the care provided by Dr.
20 Schneier to Patient A.

21 Dr. Goz, as he stated, has significant
22 experience as a spinal surgeon himself, he has
23 performed hundreds of surgeries, performed surgery
24 similar to what Dr. Schneier performed on Patient A.
25 He opines that Dr. Schneier departed from the

1 standard of care here and failed to appropriately
2 address Patient A's continued spinal stenosis.

3 I think the issue here is that Patient A
4 presented with severe stenosis starting from at
5 least December 31, 2019, until at least February,
6 2020, perhaps longer, Patient A continues to have
7 severe stenosis.

8 The pathology, according to Dr. Goz when
9 he testified, Dr. Schneier did not address this
10 after multiple times of seeing patient and
11 performing surgery on December 31, 2019, and then a
12 follow-up in January, 2020.

13 There were multi MRIs and CT scans and
14 reports that showed that the patient continued to
15 have stenosis. Also Patient A was presenting
16 symptoms that showed that he continued to suffered
17 problems from this pathology, and this went
18 unaddressed by Dr. Schneier at the correct level.
19 This was over the course of several months as well.
20 Dr. Schneier had opportunity to correct it. There
21 was a continual failure to exercise due diligence
22 and skill.

23 So specifically with regards to Count I of
24 the Complaint, Dr. Schneier did not follow the
25 standard of care and committed malpractice. Also,

1 Count III, he failed to continually exercise skill
2 and diligence regarding failure to address the
3 severe pathology. The pathology was not treated
4 regardless of what, technically, the level of
5 thoracic spine this occurred at.

6 Therefore, I think the exhibits admitted
7 here today, along with the testimony given that
8 support the allegations of malpractice and the
9 continued failure to exercise due diligence.

10 On behalf of the Investigative Committee,
11 we ask the Board to consider the record presented
12 here and render the appropriate findings and
13 discipline.

14 Thank you.

15 HEARING OFFICER BURCHAM: Thank you.

16 Ms. Thomas?

17 MS. THOMAS: Thank you.

18 CLOSING STATEMENT

19 BY MS. THOMAS:

20 Likewise, I'd like to thank all the
21 participants today as well, especially Madam Court
22 Reporter, who's been a marathon participant getting
23 us through this and staying late.

24 The Board has made several allegations
25 that they have not established against Dr. Schneier.

1 First and foremost, the Board's Complaint alleges,
2 Count I, malpractice, Count II, failure to maintain
3 complete medical records, and Count III, continual
4 failure to exercise skill or diligence.

5 With regards to Count II, the Board's
6 expert, Dr. Goz, testified, "The records are
7 complete and appropriate." As a result, we would
8 move for a directed verdict on that issue, that the
9 Board has not established Count II, and, in fact,
10 its own expert witness has resolved that count in
11 favor of Dr. Schneier.

12 With regard to the remaining allegations,
13 I would like to note that, despite the relaxation of
14 the rules of evidence and procedures in an
15 administrative proceeding such as this, there is
16 still an evidentiary burden that the Board must
17 carry. And through medical consultation and issues
18 related to the standard of care, must be established
19 to a reasonable degree of medical probability, the
20 Board did not offer any testimony or opinions today
21 stated to a reasonable degree of medical
22 probability.

23 Dr. Goz never used those words, nor were
24 opinions to that degree elicited from him. His
25 opinions at times were that he could not make a

1 decision one way or the other. They were tentative,
2 tenuous, and, in fact, he never once stated where an
3 appropriate level surgery should have been
4 performed.

5 In fact, he agreed unequivocally with the
6 statement in the June 4, 2020, MRI of the thoracic
7 spine interpreted by the radiologist that stated
8 that there was no abnormal intensity -- signal
9 intensity within the spinal cord. He agreed that
10 the edema that was present on the December 31 -- the
11 December 30, 2019, thoracic MRI had improved and
12 resolved.

13 Dr. Agarwal testified to a reasonable
14 degree of medical probability that the area of the
15 most severe pathology was treated successfully and
16 improved by the surgery performed by Dr. Schneier.

17 All of the witnesses today agreed that the
18 pathology was the edema and the constriction. This
19 is a case involving a congenital stenosis in the
20 cervical, thoracic, and lumbar spine, a condition
21 that this patient was born with, a condition that
22 operated at every level.

23 The witnesses in this case agreed that the
24 radial -- radiographic numbering was ambiguous
25 throughout the report.

1 I asked Dr. Goz, who holds himself out as
2 an expert in spine surgery as well as having
3 training and competency in neuroradiology, if he
4 could -- if he could review and interpret images.
5 He said yes. He was unable to do so. He was given
6 an opportunity to look at the totality of the images
7 on each series that was discussed today. He was
8 unable to do so. That testimony resolved in favor
9 of Dr. Schneier.

10 The testimony related to the standard of
11 care applicable at the time of Dr. Schneier's
12 surgery demonstrates that Dr. Goz is not an expert
13 and that he is not qualified to opine on the
14 standard of care in December, 2019, because he was
15 not qualified to perform the procedure at issue.

16 You must have the qualifications to
17 perform the procedure at issue at the time it was
18 performed in order to opine on the standard of care.
19 This would be akin -- and this is an extreme
20 example -- to providing a stick in the mouth to bite
21 on and liquor before the advent of anesthesiology.
22 That was the standard of care before anesthesia was
23 available for procedures, but that is not the
24 standard of care now that things have advanced and
25 modern medicine provided for the use of anesthesia.

1 To say that somebody violated the standard
2 of care requires evidence and opinions stated to a
3 reasonable degree of medical probabilities. What
4 the evidence showed today was that Dr. Schneier
5 performed at complete T10-T11 laminectomy. There
6 was no wrong-level probable surgery.

7 The medical reports and records were
8 confusing because thoracic CT and MRI count spinal
9 levels from the top down and yield a different
10 result from counting from the sacrum up, as what had
11 been done for the lumbar MRIs and X-rays and
12 intraoperative fluoroscopy. Counting from above
13 yields one's higher spinal level compared to
14 measuring below.

15 Most surgeons preferred counting from
16 below and identifying the sacrum or lowest ribs
17 because these are bony structures that are easily
18 identified at the time of surgery using fluoroscopy.

19 This is particularly difficult because the
20 un rebutted testimony established that this patient
21 had variant spinal anatomy, including complete
22 sacralization of the L5 vertebrae to the S1
23 vertebrae.

24 The laminectomy was successful as
25 demonstrated by the resolution of the cord signal

1 changes in the lower thoracic spine. The patient's
2 need for additional laminectomies is not unusual for
3 a patient such as this one who has congenital spinal
4 stenosis in all levels of the spine: cervical,
5 graphic and lumbar. Which Dr. Goz agreed was
6 unusual and not common, particularly in the setting
7 of a 49-year-old man.

8 The patient had bilateral hip replacements
9 that were complicated by a left hip dislocation and
10 a flex arthritic left knee that impacted his gait.
11 These gait abnormalities seem to be alluded to or
12 implied to be related to the surgery performed by
13 Dr. Schneier, but the subsequent operating
14 neurosurgeon, Dr. Khavkin, documented several
15 physical examinations with the absence of any
16 abnormal neurological findings. There is no
17 evidence of any permanent neurological deficit.

18 Dr. Schneider treated the most urgent
19 level of pathology in this patient, and that
20 pathology was objectively improved, as identified by
21 subsequent interpreting radiologists. And
22 admittedly by Dr. Goz himself, there was an
23 improvement.

24 It is important to note that there are
25 several providers in this case that interpreted the

1 vertebral counts in the same manner as Dr. Schneier.

2 There exists other reports that provide a
3 different count, counting from the next stem, from
4 the cervical spine stem.

5 Dr. Goz conceded and offered testimony
6 that when there is ambiguity in counting, it's
7 important to treat the pathology. And, again, he
8 did concede in his own testimony that the pathology
9 had been improved and resolved.

10 There is no wrong-level surgery, and this
11 patient's condition improved. The spinal cord
12 signal was gone on subsequent imaging.

13 In order to say that a provider did not
14 meet the standard of care or committed malpractice,
15 those are opinions that require expert -- competent,
16 qualified, expert support stated to a reasonable
17 degree of muscle probability. These are important
18 nuances that present procedural and substantive
19 rights to Dr. Schneier and must be adhered to even
20 in the administrative setting.

21 They have not been met in this case, and
22 this case should be resolved in Dr. Schneier's
23 favor.

24 There is more than sufficient evidence to
25 allow a reasonable mind to reach this conclusion,

1 including that expressed by a 20-plus-year,
2 experienced neuroradiologist that demonstrated
3 through these exhibits admitted in this case that
4 the pathology has unequivocally improved since the
5 commission of Dr. Schneier's first surgery.

6 Any delay or healing restraint or
7 inflammatory process had resolved and cleared up no
8 later than June 4, 2020, prior to the surgery
9 performed by Dr. Khavkin, the edema resolved on its
10 own, it required the construction being removed, and
11 that is what Dr. Schneier did.

12 Thank you.

13 HEARING OFFICER BURCHAM: Thank you.

14 Mr. Shogren, real quick question, counsel
15 brought up, Count II. I heard the same testimony
16 from Dr. Goz that counsel heard. That's no longer
17 part of the case; correct? It's the medical
18 records. You didn't address it in there --

19 MR. SHOGREN: That is correct.

20 HEARING OFFICER BURCHAM: Okay. All
21 right.

22 Ms. Thomas, you talked about a directed
23 verdict, in whatever order I come out with, findings
24 and all, that is how Count II will be addressed.

25 Anything further?

1 MS. THOMAS: Not from me.

2 MR. SHOGREN: Nothing further.

3 HEARING OFFICER BURCHAM: Hearing nothing
4 further, we can go off the record.

5 Thank you.

6 (Hearing ended at 5:00 P.M.)

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1 STATE OF NEVADA)
) ss.
2 COUNTY OF WASHOE)
3

4 I, BRANDI ANN VIANNEY SMITH, do hereby
5 certify:

6 That I was present on May 28, 2025, for
7 the hearing at the Nevada State Board of Medical
8 Examiners, and took stenotype notes of the
9 proceedings entitled herein, and thereafter
10 transcribed the same into typewriting as herein
11 appears.

12 That the foregoing amended transcript is a
13 full, true, and correct transcription of my
14 stenotype notes of said proceedings consisting of
15 248 pages, inclusive.

16 DATED: At Reno, Nevada, this 14th day of
17 June, 2025.
18
19

20 

21 BRANDI ANN VIANNEY SMITH
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[understand - vertebrae]

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[yellow - zoom]

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4

IC's Exhibits Admitted at
Hearing
1-5, 7-10

EXHIBIT 1

EXHIBIT 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Rachakonda D. Prabhu, M.D.
Board President



Edward O. Cousineau, J.D.
Executive Director

July 12, 2021

Michael Schneier, M.D.
10105 Banburry Cross Drive, #445
Las Vegas, NV 89144

RE: BME CASE [REDACTED]

PATIENT: [REDACTED]

Dear Dr. Schneier:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges your treatment and care of the patient may have fallen below the standard of care which may have had an adverse impact on the quality of care rendered to the above named patient.

It is alleged:

1. On December 31, 2019, the patient underwent laminectomy surgery at T10/T11 to alleviate pressure to the spinal cord.
2. The patient asserts the surgery was performed at T9/T10 with the screw placed in the spinal canal, complicating the patient's condition.
3. You failed to timely identify the misplaced screw and timely rectify it.
4. You failed to inform the patient the incorrect procedure was performed.
5. Your care of the patient resulted in additional pain, discomfort, additional surgical procedures, hospitalizations and medical expenses.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, including, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 30 calendar days.**

Please return the health care records with the signed Custodian of Records Affidavit, enclosed herewith. If you are not a custodian of the patient records, please indicate where the health care records can be obtained.

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the

8/30/22

NPMA until a thorough investigation is completed.

As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.301(4) and NAC 630.040.

Respectfully,

A handwritten signature in black ink, appearing to read 'J. LaRue', with a large, stylized flourish extending to the right.

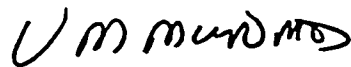
Johnna S. LaRue, CMBI
Deputy Chief of Investigations

1 disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(1)(d); further,
2 the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

3 Additionally, compliance with this order is deemed compulsory and shall not be deemed to
4 be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

5
6 Dated this 12th day of July 2021.

7 NEVADA STATE BOARD OF MEDICAL EXAMINERS
8 INVESTIGATIVE COMMITTEE

9 

10

Bret Frey, M.D., Chairman
11 Victor M. Muro, M.D., Chairman
12 Nevada State Board of Medical Examiners
13 Investigative Committee
14
15
16
17
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21
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28

STATE OF NEVADA)
) ss.
COUNTY OF _____)

1. That I am the _____ (position or title) of
_____ (name of company or employer) and in my capacity as
_____ (position or title), I am a custodian of the records of
_____ (name of company or employer).

3. That on the ____ day of the month of _____ of the year _____, I received an order for health care records in connection with the Nevada State Board of Medical Examiners Case No. [REDACTED], calling for the production of records pertaining to [REDACTED]

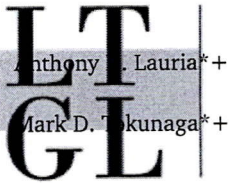
5. That the original of those records was made at or near the time of the act, event, condition, opinion or diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of _____ (name of company or employer).

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20____.

My commission expires: _____

EXHIBIT 2

EXHIBIT 2



LAURIA
TOKUNAGA
GATES &
LINN, LLP
ATTORNEYS AT LAW

Raymond R. Gates*+
Scott A. Linn*
Brian A. Rosenthal*
Paul A. Cardinale*+
Artak Paskevichyan*+
Esther Ismayelyan*
Joseph G. Helfrick*

*Licensed in California
+Licensed in Nevada

RECEIVED

AUG 30 2022

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

Please reply to Sacramento

August 29, 2022

Via Mail: JLaRue@medboard.nv.gov

Johnna S. LaRue, CMBI
Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Re: BME Case [REDACTED]

Patient: [REDACTED]

Dear Ms. LaRue:

As you know, we have been retained to represent Michael Schneier, M.D. in regard to BME Case No. [REDACTED] involving the patient, [REDACTED]. The medical condition and history of [REDACTED] is long, complicated and somewhat confusing, with several providers noting inconsistencies in [REDACTED] reported functional abilities and the actual abilities witnessed by the providers when [REDACTED] did not realize he was being observed. Further, [REDACTED] had applied for Social Security Disability long before his care and treatment with Dr. Schneier. To the extent feasible and based on the limited records available to Dr. Schneier, the medical condition and issues pertaining to [REDACTED] are set out below.

Records of University Medical Center

The earliest records which we have access to are from a hospitalization at UMC from October 21-23, 2019. He presented to the ED complaining of bilateral hip pain and "rigidity" in the

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1755 Creekside Oaks Drive, Suite 240
Sacramento, CA 95833
Tel: (916) 492-2000
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LAS VEGAS

601 South Seventh Street
Las Vegas, NV 89101
Tel: (702) 387-8633
Fax: (702) 387-8635

NSBME 006

lower extremities which he reported began "a few days ago" and he reported he was not able to ambulate or flex his lower extremities on his own without assistance. [REDACTED] had undergone bilateral hip replacements performed by [REDACTED] in 2018 and February of 2019. He was seen in the ER at Sunrise Hospital (those records are unavailable to us currently) and followed up with Dr. [REDACTED] who noted no unusual findings on x-ray. [REDACTED] reported numbness and tingling at the plantar surface of both feet (? L3-4 innervation) and decreased strength in both lower extremities.

On examination, [REDACTED] was found to have 5/5 strength in dorsiflexion and plantar flexion although there was "increased rigidity in the bilateral lower extremities with a reported inability to flex his hips or knees.

There is an Addendum Report by ED provider [REDACTED] in which the doctor noted a report by [REDACTED] that he had fallen on his belly. Now the patient reported some numbness on the plantar surface bilaterally but no new weakness or numbness. His physical examination findings are curious at best with an "inability to flex more than 30 degrees with very tense musculature.

According to a note by Nurse [REDACTED], [REDACTED] reported that a week ago he went to Sunrise, was told to follow up with his Ortho, and was given a walker. He reported 3 days of "increasing lower extremity weakness, back pain and falls."

Yet, the information given to the admitting physician, Dr. [REDACTED], differs significantly from the information provided to Nurse [REDACTED]. Dr. [REDACTED] reported 2 weeks of bilateral hip pain at 8/10 but reported he was "walking without any assistance" prior to admission. Dr. [REDACTED] also noted that [REDACTED] "denies any recent falls", does not follow up with primary care and is "noncompliant with medications." The doctor reported a past medical history notable for "substance abuse", chronic pain (including back pain) and opioid dependence. In fact, drug screening at UMC was positive for cocaine, opiates, and THC. On examination, Dr. [REDACTED] documented grossly intact sensation, 5/5 strength globally, and that otherwise Mr. Bickham was "uncooperative with exam."

A Physical Therapy initial assessment was performed by [REDACTED] DPT who noted that when asked about independent function prior to admission, the "Pt. was not forthcoming with information." When assessing the range of motion and strength of the lower extremities, DPT [REDACTED] noted 4/5 strength with rigidity and "inconsistent presentation" as to both legs. [REDACTED] was unsteady with his gait and walked on the tips of his toes in a very uncoordinated fashion.

On October 22, 2019, Dr. [REDACTED] noted that [REDACTED] was “very argumentative and yelling at [him].” That same day, Nurse [REDACTED] noted that [REDACTED] wouldn’t provide his home medication information correctly. Later notes from that day indicate [REDACTED] wanted an MRI for his hips which Dr. [REDACTED] did not feel was indicated. In fact, during the hospitalization there was no diagnosis or medical explanation identified for the odd “rigidity” of the lower extremities and inability to flex at the hips and knees. (As noted during a later hospitalization, there did not appear to be an organic cause for this odd presentation as [REDACTED] had full range of motion when examined under anesthesia.)

During the hospital stay he was treated with IV and oral pain medications for his chronic pain and opioid dependence. [REDACTED] was described as difficult, being very aggressive and angry at times. [REDACTED] was discharged on October 23, 2019, with placement at a skilled nursing facility (Harmon Hospital) for further rehabilitation and outpatient follow up with his primary care provider and orthopedic surgeon. According to [REDACTED] deposition testimony, her husband left Harmon after only one day “against medical advice.”

Desert Springs Hospital – November 5, 2019

On November 5, 2019, an ambulance was called and [REDACTED] was taken to Desert Springs Hospital where a History and Physical was performed by Dr. [REDACTED]. [REDACTED] reported that he had been ambulating with a front wheel walker until “he fell about 3 weeks ago.” He now complained of worsening leg cramping, back pain with radiculopathy and weakness so he was unable to ambulate to the bathroom and reported frequent accidents/incontinence. On examination [REDACTED] reported normal range of musculoskeletal motion with no deformity. Lower extremity strength was 4/5 bilaterally with atrophy noted. Although [REDACTED] denied substance abuse, he again tested positive for cocaine, opiates, and THC.

A CT of the lumbar spine showed a disc bulge at the L3-4 level causing “severe left and moderate right neuroforaminal narrowing.” There was a broad based bulge at L4-5 with moderate narrowing. This was followed by an MRI of the lumbar spine which was interpreted as showing severe left L5-S1 neural foraminal stenosis with moderate bilateral L4-5 and right L5-S1 stenosis. Moderate spinal canal stenosis at L3-4, mild to moderate narrowing of the canal at L4-5, and bilateral recess narrowing at L5-S1 was also reported.

In a progress note of November 6, 2019, Nurse [REDACTED] recorded that the patient refused to sign the patient assistance agreement regarding fall prevention, refused a yellow gown

and bed alarm. On November 7, 2019, Nurse [REDACTED] recorded that Security had been called because of [REDACTED] being rude to the neighboring patient.

While the Rehabilitation Services attempted to fully assess [REDACTED], they were unable to do so due to “increased muscle tone” on both lower extremities. In fact, Occupational Therapist [REDACTED] documents on November 6, 2019:

“Patient is hospitalized with inability to walk, lumbar stenosis, back pain, lumbar radiculopathy. Patient noted to have hypertonicity with movement in trunk, but when talking to therapist at the edge of bed, no abnormal tone was noted, patient able to lean forward and place both feet on the ground with ease while talking to therapist. Inconsistency noted with movement.”

On November 7, 2019, Physical Therapist [REDACTED] reported similar inconsistent and unexplainable findings. She reported:

“there are inconsistencies in pt presentation, (i.e. – Increased tone in BLE in bed, but can sit [on] EOB, Great toes [bilaterally] curled up, but flexible and then able to keep relaxed; sitting [on] EOB with {bilateral} knees well flexed; {bilateral} feet somewhat [plantar flexed], but once standing, at neutral.”

[REDACTED] was discharged on November 7, 2019, to Horizon Health & Rehabilitation for additional therapy with a diagnosis of acute on chronic back pain with myeloradiculopathy. Per his wife, he also left that facility AMA after one day.

Machuca Family Medicine – 11/14/19

[REDACTED] presented for follow up “status post ED visit” due to inability to walk and back pain. On examination the lumbar muscles were tender to palpation, bilateral straight leg raise testing was positive and he was ambulating with a walker. He was given an injection of Toradol and dexamethasone and a “referral to spine surgeon” with instructions to return in 2-4 weeks. There is no indication which spine surgeon [REDACTED] was referred to or whether he ever actually saw a spine surgeon. It does not appear that he returned until April of 2020.

Sunrise Hospital – 12/26/19

██████████ was taken by ambulance to Sunrise Hospital for low back pain of 10/10 which began that day. He felt like both legs froze and tensed up and reported an inability to walk for the past 2 months. He reported that an MRI showed bulging discs at L3-L5 and caused sciatic pain. He was noted to be taking Xarelto and Oxycodone 15 mg Q4h for pain at home and denied having a PCP or Family Physician. He denied alcohol or recreational drug use. On examination, ED physician Dr. ██████████ documented no motor or sensory deficits.

He was admitted to the hospital by Dr. ██████████ who again noted an inability to walk for 2 months and worsening pain that day so he contacted his orthopedic surgeon who told him to go to the hospital. (not clear when the conversation took place since he arrived at the hospital shortly after midnight on 12/26) Upon examination, Dr. ██████████ noted no sensory or motor deficits. The plan was to admit, get an MRI of the brain, provide IV narcotics for pain and communicate with orthopedic surgeon Dr. ██████████

An MRI of the lumbar spine on December 27, 2019, was interpreted by Dr. ██████████ as showing “no acute lumbar spine abnormality” and “severe canal narrowing at T11-12 with likely cord edema at this level.” Yet, a thoracic spine MRI performed 3 days later on December 30th was interpreted by Dr. ██████████ as showing only “mild” central canal stenosis at T7-8, T9-10 and T11-12. Instead, Dr. ██████████ felt there was severe stenosis at T10-11 with abnormal cord signal at that level and possibly at T7-8. In fact, Dr. ██████████ full report of the December 30, 2019, MRI describes “posterior disc osteophyte complexes at T9-10 and at T10-11 with moderate to severe T9-T10 and severe T10-11 foraminal stenosis.

On December 28, 2019, Dr. Schneier was asked to perform a neurosurgical consult on ██████████ ██████████ Dr. Schneier noted he was asked to consult for “lower extremity weakness” and a progressive decline in the ability to ambulate according to the patient. He noted a history of presentation to multiple ERs with some “disregard to care”. ██████████ reported a 2 month history of back and left lower extremity pain with ambulatory difficulty and “give away strength” in the left leg. The patient denied claustrophobia but was demanding anesthesia for MRI. Motor and sensory examination of the lower extremities was normal although there was some question regarding ██████████ full cooperation with the exam of the left leg.

Dr. Schneier’s consult note includes the results of x-rays of the hips and pelvis and a lumbar MRI which were previously performed. The left hip imaging did not show a dislocation although the positioning was suboptimal and the patient could not tolerate additional imaging. The MRI of the lumbar spine showed severe canal narrowing at T11-12 with likely cord edema. Dr. Schneier documented discussing and reviewing the lumbar MRI with the patient and explaining

the cephalad pole of the study suggested degenerative joint disease with slight gibbus deformity causing central canal compromise and possible conus compression. The potential risks of surgery were discussed including, but not limited to, paralysis, CSF leak, meningitis, death, coma, vascular injury, misplaced hardware and the requirement of reoperation. Further MRI imaging of the thoracic spine was ordered.

On December 29, 2019, a cardiology consult was performed by Dr. [REDACTED] in anticipation of surgery. [REDACTED] again denied recreational drug use. She found that [REDACTED] was an intermediate surgical risk with hypertension heart disease. Curiously, the exam findings reported by [REDACTED] on December 29, 2019, are markedly different than those reported by others. (Compare with December 30th findings by PA [REDACTED] below)

PA [REDACTED] reported on December 30, 2020, that [REDACTED] felt his legs were “very weak” and he wanted to proceed with spine surgery. She documented generalized weakness and increased tone of both lower extremities. He could briefly lift the legs against gravity and reported paresthesia and pain to light touch throughout both legs. She notes that she discussed the thoracic MRI findings with Dr. Schneier and surgery “involving T10-12 laminectomy” was planned. She also documented reviewing the surgery and potential risks, benefits and alternatives with [REDACTED]

On December 31, 2019, Dr. Schneier again documented discussing the potential surgery and risks and complications with the patient and his family. The plan was laminectomy, with possible facetectomy requiring pedicle screw fixation. [REDACTED] agreed to attend inpatient rehabilitation post-operatively. Once again, Dr. Schneier noted an “aggrandized exam” with [REDACTED]

The Operative Report prepared by Dr. Schneier reported spinal stenosis at T10 and T11 as both the pre-operative and post-operative diagnosis. Identification of a level in the thoracic spine is recognized as difficult with surgery at the wrong level reported by approximately 50% of spine surgeons. The reasons for this difficulty include “anatomical variations such as transitional vertebrae, rib variants, hemivertebra, and block/fused vertebrae as well as patient characteristics, such as tumors, infections, previous thoracic spine surgery, obesity, and osteoporosis” according to a recent published peer reviewed article. This can lead to variations in the identification of levels in the thoracic spine where pathology exists. In this case, Dr. Schneier identified spinal stenosis at T10 and T11 whereas the radiologist interpreted the MRI imaging as showing the most significant stenosis at T11-12. Thus, numbering discrepancies are not uncommon.

Dr. Schneier reports properly using fluoroscopy to identify the T12 rib and the T10-11 pedicles. Unfortunately, it does not appear that this imaging was retained by Sunrise Hospital. Dr. Schneier observed intraoperatively thickened ligament depressing the cord which he addressed during the procedure. He performed widening of the canal bilaterally and personally observed cord expansion and pulsation of the cord with decompression. Pedicle screws were placed and intra-operative neuromonitoring confirmed that the screws did not breach the pedicle using CMAP testing according to Dr. Craig Carroll.

PAC [REDACTED] reported on January 1, 2020, that [REDACTED] was no longer having spasms and his legs were improved from prior to the operation. On January 2, 2020, [REDACTED] reported that [REDACTED] reported he was doing better with increased movement and less leg pain since Dr. Schneier's surgery. He continued to have "increased tone" (rigidity) in the lower extremities for which he was receiving baclofen.

Initially, the plan was to discharge [REDACTED] for rehabilitation per physical therapy recommendation on January 3, 2020.

On January 4, 2020, PAC [REDACTED] (PA for physical medicine physician Dr. [REDACTED]) reported that the patient presented to the ED with a past history of L3-L5 bulging disc and new 10/10 left hip pain. He reported feeling like both legs "froze and tensed up" and he claimed an inability to walk for the past 2 months. The patient was seen by neurosurgery who recommended baclofen and Decadron and cleared the patient for skilled nursing placement. Subsequently, a physical therapist noted the left lower extremity was externally rotated and an x-ray showed dislocation of the femoral head. Thoracic MRI was ordered and was interpreted as showing mild T7-8, T9-10 and T11-12 central canal stenosis with severe narrowing at T10-11 and abnormal cord signal at T10-11 and possibly T7-8. Now, for the first time in any record available, there is a report of thoracic pain in addition to lumbar pain and extremity pain. PAC [REDACTED] reports that the patient was status post T10-11 laminectomy and cord decompression with pedicle screw fixation. The patient now had acute hip pain secondary to dislocation.

Curiously, during this hospitalization, [REDACTED] held the left knee in flexion but when the knee was examined while Mr. [REDACTED] was under anesthesia, there were no restrictions to the range of motion of the knee.

Dr. [REDACTED] performed a consultation on January 5, 2020, in which he noted that [REDACTED] had been followed in his office and there were "occasional questions about instability in the left

hip” but no frank dislocation until now. He reports x-rays on 12/26 showed the hips in place but a film on 1/3 showed the left hip to be dislocated. On examination external rotation and shortening of the left leg consistent with a left hip dislocation and reduction under anesthesia was recommended although he noted that revision arthroplasty may be needed.

Discharge was again planned for January 7, 2020, and [REDACTED] was to follow with Orthopedic Surgeon Dr. [REDACTED] in 1-2 weeks and with Dr. Schneier in 6 days. This was delayed, however, as Dr. [REDACTED] noted recurrent dislocations in the left hip and performed a revision total hip arthroplasty on January 9th.

[REDACTED] returned to the hospital on January 22, 2020, and ED physician [REDACTED] describes “bilateral lower extremity spasticity left > right with normal muscle strength and sensation.” He noted that a CT showed possible pedicle screw breach and that Dr. Schneier was contacted.

Dr. Schneier prepared his consultation report on the morning of January 23, 2020. In that report he noted that [REDACTED] was “status post thoracic laminectomy and pedicle screw placement T9-T10 with laminectomy extending into the T10/11 disc space. The patient now complained of left lower extremity pain with restriction in knee extension. The patient had no sensory deficit, no motor deficit (5/5) and normal bowel and bladder control.

Dr. Schneier noted that he reviewed the CT scan and found no CSF extravasation and the thecal sac was not impinged. He planned to take [REDACTED] to surgery, removed the screws and get a further MRI without the artifact caused by the hardware.

[REDACTED] was readmitted on January 24, 2020. The records show a questionable report of a pedicle screw entering the thecal sac. Repeat surgery by Dr. Schneier confirmed there was no breach of the pedicle and the hardware was removed. [REDACTED] was noted to be doing better and was preparing for transfer to skilled nursing but then experienced severe spasticity that prevented any movement of his legs and prevented rehab.

On January 31, 2020, Dr. [REDACTED] prepared a consultation in which he noted [REDACTED] was doing fairly well after the left hip revision and was standing and walking with a walker. He was seen in Dr. [REDACTED] office where he complained of pain in the knee and restricted movement. Dr. [REDACTED] noted that an MRI of the left knee “showed no structural change that would explain his knee pain and contracture.” Dr. [REDACTED] noted that there were no concerning

findings on examination. Further, at the time of the revision surgery (January 9, 2020) there was no limitation to range of motion in the knee with 0 degrees extension and 120 degrees flexion.

On February 4, 2020, an MRI interpreted by Dr. [REDACTED] described “post-operative changes” from laminectomy at T9 and T10 with removal of hardware and “severe canal stenosis at T10/T11 secondary to disc protrusion and scar tissue from laminectomy at T10.” It must be noted that in the MRI performed at Sunrise Hospital prior to Dr. Schneier’s December 31st procedure, the most significant stenosis was identified at T11-T12. Now, Dr. Hardman describes stenosis at T10-T11.

Dr. Schneier’s progress note of February 4, 2020, records that the patient was being evaluated for inpatient rehabilitation but had to be able to perform 3 hours per day to meet criteria. He noted that the thoracic MRI done that day did not show signal edema like the initial 12/31 MRI did. There was no evidence of post laminectomy spondylolisthesis or a CSF leak. There was 5/5 strength in all major muscle groups of the lower extremities but Mr. [REDACTED] continued to hold his left leg flexed at the knee and claimed he was unable to perform knee extension.

A Discharge Summary was prepared on February 10, 2020, by Dr. [REDACTED] who noted that [REDACTED] continued to report “back spasms” and remained weak. He was awaiting placement at a skilled nursing facility which occurred on February 16, 2020.

On February 15, 2020, Radiologist Dr. [REDACTED] describes “persistent cord compression at T10-T11” similar to that described by Dr. [REDACTED] due to “scar tissue” and Dr. [REDACTED] reported effacement of the dorsal CSF by enhancing granulation tissue. Dr. [REDACTED] reports “improved patency of the central canal at T9-T10 and only “mild central canal stenosis without cord compression” at T11-T12.

A progress note by Dr. [REDACTED] noted that [REDACTED] was going to be discharged to a skilled nursing facility. A repeat MRI of the thoracic spine showed “significant spinal stenosis due to scar tissue.” Neurologist Dr. [REDACTED] reported on February 16, 2020, that [REDACTED] again reported spasms and leg weakness. On examination, he had normal strength in the legs normal sensory function. Increased tone (rigidity) was reported. Dr. [REDACTED] noted that after the hardware removal by Dr. Schneier, [REDACTED] was better and preparing for transfer to skilled nursing. Over the past few days, however, he had a significant decline with severe spasticity where his muscles are rock hard and unable to relax. This prevents movement and rehab. She noted that the prior MRI of February 4th showed “seroma and scarring that may have worsened over the past few days.

According to the History and Physical prepared by Dr. [REDACTED] prepared on March 11, 2020, [REDACTED] reported a "one-week history" of pain and that "on discharge in February he was doing well and was able to ambulate on his right lower extremity as his left leg was in permanent flexion. Over the past week he reports bilateral lower extremity spasms, weakness and back pain.

A Physical Medicine and Rehabilitation consult was performed by Dr. [REDACTED] who noted that [REDACTED] was "refusing therapy."

[REDACTED] PAC noted that [REDACTED] reported he had been doing well at home with increased lower extremity strength and exercising several times per day. He reported that over the prior weekend he developed increased muscle stiffness and spasms in both legs. He denied having any back pain. He did report persistent numbness and tingling in the feet at the end of the day.

On examination he had full strength in the right lower extremity and increased tone with decreased strength in the right although he was now lifting the leg against gravity more easily. During the hospital stay, they were trying to wean [REDACTED] off of IV narcotics for discharge home with outpatient pain management and neurosurgery follow up. During the stay he was receiving Diazepam, Toradol, dilaudid and Oxycodone. He was discharged home on March 16, 2020, with instructions to continue with pain management.

[REDACTED] – April 21, 2020 & April 22, 2020

[REDACTED] returned to this primary care provider for the first time since November complaining he was unable to bear weight on the left leg and he could not fully extend his knee. He reports he went to PT but they could not treat him due to severe nerve damage.

The following day, [REDACTED] requested referral to a pain specialist. (no reason given why he did not follow up with the prior pain management physician) He now reported pain in his spine and legs which was constant and severe at 8-10/10. A referral was made to an unknown pain management physician.

Dr. [REDACTED] - Clinical Neurology Specialists

Dr. [REDACTED] saw [REDACTED] on 3 occasions and performed EMG and NCV testing. He ordered a further MRI of the thoracic spine. Dr. [REDACTED] notes a history reported by [REDACTED] of inability to walk since approximately September of 2019. [REDACTED] was a "poor historian" and complained of "pain in the distal legs and feet." On examination [REDACTED] was found to have intact sensation, but reduced strength (4/5 on right and 4-/5 on left) in the lower extremities. On a subsequent visit he performed EMG testing which was normal. Nerve conduction velocities were slowed in both legs indicating sensory peripheral neuropathy. There was no evidence of motor neuron disease or myopathy. He planned to perform somatosensory evoked response testing.

On May 18, 2020, the results of an MRI performed at Desert Radiology were reported by Dr. [REDACTED]. He described severe endplate disease at T9-10 and T10-11. There was moderate central canal stenosis at T9-10 (7mm) and severe central canal stenosis at T10-11 (6mm). He was unable to identify abnormal signal within the cord.

Dr. [REDACTED] report of May 28, 2020, [REDACTED] reported consistent weakness in the lower extremities with tightness and spasms. Evaluation of potential abnormal signal on the MRI was difficult. Dr. [REDACTED] reported that electrodiagnostic studies of the lower extremities did not explain the degree of weakness and pain in the bilateral lower extremities. He later stated that somatosensory evoked potential of the lower extremity was abnormal which he thought was "due to thoracic myelomalacia.

Desert Springs Hospital

According to ER physician Dr. [REDACTED], [REDACTED] reported back pain present since December of 2019 which was constant and moderate. He also reported left foot numbness and involuntary movement of the left big toe, a symptom never previously reported. Dr. [REDACTED] physical examination was entirely normal except for reports of tenderness to palpation in the lumbar spine.

[REDACTED] was seen by Dr. [REDACTED] on May 30, 2020. The history recorded by Dr. [REDACTED] is not accurate and describes "misplaced hardware" and that the patient showed no improvement following surgery by Dr. Schneier. The description of "progressive worsening" with difficulty walking and use of a walker shows that Dr. [REDACTED] was not aware that [REDACTED] had reported difficulty walking and use of a walker for many months and even before any treatment by Dr. Schneier. He notes that [REDACTED] had no sensory deficits and was able to lift his legs off of the bed. There is no mention of rigidity or lack of motion in the left knee.

Spring Valley Hospital

On May 31, 2020, a Neurology Consult was documented by Dr. [REDACTED]. The patient reported low back pain and left lower extremity weakness with worsening symptoms over the "past several weeks." On examination, Dr. [REDACTED] recorded that "tone was intact" and there was normal sensation to light touch.

Dr. [REDACTED] authored another consult note on June 6, 2020, and once again, misstates the history and misstates the records, even his own. He reports "profound weakness" in the left leg at the time of his evaluation but documents 4-/5 motor strength and a patient who is able to ambulate with a walker. Dr. [REDACTED] asserts that the patient's symptoms worsened and deteriorated when a review of the records dating back to November of 2019 records bilateral lower extremity strength of 4/5 at that time. Dr. [REDACTED] fails to mention that it was post-operative scar tissue identified by Radiologists Dr. [REDACTED] and Dr. [REDACTED] in February which was causing the canal stenosis at T10-11.

Not surprisingly given the long history of opioid use by [REDACTED] there are numerous reports in the Spring Valley Hospital records of demands for opioids to physicians and staff.

Dr. [REDACTED] additional records will not be addressed except to note that on an office visit of December 29, 2020, [REDACTED] was reporting the same "spasm" in his lower extremities he had reported in the past. In fact, it was this same unexplained "spasm" which led to [REDACTED] hospitalization at UMC from October 21-23, 2019, where Physical Therapist [REDACTED] noted 4/5 strength with rigidity and "inconsistent presentation" by the patient. During the November 2019 hospitalization at Desert Springs Hospital, Occupational Therapist Irene Wilson documented that [REDACTED] presented with increased tone when knowingly observed but had no restrictions in movement when he did not think he was being watched. The same inconsistencies in the patient's presentation were documented by Physical Therapist [REDACTED] while at Desert Springs.

[REDACTED] now reported loss of sensation in the left leg although all of Dr. [REDACTED] prior office notes reflected "sensation intact for light touch." His subjective reports of sensory function in the lower extremities have also varied from hospitalization to hospitalization and from practitioner to practitioner. What has not changed is the desire of [REDACTED] to receive opioids.

Response to Specific Allegations

- 1) Dr. Schneier admits that the patient was taken to surgery on December 31, 2019, with the intent to alleviate stenosis of the central canal in the thoracic spine. The precise level of intervention would depend on intraoperative findings. Further, the interpretation of levels in the thoracic spine on imaging is difficult as shown by the disagreement among radiologists as to the levels of “severe pathology” in [REDACTED]
- 2) Surgery was performed at the level where pathology was found intraoperatively and compression of the canal was relieved as described in Dr. Schneier’s operative report. It should be noted that subsequent MRI studies no longer described the presence of the abnormal cord signal seen in the pre-operative imaging. While the imaging prior to Dr. Schneier’s December 31, 2019, surgery show swelling in the spinal cord, the imaging following this procedure show that this swelling has been relieved. That was the goal of the procedure. In fact, the June 4, 2020, MRI report from Dr. [REDACTED] at Desert Radiology specifically reports that “The visualized spinal cord demonstrates normal signal intensity.” This is in marked contrast to the MRI of December 30, 2019, at Sunrise Hospital prior to the surgery by Dr. Schneier which was interpreted by Dr. [REDACTED] as showing abnormal cord signal in the thoracic spine. (please compare Saggital T2 series 7, Image 11 on 12/30/19 MRI with Saggital T2 series 5, Image 10 on June 4, 2020 MRI) Further, subsequent imaging describes post-operative scar tissue as the source of narrowing of the canal at the T10-11 level. While a CT scan was interpreted as potentially showing a pedicle screw breach, intra-operative neuromonitoring at the time of the December 31st surgery did not indicate such a breach and no pedicle breach was found upon the second exploratory surgery by Dr. Schneier.
- 3) There was no misplaced screw per neuromonitoring and personal observation at surgery.
- 4) The incorrect procedure was not performed.
- 5) [REDACTED] has a variety of complex and often unexplained medical conditions that have waxed and waned over time. His rigidity, increased tone, left knee stiffness are not easily explained, especially when full range of motion was noted when [REDACTED] was under anesthesia. [REDACTED] is clearly a “care-seeker” and it does not appear from the limited records available that the “additional procedures, hospitalizations, and medical expenses” have been of any benefit to [REDACTED] whatsoever. Dr. Schneier suspected as much after treating him on several occasions which is why he declined to return him for further surgery when MRIs in February showed scar tissue again causing canal stenosis but no abnormal signal suggesting compression and swelling in the cord. In fact, [REDACTED] appears no better off following Dr. [REDACTED] thoracic procedure than he was prior to that intervention. It is understood that Dr. [REDACTED] may have also convinced

Johnna LaRue
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██████████ that cervical spine surgery was needed although throughout the medical records discussed above, there were no complaints associated with the cervical spine.

It is submitted that the care and treatment of ██████████ by Dr. Schneier was at all times appropriate and within the standard of care. Now that many of the records of ██████████ numerous hospitalizations and inconsistent presentations are available, it is clear that ██████████ was an extremely difficult patient who appeared to briefly improve with whatever treatment he received, only to return for additional intervention, including narcotic medications, a short time later. In fact, the most recent records from late 2020 from ██████████ office suggest that ██████████ is reporting essentially the same unexplained “rigidity” and “spasm” in his left leg that he reported in October and November of 2019 and which several therapists noted appeared non-physiologic. After further hip replacement surgery and 3 spine procedures, ██████████ continues to subjectively report the same symptoms. Further, it appears that he may have undergone cervical spine surgery by Dr. ██████████ although not a single report of c-spine symptoms is noted in the records. Presumably, he continues to have the same lumbar spine stenosis initially identified at Desert Springs Hospital in November of 2019. ██████████ was referred for inpatient therapy on at least 3 occasions and left AMA from at least two of those placements after only 1 day. Thus, there are numerous questions still unanswered regarding the complex medical and possibly psychological picture presented by ██████████

Dr. Schneier was presented with an unknown patient presenting with complaints of pain and inability to function whose thoracic MRI showed cord compression, swelling and abnormal signal. Following surgery, this swelling and compression was relieved and subsequent imaging no longer showed abnormal signal intensity. This is clear if the comparable MRI imaging from the 12/30/19 study and the 6/4/20 are reviewed side by side. Surgery was performed correctly and appropriately regardless of whether ██████████ subjective complaints and largely unexplained symptoms persisted.

Very truly yours,

LAURIA TOKUNAGA GATES & LINN, LLP

/s/ Anthony D. Lauria
Anthony D. Lauria

ADL/mep

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I, Michael Schneier M.D., have reviewed the above Response to the allegations made against me, confirm that the Response is a true and accurate representation of the care provided to [REDACTED], and adopt the Response as though fully set forth by my own hand.

Dated: August 29, 2022

A handwritten signature in black ink, appearing to be 'MS', is written over a horizontal line. The signature is stylized and cursive.

Michael Schneier, M.D.

EXHIBIT 3

EXHIBIT 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive
Reno, NV 89521

Victor M. Muro, M.D.
Board President



Edward O. Cousineau, J.D.
Executive Director

April 19, 2022

Sunrise Hospital and Medical Center
ATTN: Health Care Records/ ROI & Radiology
3186 S. Maryland Parkway
Las Vegas, NV 89109

RE: BME CASE NUMBER: [REDACTED]

PATIENT: [REDACTED]; **DOB:** [REDACTED]

To Whom It May Concern:

Pursuant to Nevada law (Nevada Revised Statutes (NRS) 629.061), the Nevada State Board of Medical Examiners requests copies of the health care records of the above named patient, **to include copies of any X ray or other films**, treated at your facility **beginning January 1, 2019 to the present date**. **If the health care records and films are available to be provided on disk that is preferred. Please provide the health care records in an electronic searchable format.**

NRS 629.061 requires each provider of health care to make the health care records of a patient available for physical inspection and shall furnish a copy of the records to any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

NRS 629.021 defines health care records as: "any reports, notes, orders, photographs, X-rays or other recorded data or information whether maintained in written, electronic or other form which is received or produced by a provider of health care, or any person employed by a provider of health care, or any person employed by a provider of health care, and contains information relating to the medical history, examination, diagnosis or treatment of the patient."

Please return the health care records with the signed Custodian of Records Affidavit, enclosed herewith.

The Board investigation files are confidential. The physician-patient confidentiality is protected by the Board and its staff as required by law.

Please forward the records to the Investigative Committee of the Board **within 21 days**. If you have questions or we may be of assistance, please call me at (775) 324-9377.

Respectfully,


Johnna S. LaRue, CMBI
Deputy Chief of Investigations

Telephone 775-688-2559 • Fax 775-688-2321 • medboard.nv.gov • nsbme@medboard.nv.gov

NSBME 021

8 CDs X-rays
4/25/22

STATE OF NEVADA)
) ss.
COUNTY OF _____)

1. That I am the _____ (position or title) of _____ (name of company or employer) and in my capacity as _____ (position or title), I am a custodian of the records of _____ (name of company or employer).
2. That _____ (name of company or employer) is licensed to do business as a _____ in the State of Nevada.
3. That on the ____ day of the month of _____ of the year _____, I received a request for health care records in connection with the Nevada State Board of Medical Examiners Case No. _____ calling for the production of records pertaining to _____

4. That I have examined the original of those records and have made or caused to be made a true and exact copy of them and the reproduction attached hereto is true and complete.
5. That the original of those records was made at or near the time of the act, event, condition, opinion or diagnosis recited therein by or from information transmitted by a person with knowledge, in the course of a regularly conducted activity of _____ (name of company or employer).

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20____.

My commission expires: _____

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 5

EXHIBIT 5

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 7

EXHIBIT 7

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 8

EXHIBIT 8

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT 9

EXHIBIT 9

The Prevalence of Wrong Level Surgery Among Spine Surgeons

Milan G. Mody, MD, Ali Nourbakhsh, MD, Daniel L. Stahl, MD, Mark Gibbs, MD,
Mohammad Alfawareh, MD, and Kim J. Garges, MD

Study Design. A questionnaire study.

Objective. To evaluate the prevalence of wrong level surgery among spine surgeons and their use of preventive measures to avoid its occurrence.

Summary of Background Data. Wrong site surgery fails to improve the patient's symptoms and has medical, emotional, social, and legal implications. Organizations such as the North American Spine Society and the Joint Commission on Accreditation of Healthcare Organizations have established guidelines to prevent wrong site surgery. Spine surgeons' compliance with these guidelines and the prevalence of wrong-level spine surgery have not been investigated previously.

Methods. All members of the American Academy of Neurologic Surgeons ($n = 3505$) were sent an anonymous, 30-question survey with a self-addressed stamped envelope.

Results. A total of 415 (12%) surgeons responded. Sixty-four surgeons (15%) reported that, at least once, they had prepared the incorrect spine level, but noticed the mistake before making the incision. Two hundred seven (50%) reported that they had done 1 or more wrong level surgeries during their career. From an estimated 1,300,000 spine procedures, 418 wrong level spine operations had been performed, with a prevalence of 1 in 3110 procedures. The majority of the incorrect level procedures were performed on the lumbar region (71%), followed by the cervical (21%), and the thoracic (8%) regions. One wrong level surgery led to permanent disability, and 73 cases resulted in legal action or monetary settlement to the patient (17%).

Conclusion. There is a high prevalence of wrong level surgery among spine surgeons; 1 of every 2 spine surgeons may perform a wrong level surgery during his or her career. Although all spine surgeons surveyed report using at least 1 preventive action, the following measures are highly recommended but inconsistently adopted: direct preoperative communication with the patient by the surgeon, marking of the intended site, and the use of intraoperative verification radiograph.

Key words: spine, wrong level surgery, prevalence.
Spine 2008;33:194–198

Wrong site surgery not only fails to improve the patient's symptoms, but has profound medical, legal, social, and emotional implications.¹ An American Academy of Orthopedic Surgeons (AAOS) bulletin report stated, "A successful legal defense to surgery performed on the incorrect limb is almost impossible."² In 2006, wrong site surgery was reported to be the second most common sentinel event (13%) by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).³ A 2000 publication of the National Academy of Medicine, "To Err is Human: Building a Safer Health System," brought patient safety standards to national attention⁴; however, AAOS first addressed the issue in an advisory statement issued in 1997, recommending that surgeons put their initials on the operation site.⁵ This was followed by the "Sign Your Site" awareness campaign in 1998.⁶ The North American Spine Society (NASS) developed the "Sign, Mark and Radiograph (SMAx)" program in 2001, consisting of a checklist for patient safety.⁷ In 2003, the JCAHO promulgated the "Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery," which emphasized 3 requirements: pre-operative verification (checking the relevant medical documents and their consistency with each other and the surgical team's understanding of the intended patient, surgery site, and procedure), site marking (in a way that would be clear after draping of the patient), and a "time out" immediately before starting the operation (to verify the relevant medical information by active communication among all members of the surgical and procedural team).⁸ Since July 2004, all accredited hospitals have been required to implement this protocol.⁹ JCAHO and NASS guidelines are mostly compatible, for example both of them require the surgeon to perform an intraoperative radiograph. Although NASS recommendations mandate personal marking of the surgery site on the patient by the primary surgeon, JCAHO guidelines do not specify who should mark the site.¹⁰

In 2000, Meinberg and Stern investigated the prevalence of wrong site surgery and the use of preventive measures among hand surgeons.¹¹ Twenty-one percent of respondents in their study reported performing a wrong site operation at least once, and 16% reported that they had prepared the wrong site, but noticed the error before incision.

Wrong level/part surgery is defined as "a surgical procedure that is performed at the correct site, but at the wrong level or part of the operative field."¹² Wrong level surgery in the spine will fail to resolve the pathologic

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The manuscript submitted does not contain information about medical device(s)/drug(s).

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abnormality, likely fail to resolve the clinical symptoms, may subject the patient to accelerated degenerative changes at a previously asymptomatic or normal level,¹³⁻¹⁸ and result in unnecessary postsurgical scarring with implications of increased surgical difficulty at the time of any revision surgery. Out of a total of 17,058 lumbar disc operations, 24 (0.14%) cases of surgical failure were reported because of wrong disc level surgery.^{19,20} To the authors' knowledge, the prevalence of wrong level surgery among spine surgeons and the preventive measures they undertook to avoid it has not been previously described.

Materials and Methods

A 30-question survey was sent to the entire membership of the American Association of Neurologic Surgeons ($n = 3505$) in February and March 2006. The 3-part questionnaire was a modified version of the survey used by Meinberg and Stern in their study on the incidence of wrong site surgery among hand surgeons.¹⁰ The first section posed questions about the surgeon's age, training (neurologic or orthopedic surgeon), years in practice, estimated annual operative load, information about whether they had prepared and draped an incorrect spine level but noticed the mistake before operation, or performed wrong level surgery (and, if yes, how many times?); the second section consisted of questions regarding details of any wrong level surgeries performed throughout the surgeon's career, including the level, the type of anesthesia used, when the error was recognized, and whether or not it resulted in permanent disability or legal action; and the third section included questions about any precautions that the surgeon should routinely take to avoid wrong level surgery according to the recommendations of JCAHO (Table 4). There were 4 options (always, usually, occasionally, and never) for each question. These questions were designed to evaluate the practice guidelines of the responding surgeon in comparison to the recommended guidelines by JCAHO and NASS.

The total number of procedures performed by the responding surgeons during their career could be estimated by the duration of practice multiplied by the estimated annual surgical load, which were both reported by each responding surgeon. The annual risk of wrong level surgery for each surgeon was calculated by dividing the number of wrong level surgeries performed by the duration of practice. All the data were entered into SPSS v.13 (SPSS Inc., Chicago, IL) and analyzed. The correlations were tested by χ^2 test. Unless explicitly stated otherwise, the significance level was $P < 0.05$.

Results

Four hundred fifteen questionnaires were completed and returned to the investigators (12% response rate). Three hundred eighty respondents were from the United States (92%); the remaining 35 (8%) were from different countries. The majority of the respondents were neurosurgeons (92%).

The mean age and standard deviation was 54.2 ± 10.5 years. The mean duration of practice and standard deviation was 20.6 ± 10.5 years.

Sixty-four surgeons (15%) reported that, at least once, they had prepared the incorrect spine level, but

Table 1. The Frequency of Wrong Level Surgery During the Entire Career

No. Wrong Level Surgeries	Frequency (%)
1	109 (54.5)
2	46 (23)
3	25 (12.5)
4	6 (3)
5	7 (3.5)
≥ 6	7 (3.5)
Total	200

noticed the mistake before making the incision for the correct level. Two hundred seven (50%) reported that they had performed 1 or more wrong level surgeries during their career. Table 1 shows the frequency of wrong level surgery among responding surgeons (7 respondents did not report how many wrong level procedures they had performed). Sixty-eight percent of the respondents were in private practice, and the percentage of surgeons in academic practice or combined academic and private practice was 15% and 17%, respectively. From an estimated 1,300,000 spine procedures, 418 wrong level spine operations had been performed, with a prevalence of 1 in 3110 procedures.

The majority of incorrect level procedures were performed in the lumbar spine (71%), followed by cervical (21%), and thoracic (8%) regions. From the 407 cases in which the anesthesia type was identified, 403 underwent general anesthesia (99%) and 4 underwent spinal or local anesthesia (1%). Fifty percent of wrong level surgeries were discovered intraoperatively, whereas 31% were discovered in the postoperative follow-up and 19% in the immediate postoperative period. One wrong level surgery led to permanent disability, whereas 73 cases resulted in legal action or monetary settlement to the patient (17%).

There was a higher rate of wrong level surgery seen with the increased age of the surgeon ($P = 0.024$) and longer duration of practice ($P = 0.025$). However, annual risk showed significant decrease with the increase in the duration of practice ($P < 0.001$) (Tables 2 and 3). The rate of incorrect level surgery was not significantly higher in surgeons with a higher annual surgical load ($P = 0.22$). Additionally, there was no significant difference be-

Table 2. Duration of Practice and the Rate of Wrong Level Spine Surgery During the Entire Career

Years in Practice	Wrong Level Spine Surgery Rate	Annual Risk of Wrong Level Surgery
0-9	32%	25%
10-19	50%	14%
20-29	56%	8%
30-39	55%	8%
40-49	56%	9%

Annual risk of wrong level operation is also shown.

Table 3. Surgeon's Age and the Rate of Wrong Level Spine Surgery During the Entire Career

Age	Wrong Level Spine Surgery Rate
30–39	31%
40–49	44%
50–59	55%
60–69	59%
70–79	46%

tween surgeons in academic and private practice ($P = 0.29$).

The different preventive measures used by responding surgeons to avoid wrong level surgery are summarized in Table 4. All surgeons reported using at least 1 preventive measure.

■ Discussion

Wrong site surgery occurs most commonly in orthopedics, urology, and neurosurgery.²¹ Five to 10 cases of wrong site surgery are reported to the JCAHO every month.²² Between 1985 and 1995, the Physician Insurers Association of America reported 331 paid claims for suits involving wrong site surgery, with a median payout ranging from \$48,087 to \$76,167.²³ In a study on all the wrong site surgery cases reported to a single large malpractice insurer between 1985 and 2004, Kwaan *et al* estimated the prevalence of wrong vertebral level or wrong side laminectomy of the spine to be 15 in 1,426,901 inpatient surgical procedures (1 in 95,127). The incidence rate in Kwaan *et al*'s study may underestimate the true rate of wrong site operations, because only those cases that prompted claims or reports to the malpractice insurer were identified. Furthermore, the reported incidence rate included all surgical procedures, not spine surgery specifically.⁹

According to the JCAHO, contributing factors to wrong site surgery include emergent cases; unusual physical characteristics of the patient, including morbid obesity, physical deformity, or congenital variations; unusual time pressures to start or complete the procedure; unusual equipment or setup in the operating room; multiple surgeons involved in the case; and multiple procedures being performed during a single surgical visit. The major root cause of wrong site surgery is breakdown in

communication between the surgical team and the patient and family.^{3,21}

The prevalence of at least 1 wrong level surgery among spine surgeons (50%) is 2.5 times more than that for wrong site surgery among hand surgeons in Meinelberg and Stern's study (20%).¹¹ The prevalence of wrong level surgery on the spine (1 in 3110 procedures) is almost 9 times more than the prevalence of wrong site operation in hand surgery (1 in 27,686 procedures).¹¹ These results signify the extent of the problem in spine surgery. One wrong level surgery in 3110 procedures is a crude estimate and may not reflect the exact prevalence. The annual workload of surgeons can not be determined accurately, because it may not be consistent over the course of a surgeon's career. Our results were obtained after implementation of the prevention guidelines in all accredited hospitals in 2004, whereas the study by Meinelberg and Stern was performed in 2000, before these guidelines were put into place. However, the results for the 2 studies can be compared because they both evaluate the number of occurrences of wrong site surgery during a surgeon's career.

There are several factors that may contribute to the high prevalence of wrong level surgery among spine surgeons. Because of the average number of years in practice (21 years) in our study, many of these procedures were performed before the establishment of guidelines for wrong level surgery. Secondly, only 80% of surgeons reported to always use a strict guideline to obtain an intraoperative radiograph, which is crucial in wrong level surgery prevention.^{3,7,24} However, obtaining intraoperative radiographs does not guarantee correct level surgery. The limitations of intraoperative radiograph include: (a) misinterpretation of the image because of congenital variations, inadequate radiologic exposure, or incorrect counting of the spine level; (b) inadequate radiologic visualization because of large body size or surgical table limitation; and (c) failure to recognize the absence of an expected lesion in the operative level.²⁰ When an intraoperative radiograph is used after exposure, the surgeon marking the intended site on the patient may be redundant, but is certainly another crucial preventive measure.²⁵

However, only 51% of the surgeons reported to always personally mark the intended level, and 20% had their op-

Table 4. The Use of Prevention Measures to Avoid Wrong Level Surgery by Spine Surgeons

	Always (%)	Usually (%)	Occasionally (%)	Never (%)	Total
Personal review the office notes	381 (94)	18 (4)	6 (1.5)	2 (0.5)	407
Personal review of the operation consent form	268 (67)	55 (14)	42 (10)	37 (9)	402
Review of the operation consent form by the OR staff	324 (82)	46 (11)	12 (3)	15 (4)	397
Personal review of the patient's radiograph	397 (98)	10 (2)	0	0	407
Personal discussion with the patient before anesthesia	232 (57)	93 (23)	62 (15)	19 (5)	406
Discussion with the patient by OR staff before anesthesia	310 (78)	65 (16)	16 (4)	7 (2)	398
Personal marking of the intended level	205 (51)	54 (13)	36 (9)	108 (27)	403
Marking of the intended level by OR staff	81 (20)	37 (9)	38 (10)	241 (61)	397
Use of intraoperative radiograph	327 (80)	63 (15)	16 (4)	2 (1)	408
Personal review of the office consent form, if any	165 (79)	27 (13)	6 (3)	11 (5)	209

erating room staff always mark the level. Both NASS⁷ and AAOS¹⁰ guidelines recommend that surgeons personally mark the intended surgical site. DiGiovanni *et al's* study showed that only 59% of the patients, who were instructed by their surgeon about marking their own body for surgery, marked "NO" on the nonoperative extremity.²⁶ Therefore, the patient cannot be relied on for accurate marking.

Lumbar surgery constitutes a major portion of neurosurgery practice,²⁷ which may explain why it is the most common site for wrong level surgery in our sample. The low incidence of wrong level surgery in the thoracic spine may be because of both the infrequency of surgery performed in this region, and increased vigilance of the surgeon to correlate the level with radiographs during the operation (because of the difficulty of obtaining an intraoperative radiograph which correlates with anatomic features). The reported number of wrong level operations during a surgeon's career showed a correlation with increased age of the surgeon and the number of years the surgeon had been in practice. These results are compatible with Meinberg and Stern's study on hand surgery.¹¹ Experienced surgeons have a lower annual risk of performing a wrong level operation than inexperienced surgeons. We found no difference between academic and private practice and among surgeons with different annual work loads, suggesting that working in a teaching environment or busy center and the presence of residents or fellows may not have an effect on the risk for wrong level surgery.

Although permanent disability was reported in just 1 case, 1 out of 6 cases resulted in legal action or monetary settlement to the patient. The aforementioned results underscore the high risk of wrong level surgery for all spine surgeons, which merits a high level of awareness and precaution. All patients should be informed about the potential risk of wrong level surgery by the spine surgeon during the informed consent process, and this should be documented.²⁰

More than 90% of the surgeons always reviewed the office notes and patient's imaging studies before surgery, and all of the surgeons in our sample took at least 1 preventive measure to avoid wrong level surgery. Direct communication between the surgeon and the patient before anesthesia in the holding area received less attention as a preventive measure from spine surgeons (57%). Almost 78% of surgeons always had their operating room staff carry out this task. Our results demonstrate a higher or almost identical percentage of respondents performing each preventive measure than reported in Meinberg and Stern's study on hand surgery.¹¹ Although the effectiveness of the aforementioned guidelines by different medical societies cannot be evaluated by our study, their role in this increased awareness and utility of preventive measures can not be overlooked.

The current recommendations for prevention of wrong site/level surgery from NASS, JCAHO, and AAOS are similar. These recommendations include adhering to the JCAHO 2-stage approach recommendations for spine

cases (marking the skin in the general region of the spine and verification of the site in the operating room during the time-out), use of a radiopaque marker at the operation site after opening the skin and comparing preoperative and intraoperative²⁴ radiographs, establishing comprehensive communication with the patient and the members of the operating team,²⁸ and marking the site by the surgeon himself or herself, involving the patient in confirming the site either through the informed consent or marking,^{10,25} awareness of congenital anomalies like transitional vertebra,²⁹ consideration of the risk factors of wrong level/site surgery (undue time pressure, unusual equipment setup, and multiple surgeons or procedures), and developing verification checklists that include related medical records and diagnostic studies.^{9,30} The use of intraoperative computed tomography scan,^{31,32} spinal neuronavigation,^{33,34} transligamentous ultrasound,³⁵ and longitudinal grid tubes surface markers filled with halibut liver oil (in patients with scoliosis)^{20,36} are other methods that can be used, but their feasibility is outside the scope of this study.

The limitations of our study include the inherent limitations of questionnaire studies, such as relying on the surgeon's recall. The prevalence of wrong level surgery may have been underestimated because of an unwillingness to report it by some surgeons. The low response rate may have been because of the length of the questionnaire (30 questions) or the busy schedules of the neurosurgeons. However, because of the large number of surgeons polled, we received a high enough number of questionnaires back to report the results.^{37,38} Most of our questionnaires were filled by surgeons practicing in the United States where penalties and legal consequences may decrease the incidence of wrong level surgery.

There is a high prevalence of wrong level surgery among spine surgeons; 1 of every 2 surgeons may perform a wrong level surgery during his or her career. This signifies a potential high likelihood of wrong level surgery, probably because of the unique features of spine. The results of this study suggest that the use intraoperative radiographs, personal marking of the intended site, and direct communication between the surgeon and the patient before anesthesia are weak areas in the spine surgery process. In order to decrease the incidence of wrong level surgery and minimize the associated clinical and socioeconomic morbidity, wider adoption and strict adherence to these preventive guidelines is recommended.

■ Key Points

- Wrong site surgery fails to improve the patient's symptoms and has medical, emotional, social, and legal implications.
- Spine surgeons' compliance with established guidelines for preventing wrong site surgery and the prevalence of wrong-level spine surgery have not been investigated previously.

- A total of 415 (12%) surgeons responded to a questionnaire. Of an estimated 1,300,000 spine procedures, 418 wrong-level spine operations were performed, with a prevalence of 1 in 3110 procedures.
- There is a high prevalence of wrong level surgery among spine surgeons; 1 of every 2 spine surgeons may perform a wrong level surgery during his or her career.
- The following measures are highly recommended but inconsistently adopted to help prevent wrong site surgery: direct preoperative communication with the patient by the surgeon, marking of the intended site, and the use of intraoperative verification radiograph.

References

- Levy DA. No defense for wrong-site surgery. *AAOS Bull* 1998;46:18.
- Dunn D. Surgical site verification: A through Z. *J Perianesth Nurs* 2006;21:317-31.
- Sentinel Event Statistics as of June 30, 2006. Available at: <http://www.jointcommission.org/SentinelEvents/Statistics/>.
- Kohn LT, Corrigan JM, Donaldson MS. *To Err is Human: Building a Safer Health System*. Washington DC: National Academy Press; 2000.
- Canale ST. Wrong-site surgery. *Clin Orthop* 2005;433:26-9.
- Oregon Association of Hospitals and Health Systems. Hints on preventing surgery on wrong site (2006). Available at: <http://www.aracnet.com/~oahhs/issues/safety/surgery.htm>.
- North American Spine Society. *Prevention of Wrong-Site Surgery: Sign, Mark & X-ray (SMax)*. LaGrange, IL: North American Spine Society; 2001.
- Joint Commission on Accreditation of Healthcare Organizations. Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery July 21, 2003. Available at: http://www.jointcommission.org/NR/rdonlyres/E3C600EB-043B-4E86-B04E-CA4A89AD5433/0/universal_protocol.pdf. Accessed February 1, 2007.
- Kwaan MR, Studdert DM, Zinner MJ, et al. Incidence, patterns, and prevention of wrong-site surgery. *Arch Surg* 2006;41:353-8.
- Anonymous. Marking the site for spinal surgery. *OR Manager* 2004;20:9.
- Meinberg EG, Stern PJ. Incidence of wrong-site surgery among hand surgeons. *J Bone Joint Surg Am* 2003;85:193-7.
- Anonymous. Patient safety first alert—implementing a correct site surgery policy and procedure. *AORN J* 2002;76:785-8.
- Gupta MC, Khan SN. Lumbar discectomy and stenosis surgery. In: Rao RD, ed. *Complications in Orthopaedics Spine Surgery*. Rosemont, IL: AAOS; 2006:55.
- Lopez-Espina CG, Amirouche F, Havalad V. Multilevel cervical fusion and its effect on disc degeneration and osteophyte formation. *Spine* 2006;31:972-8.
- Eck JC, Humphreys SC, Lim TH, et al. Biomechanical study on the effect of cervical spine fusion on adjacent-level intradiscal pressure and segmental motion. *Spine* 2002;27:2431-4.
- Chen CS, Cheng CK, Liu CL, et al. Stress analysis of the disc adjacent to interbody fusion in lumbar spine. *Med Eng Phys* 2001;23:483-91.
- Goto K, Tajima N, Chosa E, et al. Effects of lumbar spinal fusion on the other lumbar intervertebral levels (three-dimensional finite element analysis). *J Orthop Sci* 2003;8:577-84.
- Chosa E, Goto K, Totoribe K, et al. Analysis of the effect of lumbar spine fusion on the superior adjacent intervertebral disk in the presence of disk degeneration, using the three-dimensional finite element method. *J Spinal Disord Tech* 2004;17:134-9.
- Roberts MP. Complications of lumbar disc surgery. In: Hardy RW Jr, ed. *Lumbar Disc Disease*. New York: Raven Press Ltd;1993:161-70.
- Goodkin R, Laska LL. Wrong disc space level surgery: medicolegal implications. *Surg Neurol* 2004;61:323-41.
- Joint Commission on Accreditation of Healthcare Organizations. A follow-up review of wrong-site surgery. *Sentinel Event Alert* 2001:24.
- Frequently asked questions (FAQs) regarding the ensuring of correct surgery directive. Available at: http://www.sciencedirect.com/science?_ob=RedirectURL&_method=externObjLink&_locator=url&_cdi=6914&_plusSign=%2B&_targetURL=http%253A%252F%252Fwww.patientsafety.gov. Accessed June 7, 2006.
- OK plan to end wrong-site surgeries. *AAOS Bull* Oct 1997. Available at: <http://www2.aaos.org/aaos/archives/bulletin/oct97/wrong.htm>. Accessed February 1, 2007.
- Ammerman JM, Ammerman MD, Dambrosia J, et al. A prospective evaluation of the role for intraoperative x-ray in lumbar discectomy. Predictors of incorrect level exposure. *Surg Neurol* 2006;66:470-3.
- Wong DA, Herring SA. Protecting patients and preventing medical errors. A progress report on NASS' patient safety initiative. *SpineLine* 2003;4:24-6.
- DiGiovanni CW, Kang L, Manuel J. Patient compliance in avoiding wrong-site surgery. *J Bone Joint Surg Am* 2003;85:815-19.
- Fager CA. Malpractice issues in neurological surgery. *Surg Neurol* 2006;65:416-21.
- Bjorn B, Rabol LI, Jensen EB, et al. Wrong-site surgery: incidence and prevention. *Ugeskr Laeger* 2006;168:4205-9.
- Malanga GA, Cooke PM. Segmental anomaly leading to wrong level disc surgery in cauda equina syndrome. *Pain Physician* 2004;7:107-10.
- Beyea SC. Ensuring correct site surgery. *AORN J* 2002;76:880-2.
- Haberland N, Ebmeier K, Grunewald JP, et al. Incorporation of intraoperative computerized tomography in a newly developed spinal navigation technique. *Comput Aided Surg* 2000;5:18-27.
- Hum B, Feigenbaum F, Cleary K, et al. Intraoperative computed tomography for complex craniocervical operations and spinal tumor resections. *Neurosurgery* 2000;47:374-80.
- Schlenzka D, Laine T, Lund T. Computer-assisted spine surgery. *Eur Spine J* 2000;9(suppl 1):S57-S64.
- Bolger C, Wigfield C. Image-guided surgery: applications to the cervical and thoracic spine and a review of the first 120 procedures. *J Neurosurg* 2000;92(2 suppl):175-80.
- Henegar MM, Vollmer DG, Silbergeld DL. Intraoperative translaminar ultrasound in the evaluation of thoracic intraspinal disease. *Technique Spine* 1996;21:124-7.
- English PT, Dougal C, Griffiths PD, et al. Technical note: a simple method for skin/lesion localization using magnetic resonance imaging. *Br J Radiol* 1994;67:813-15.
- Eck JC, Nachtigall D, Humphreys SC, et al. Questionnaire survey of spine surgeons on the use of methylprednisolone for acute spinal cord injury. *Spine* 2006;31:E250-E253.
- Molloy S, Price M, Casey AT. Questionnaire survey of the views of the delegates at the European Cervical Spine Research Society meeting on the administration of methylprednisolone for acute traumatic spinal cord injury. *Spine* 2001;26:E562-E564.

EXHIBIT 10

EXHIBIT 10

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Research/Publications:

Published Manuscripts

- Symptomatic Postoperative Epidural Hematoma in the Lumbar Spine. Butler AJ, Donnally CJ 3rd, Goz V, Basques BA, Vaccaro AR, Schroeder GD. *Clin Spine Surg*. 2021 Dec 20
- Zeidan M, Goz V, Lakomkin N, Spina N, Brodke DS, Spiker WR. Predictors of Readmission and Prolonged Length of Stay after Cervical Disc Arthroplasty. *Spine (Phila Pa 1976)*. 2020 Dec 8
- Donnally CJ 3rd, Patel PD, Canseco JA, Divi SN, Goz V, Sherman MB, Shenoy K, Markowitz M, Rihn JA, Vaccaro AR. Current incidence of adjacent segment pathology following lumbar fusion versus motion-preserving procedures: a systematic review and meta-analysis of recent projections. *Spine J*. 2020 Oct;20(10):1554-1565
- Donnally III CJ, Patel PD, Canseco JA, Shenoy K, Divi SN, Goz V, Arain AR, Vaccaro AR. Hepatitis C Virus Infection as a Predictor of Complications and Increased Costs Following Primary Lumbar Fusion Surgery. *Spine (Phila Pa 1976)*. 2020 Mar 19.
- Goz V, Martin B, Donnally CJ, Brodke D, Spina N, Spiker WR. Potential Selection Bias in Observational Studies Comparing Cervical Disc Arthroplasty to Anterior Cervical Discectomy and Fusion. *In Press: Spine (Phila Pa 1976)*
- Shenoy K, Goz V, Levine M, Kay D. Should Initial Management for Lumbar Herniated Nucleus Pulposus Resulting In a Dense Nerve Palsy Be Surgical. *In Press: Clin Spine Surg*
- Donnally CJ, Schiller NC, Butler AJ, Sama AJ, Bodnar KJ, Goz V, Shenoy K, Vaccaro AR, Hilibrand AS. Trends in Leadership at Spine Surgery Fellowships. *In Press: Spine (Phila Pa 1976)*.
- Goz V, Spiker WR, Brodke D. Mobile messaging and smartphone apps for patient communication and engagement in spine surgery. *Ann Transl Med*. 2019 Sep;7(Suppl 5):S163

- Goz V, Weinreb J, Schwab F, et al. "Comparison of Complications, Costs, and Length of Stay of Three Different Lumbar Interbody Fusion Techniques: An Analysis of the Nationwide Inpatient Sample Database". *Spine J.* 2014 Sep 1;14(9):2019-27.
- Goz V, McCarthy I, Weinreb J, et al. "Venous Thromboembolic Events in Spine Surgery Patients; which patients are high risk?". *J Bone Joint Surg Am.* 2014 Jun 4;96(11):936-942. Epub 2014 Jun 4.
- Qureshi S, Goz V, McAnany S et al. "Health Utility Index of Patients with Single Level Cervical Degenerative Disc Disease; Comparison of Anterior Cervical Discectomy and Fusion with Cervical Disc Arthroplasty". *J Neurosurg Spine.* 2014 May;20(5):475-9.
- Marascalchi BJ, Passias PG, Goz V, et al. "Comparative Analysis of Cauda Equina Syndrome (CES) Patients versus an Unaffected Population Undergoing Spinal Surgery." *Spine (Phila Pa 1976).* 2014 Mar 15;39(6):482-90.
- Qureshi S, McAnany S, Goz V, et al. "Cost-Effectiveness Analysis: Comparing Single-Level Cervical Disc Replacement and Single-Level Anterior Cervical Discectomy and Fusion". *J Neurosurg Spine.* 2013 Nov;19(5):546-54.
- Goz V, Weinreb J, McCarthy I, et al. "Perioperative Complications and Mortality after Spinal Fusions; Analysis of Trends and Risk Factors". *Spine (Phila Pa 1976).* 2013 Oct 15;38(22):1970-6
- Goz V, Qureshi S, Hecht A. "Arytenoid Dislocation As a Cause of Prolonged Hoarseness after Cervical Discectomy and Fusion". *Global Spine J.* 2013 Mar;3(1):47-50.
- Goz V, Koehler SM, Egorova NN, Moskowitz AJ, Guillaume SA, Hecht AC, Qureshi SA. "Kyphoplasty and vertebroplasty: trends in use in ambulatory and inpatient settings". *Spine J.* 2011 Aug;11(8):737-44.
- Wang Q, Luan W, Goz V, Burakoff SJ, Hiotis SP. "Non-invasive in vivo imaging for liver tumour progression using an orthotopic hepatocellular carcinoma model in immunocompetent mice." *Liver Int.* 2011 Sep;31(8):1200-8.

Textbook Chapters

- Pastore M, Viola A, Goz V, Tamimi N, Vaccaro A. "Radiographic Evaluation of the Upper Cervical Spine". In Louie, Samartzis, An (Eds), *Atlas of Spinal Imaging*. Philadelphia, PA. Forthcoming 2020
- Goz V, Baker J, Brodke D. Patient Reported Outcome Measures: Development, Available Tools, and Applications in Spine Surgery. In Klineberg E (Ed), *Adult Lumbar Scoliosis: A Clinical Guide to Diagnosis and Management*. New York, NY. 2016
- Goz V, Brodke DS, Spiker WR. Big Data in Healthcare. In EC Benzel (Ed), *Spine Surgery*. Philadelphia, PA. Forthcoming 2016
- Goz V, Spiker WR. Lumbar Stenosis and Spondylolisthesis. In CM Bono (Ed), *Orthopaedic Surgery Essentials: Spine*, Second Edition. Philadelphia, PA. 2016
- Gerling M, Goz V (2015). Differential Diagnosis of Spinal Disorders. In TJ Errico (Ed.), *Spinal Disorders and Treatment: The NYU-HJD Comprehensive Textbook* (pp. 23-29). New Delhi, India: JayPee Publishers.
- Robles JC, Goz V (2015). Diagnostic and Therapeutic Value of Spinal Injections. In TJ Errico (Ed.), *Spinal Disorders and Treatment: The NYU-HJD Comprehensive Textbook* (pp. 193-200). New Delhi, India: JayPee Publishers.

Podium Presentations

- Goz V. Overview of CMS and Bundled Payment Program related to Spine Surgery: BPCI, BPCIA. *CSRS 2020 Podium Presentation*
- Goz V. COVID-19: A Cataclysmic Even of Global Significant. *NASS 2020 Annual Meeting*.
- Donnally C, Patel P, Consecro J, Shenoy K, Divi S, Goz V, Arain A, Vaccaro A. Hepatitis C virus infection as a predictor of complications and increased costs following primary lumbar fusion surgery. *NASS 2020 Podium Presentation*.
- Spiker WR, Brodke DS, Spina N, Lawrence B, Goz V, Martin B. Difference in Patient Cohorts for Cervical Disc Arthroplasty (CDA) and Anterior Cervical Discectomy and Fusion (ACDF). *CSRS 2018 Annual Meeting*.

- **Goz V, Martin B, Brodke DS, Spina N, Spiker WR.** Potential Selection Bias in Observational Studies Comparing Cervical Disc Arthroplasty to Anterior Cervical Discectomy and Fusion. *NASS 2018 Annual Meeting.*
- **Goz V, Lakomkin N, Kothari P, Lee N, Cheng J, Brodke D, Spiker R.** The Utility of Pre-Operative Labs in Predicting Post-Operative Complications Following Posterior Lumbar Fusion. *AAOS Annual Meeting 2018 Podium Presentation*
- **Lakomkin N, Goz V, Kothari P, Lee N, Cheng J, Brodke D, Spiker R.** The Utility of Pre-Operative Labs in Predicting Post-Operative Complications Following Posterior Lumbar Fusion. *AO Global Spine Conference 2017*
- **Goz V, Buser Z, D'Oro A, et al.** Trends in Cost and Utilization of Biologics in Anterior Cervical Discectomy and Fusions. *NASS 2016 Podium Presentation*
- **Goz V, Errico T, Weinreb J, Koehler S, Hecht A, Lafage V, Qureshi S.** "Vertebroplasty and Kyphoplasty: National Outcomes and Trends in Utilization from 2005 through 2010". *NASS 2013 Podium Presentation*
- **Goz V, Weinreb J, McCarthy I, Passias P, Lafage V, Errico T.** "Complications of Primary versus Revision Spinal Fusion for Adolescent Idiopathic Scoliosis". *NASS 2013 Podium Presentation*
- **Goz V, Dallas K, Weinreb J, Bendo J, Lafage V, Errico T.** "Venous Thromboembolic Events in Spine Surgery Patients; which patients are high risk?". *IMAST 2013 Podium Presentation*
- **Goz V, Dallas K, Weinreb J, Bendo J, Lafage V, Errico T.** "Venous Thromboembolic Events in Spine Surgery Patients; which patients are high risk?". *Sir Robert Jones Lecture Series 2013*
- **Paul J, Lonner B, Goz V, Weinreb J, Toombs C, Errico T.** "Complication Rates are Reduced for Revision Adult Spine Deformity Surgery Among High Volume Hospitals and Surgeons". *NASS 2013 Podium Presentation*

Poster Presentations

- **Goz V, Lakomkin N, Jalali A, Gaffney C, Bailey T, Pelt C, Peters C, Gililland J.** Total Hip Arthroplasty in Obese Patients; When do Risks Outweigh Benefits? *AAOS 2018.*
- **Goz V, Lakomkin N, Jalali A, Gaffney C, Bailey T, Pelt C, Peters C, Gililland J.** Total Hip Arthroplasty in Obese Patients; When do Risks Outweigh Benefits? *American Association of Hip and Knee Surgeons 2018.*
- **Spiker WR, Brodke DS, Spina N, Lawrence B, Goz V, Martin B.** National Trends in C2 Fractures and their Treatment: An 11 year National Inpatient Sample Study. *Global Spine Congress 2018.*
- **Goz V, Lakomkin N, Jalali A, Gaffney C, Bailey T, Pelt C, Peters C, Gililland J.** Total Hip Arthroplasty in Obese Patients; When do Risks Outweigh Benefits? *AAOS 2018.*
- **Goz V, Buser Z, D'Oro A, Yoon S, Park J, Youssef J, Meisel HJ, Wang J, Brodke D.** Structural Allograft versus Synthetic Cage; Analysis of Complications in Anterior Cervical Discectomy and Fusion. *Global Spine Congress 2017.*
- **Lakomkin N, Goz V, Cheng JS, Brodke DS, Spiker RW.** "The Utility of Pre-Operative Labs in Predicting Post-Operative Complications Following Posterior Lumbar Fusion". *NASS 2016.*
- **Goz V, Rane A, Abtahi A et al.** "Geographic Variations in the Cost of Spine Surgery". *NASS 2015.*
- **Goz V, Weinreb JH, Dallas K, Paul J, Lafage V, Errico TJ.** "Cervical Disc Arthroplasty versus Anterior Cervical Discectomy And Fusion; Analysis of Perioperative Outcomes and Trends in Utilization". *NASS 2013.*
- **Goz V, Weinreb JH, Dallas K, Protosaltis T.** "Cervical Disc Arthroplasty versus Anterior Cervical Discectomy And Fusion; Analysis of Perioperative Outcomes and Trends in Utilization". *CSRS-Europe 2013.*
- **Goz V, Weinreb J, Lafage V, Errico T.** "Perioperative Complications and Mortality after Spinal Fusions; Analysis of Trends and Risk Factors". *NASS 2013.*

- **Goz V, Weinreb J, Lafage V, Errico T.** "Perioperative Complications and Mortality after Spinal Fusions; Analysis of Trends and Risk Factors". *SRS 2013*.
- **Goz V, Weinreb J, Lafage V, Errico T.** "Perioperative Complications and Mortality after Spinal Fusions; Analysis of Trends and Risk Factors". *IMAST 2013*.
- **Goz V, Dallas K, Weinreb J, Bendo J, Lafage V, Errico T.** "Venous Thromboembolic Events in Spine Surgery Patients; which patients are high risk?". *NASS 2013*.
- **Goz V, Koehler SM, Egorova NN, Moskowitz AJ, Guillerme SA, Hecht AC, Qureshi SA.** "Kyphoplasty and vertebroplasty: trends in use in ambulatory and inpatient settings". *AAOS 2010*.
- **Goz V, Dallas K, Colvin A.** "Low Prevalence Of Femoroacetabular Impingement Findings On MRI In Asymptomatic Women". *ISHA 2011*.
- **Goz V, Wang Q, Luan W, Hiotis SP.** "A Mouse Model for Hepatocellular Carcinoma which Produces Murine Alpha-Fetoprotein, Measurable in the Plasma, with Tumor Progression". *Society of Surgical Oncology 2011*.
- **Lakomkin N, Goz V, Cheng JS, Brodke DS, Spiker RW.** "The Utility of Pre-Operative Labs in Predicting Post-Operative Complications Following Posterior Lumbar Fusion". Poster Presentation. *North American Spine Society 2016*.
- **Paul J, Lonner B, Goz V, Weinreb J, Toombs C, Errico T.** "Complication Rates are Reduced for Revision Adult Spine Deformity Surgery Among High Volume Hospitals and Surgeons". *SRS 2013 Poster Presentation*.
- **Paul J, Lonner B, Goz V, Weinreb J, Toombs C, Errico T.** "Complication Rates are Reduced for Revision Adult Spine Deformity Surgery Among High Volume Hospitals and Surgeons". *IMAST 2013 Poster Presentation*.
- **Paul J, Lonner B, Goz V, Weinreb J, Toombs C, Errico T.** "Higher Volume Hospitals and Surgeons Perform Increased Rates of Complex Adult Spine Deformity Surgeries." *IMAST 2013 Poster Presentation*.
- **Norton R, Klifto C, Goz V, Bendo J.** "Degenerative Spondylolisthesis: an Analysis of Trends within the National Inpatient Sample (NIS) Database." *NASS 2013*.

Boards, Committees, Etc

- | | |
|---|-------------------|
| • University of Nevada, Reno School of Medicine - Community Faculty | 10/2021 – Current |
| • Nevada Orthopedic Society Board Member | 10/2020 – 10/2022 |
| • Reviewer for Bone and Joint Journal | 11/2019 – Present |
| • Reviewer for Global Spine Journal | 06/2017 – Present |
| • Reviewer for The Spine Journal | 05/2015 – Present |
| • NASS Evidence-Based Guideline Development Committee | 07/2019 – Present |
| • NASS Registry Committee | 11/2015 – 01/2021 |

Professional Societies

- American Academy of Orthopaedic Surgeons (AAOS)
- North American Spine Society (NASS)

Proficiencies

- Administrative Claims Databases
 - Extensive work/research experience with large claims databases including Medicare, Nationwide Inpatient Sample, National Surgical Quality Improvement Program (NSQIP) database, Pearl Diver, New York SPARCS, and others.
- Language
 - Fluent in Russian
- Statistics
 - R statistics programming language, SPSS

Hobbies

- Rock climbing, Skiing, Mountain Biking

Dr. Schneider's Exhibits Admitted at Hearing “Culled” Exhibits:

Exhibit A

Exhibit B

Exhibit C (still shot with markers, “Combined imaging studies patient marked”, and “Side by side thoracic”)

Exhibit E

Exhibit F

Exhibit G

Exhibit H

Exhibit I

Exhibit J

Exhibit K

Exhibit P

Exhibit Q

EXHIBIT A

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT B

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT C

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT E

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT I

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT J

EXHIBIT K

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT P

MEDICAL RECORDS

This exhibit contains personal medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310.

EXHIBIT Q

Curriculum Vitae



EDUCATION:

07/1997 – 06/1998 - Fellowship, Neuro-Oncology – Cedars Sinai Medical Center
07/1995 – 07/1996 - Fellowship, Reconstructive Spine Surgery – University of New Mexico
07/1994 – 06/1995 - Chief Residency, Neurological Surgery – Montefiore Medical Center, Albert Einstein College of Medicine
07/1990 – 06/1994 - Residency, Neurological Surgery - Montefiore Medical Center, Albert Einstein College of Medicine
06/1989 – 06/1990 - Internship, General Surgery - Montefiore Medical Center, Albert Einstein College of Medicine
09/1985 – 06/1989 - Doctor of Medicine, New York University School of Medicine
09/1982 – 06/1985 - BA, Economics – University of Pennsylvania

POST GRADUATE EXPERIENCE:

07/2013 – Present – Neurosurgeon, Private Practice (Las Vegas, NV)
08/2005 – 06/2013 – Neurosurgeon, Private Practice (Los Angeles, CA)
10/2004 – 07/2005 – Neurosurgeon, Albert Einstein Medical Center (Philadelphia, PA)
01/2002 – 09/2004 – Chief of Neurosurgery, Frankford Healthcare System (Philadelphia, PA)
06/1999 – 12/2001 – Director of Reconstructive Spine Surgery (University of New Mexico)
08/1998 – 06/1999 – Neurosurgeon, Private Practice (Portland, OR)
07/1997 – 08/1998 – Fellowship, Neuro-Oncology (Staten Island, NY)
09/1996 – 06/1997 – Neurosurgeon, Private Practice (Staten Island, NY)
07/1995 – 07/1996 – Fellowship, Reconstructive Spine Surgery (University of New Mexico)

LICENSURE:

Nevada – 14728
California – G84184
DEA – BS4547711
UPIN – G05328

NPI – 1891734075

BOARD CERTIFICATION:

May 2000 - American Board of Neurological Surgery

Recertified 2009 – American Board of Neurological Surgery

AWARDS:

1994 – Residency Research Award, New York Neurosurgical Society

1993 – Residency research Award, New York Neurosurgical Society

1991 – Leo Davidoff Society Residency Award, Albert Einstein College of Medicine

1987 – Levin Foundation Grant, Weitzman Institute (Rehovot, Israel)

HONORARY AND PROFESSIONAL SOCIETIES:

-Surgical Review Committee, St. John's Hospital Review Journal of Spine

-Advisory Board journal of Spine

-ARGOS International Spine Society

-Radichian Society

-Society Lateral Access Surgery, American Association of Neurological Surgeons

-American Association of Neurological Surgeon

PUBLICATIONS:

Schneier, M., Textbook Contributor; "Biomechanics of Spine Stabilization"; AANS Press

Schneier, M., Mehler MF, Kessler JA. Preferential Maturation and Migrations into Brain of Neural Progenitor Cells Following One Marrow Implantation, submitted

Krulwich, Schneier, M., Guffanti. Buffering Capacity of Bacilli that Grow at Different pH Ranges. J Bacteriology, 162 (2), 768-772 (1985)

Guffanti, Fuchs, Schneier, M., Krulwich. Trans-membrane Electrical Potentials, J. Biological Chemistry, 295 (5), 2971 (1984)

Abstracts:

Schneier, M., Mehler MF, Kessler JA. Preferential Maturation and Migration into Brain of Neural Progenitor Cells Following Bone Marrow Implantation, American Association of Neurological Surgeons, San Diego, CA (1994)

Schneier, M., De Los Reyes RA. Cerebral Revascularization via Non-reversed Saphenous Vein Graft, Congress Of Neurosurgery, Washington D.C., (1993)

Mehler MF, Rosenthal, R., Schneier, M., Spray DC, Kessler JA. Hematolymphopoietic Cytokines Regulate Differentiation of Neuronal Progenitor Cells in Vitro. Neurology 43 A231, (45th Annual Meeting of American Academy of Neurology, NY, NY (1993)

Rosenthal R., Mehler MF, Schneier, M., Spray DC, Kessler JA. Ontogeny of Electrical Responsiveness of Immortalized Murine Hippocampal Progenitor Cells, Annual Meeting FASEB/Experimental Biology, New Orleans, LA (1993)

Mehler MF, Rosenthal, R., Schneier, M., Spray DC, Kessler JA. Erythromyeloietic Interleukins Program Progressive Neuronal Differentiation of Hippocampal Stem and Progenitor Cells. Annual Meeting, FASEB/Experimental Biology, New Orleans, LA (1993)

Mehler MF., Schneier, M., Kessler JA. All Major CNS Elements Arise from a Single Neural Stem Cell. 118 Annual Meeting. American Neurological Association, Boston, MA (1993)

Papavasiliou AK, Goodrich JT., Schneier, M., Mehler MF., Kessler JA. The Role of Macrophage Colony Stimulation Factor in Medulloblastoma. Congress of Neurosurgery, San Francisco, CA. (1995)

US PATENTS:

Facet Joint Pain Relief Method and Apparatus – Patent # 6,014,588 (Jan 11, 2000)
Dynamic Spinal Implant or Joint Replacement – Patent# 11/254,615 (Oct 20, 2005)

CORPORATE CONSULTING AGREEMENTS:

Lifespine Corp, 13951 S. Quality Drive Huntley, IL 60142 - Microsurgical Technique and Instrumentation development for lateral interbody fusion implant.

Nuvasive Corp, 7475 Lusk Blvd., San Diego, CA 92121 – Facet/joint pain relief method. Shared Patent (# 6.014.588)

Neurostructures LLC., 16 technology Dr., Suite 164 Irvine, CA 92618 – Lateral inner body instrumentations and implants.

5

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 24-40539-1

Against:

FILED

IRA MICHAEL SCHNEIER, M.D.

AUG 08 2024

Respondent.

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: Ismael

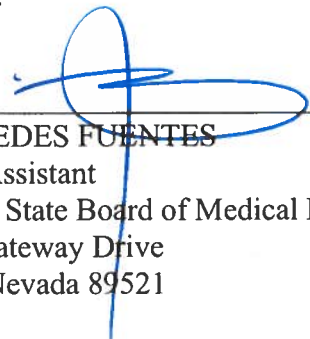
PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on July 30, 2024, I sent the **COMPLAINT**, as well as required fingerprinting card with instructions to:

IRA MICHAEL SCHNEIER, M.D.

via USPS Certified Mail, Tracking No. 9171 9690 0935 0254 6116 53, and was delivered on August 5, 2024. See **Exhibit 1**.

DATED this 8th day of August, 2024.


MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521



August 8, 2024

Dear Mercedes Fuentes:

The following is in response to your request for proof of delivery on your item with the tracking number:
9171 9690 0935 0254 6116 53.

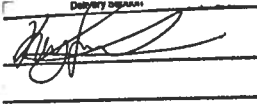
Item Details

Status:	Delivered, Left with Individual
Status Date / Time:	August 5, 2024, 1:29 pm
Location:	LAS VEGAS, NV 89144
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™ Return Receipt Electronic

Shipment Details

Weight:	0.7oz
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Recipient Signature

Signature of Recipient:	
Address of Recipient:	

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Sincerely,
United States Postal Service®
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Washington, D.C. 20260-0004

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FAQs >

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Remove X

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Add to Informed Delivery (<https://informedelivery.usps.com/>)**Latest Update**

Your item was delivered to an individual at the address at 1:29 pm on August 5, 2024 in LAS VEGAS, NV 89144.

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Delivered**Delivered, Left with Individual**

LAS VEGAS, NV 89144

August 5, 2024, 1:29 pm

Departed USPS Regional Facility

LAS VEGAS NV DISTRIBUTION CENTER

August 3, 2024, 8:22 am

Arrived at USPS Regional Facility

LAS VEGAS NV DISTRIBUTION CENTER

August 3, 2024, 2:24 am

In Transit to Next Facility

August 2, 2024

Arrived at USPS Regional Origin Facility

RENO NV DISTRIBUTION CENTER

August 1, 2024, 11:47 pm

Feedback

- Departed Post Office

RENO, NV 89510

August 1, 2024, 6:44 pm
- USPS picked up item

RENO, NV 89510

August 1, 2024, 6:01 pm
- Hide Tracking History

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Text & Email Updates	▼
Return Receipt Electronic	▼
USPS Tracking Plus®	▼
Product Information	▼
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Track Another Package

Enter tracking or barcode numbers

Need More Help?

Contact USPS Tracking support for further assistance.

FAQs

FILED

SEP 23 2024

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: _____

1 Melanie L. Thomas
mthomas@wshblaw.com
2 Nevada Bar No. 12576
WOOD, SMITH, HENNING & BERMAN LLP
3 2881 Business Park Court, Suite 200
Las Vegas, Nevada 89128-9020
4 Phone: 702.251.4100 ♦ Fax: 702.251.5405
Attorneys for Respondent Ira Michael Schneier,
5 *M.D.*

6 **BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA**

7 *****

8
9 In the Matter of Charges and Complaint
Against:

Case No. 24-40539-1

10 IRA MICHAEL SCHNEIER, M.D.,

ANSWER AND NOTICE OF DEFENSE

11 Respondent.
12
13

14 IRA MICHAEL SCHNEIER, M.D. ("Dr. Schneier"), by and through his counsel, WOOD,
15 SMITH, HENNING & BERMAN LLP hereby submits his Answer and Notice of Defense.

16 1. Respondent admits the allegations contained in Paragraph 1 of the Board's
17 Complaint.

18 2. Answering Paragraph 2 of the Board's Complaint, Respondent is without sufficient
19 knowledge and information to form a belief as to the truth or falsity of the phrase "at the time of the
20 events at issue" and therefore denies this allegation. Respondent admits that the patient was 49-
21 years-old at the time of Respondent's care.

22 3. Answering Paragraph 3 of the Board's Complaint, Respondent denies, as phrased,
23 that Patient A was admitted to Sunrise Hospital on December 26, 2019, with complaints of lower
24 back pain, weakness, and inability to walk. Respondent admits that the radiologist interpreted
25 Patient A's MRI of the lumbar spine on December 27, 2019, as showing severe canal narrowing at
26 the T11-T12 level. Respondent admits that the radiologist interpreted Patient A's MRI of the
27 thoracic spine on December 30, 2019, as showing severe central stenosis at the T10-T11 level.

28 4. Answering Paragraph 4 of the Board's Complaint, Respondent denies, as phrased,

WOOD, SMITH, HENNING & BERMAN LLP
2881 BUSINESS PARK COURT, SUITE 200
LAS VEGAS, NEVADA 89128-9020
TELEPHONE 702.251.4100 ♦ FAX 702.251.5405

1 that the thoracic laminectomy for spinal cord decompression with pedicle screw fixation and onlay
2 lateral transverse fusion was intended to be performed at the T10-T11 level. Respondent further
3 denies, as phrased, the allegations that Respondent diagnosed Patient A with thoracic myelomalacia
4 myelopathy with spinal stenosis at the T10-T11 level.

5 5. Answering Paragraph 5 of the Board's Complaint, Respondent denies, as phrased,
6 that Respondent "failed" to perform surgery on Patient A's "main pathology at the T10-T11 level."
7 Respondent admits that the patient was taken to surgery on December 31, 2019, with the intent to
8 alleviate stenosis of the central canal in the thoracic spine. The precise level of intervention would
9 depend on intraoperative findings. Further, the interpretation of levels in the thoracic spine on
10 imaging is difficult as shown by the disagreement among radiologists as to the levels of "severe
11 pathology" in Patient A. Surgery was performed at the level where pathology was found
12 intraoperatively and compression of the canal was relieved as described in Respondent's operative
13 report. It should be noted that subsequent MRI studies no longer described the presence of the
14 abnormal cord signal seen in the pre-operative imaging. While the imaging prior to Respondent's
15 December 31, 2019, surgery show swelling in the spinal cord, the imaging following this procedure
16 show that this swelling has been relieved. That was the goal of the procedure. In fact, the June 4,
17 2020, MRI report from Dr. [REDACTED] at Desert Radiology specifically reports that "The
18 visualized spinal cord demonstrates normal signal intensity." This is in marked contrast to the MRI
19 of December 30, 2019, at Sunrise Hospital prior to the surgery by Respondent which was interpreted
20 by Dr. [REDACTED] as showing abnormal cord signal in the thoracic spine. (compare Saggital T2 series
21 7, Image 11 on 12/30/19 MRI with Saggital T2 series 5, Image 10 on June 4, 2020 MRI). Further,
22 subsequent imaging describes post-operative scar tissue as the source of narrowing of the canal at
23 the T10-11 level. The incorrect procedure was not performed.

24 6. Answering Paragraph 6 of the Board's Complaint, Respondent denies, as phrased,
25 that Patient A returned to Sunrise Hospital on January 22, 2020 with complaints of continued severe
26 pain, spasms, and numbness in the bilateral lower extremities. Respondent denies that his original
27 intention was to perform the laminectomy at the T10-T11 level. Respondent admits that there was
28 some concern of a medial breach of the T9 screw, but no pedicle breach was found upon the second

1 exploratory surgery by Respondent. There was no misplaced screw per neuromonitoring and
2 personal observation at surgery.

3 7. Answering Paragraph 7 of the Board's Complaint, Respondent denies, as phrased,
4 that the second surgery was performed on Patient A on January 23, 2020. Respondent admits that
5 the second surgery did not include the T10-T11 level, but denies the remainder of the allegations.

6 8. Answering Paragraph 8 of the Board's Complaint, Respondent denies that the
7 laminectomy was performed at the incorrect level. Respondent further denies that Patient A required
8 a laminectomy at the T10-T11 level.

9 9. Answering Paragraph 9 of the Board's Complaint, Respondent admits that the
10 February 4, 2020 MRI of the thoracic spine showed "severe canal stenosis at T10/T11 secondary to
11 disc protrusion and scar tissue from laminectomy at T10," and denies the remainder of the allegation.
12 Respondent is without knowledge or information to admit the allegation that Patient A reported
13 spasticity in his lower extremities and functional decline on February 13, 2020, and therefore on
14 that basis denies the same. Respondent denies, as phrased, the allegation that Patient A underwent
15 further MRI testing on February 15, 2020 which demonstrated continued severe central stenosis at
16 the T10-T11 level; however Respondent admits that this MRI showed "persistent cord compression
17 due to a worsening ventral epidural lesions that are favored to represent post operative blood
18 products. Additional underlying mild disc bulge. Associated complete effacement of CSF ventral
19 to the cord. Compression of the lower thoracic cord to any 5 mm AP at this level. Associated
20 abnormal T2 hyperintensity in the cord, which was also noted on the prior MRI of 2/4/2020."
21 Respondent lacks knowledge or information to admit or deny the allegations regarding the May 13,
22 2020 MRI, and on that basis denies the same.

23 10. Respondent lacks knowledge or information to admit or deny the allegations in
24 paragraph 10 of the Board's Complaint, related to May 29, 2020, and therefore denies the same.
25 Respondent admits that Patient A later underwent a T10-T11 laminectomy performed by another
26 surgeon.

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COUNT I

NRS 630.301(4)—Malpractice

11. Answering Paragraph 11, this Answering Respondent repeats and realleges his responses to Paragraphs 1 through 10.

12. Paragraphs 12 through 15 of the Board's Complaint contain legal conclusions that do not call for a response from this Answering Respondent. To the extent that these allegations call for a response from this Answering Respondent, this Answering Respondent is without sufficient knowledge and information to form a belief as to the truth or falsity of the allegations contained in Paragraphs 12 through 15, and therefore denies these allegations.

COUNT II

NRS 630.3062(1)(a)—Failure to Maintain Complete Medical Records

13. Answering Paragraph 16, this Answering Respondent repeats and realleges his responses to Paragraphs 1 through 15.

14. Paragraph 17 of the Board's Complaint contains legal conclusions that do not call for a response from this Answering Respondent. To the extent that these allegations call for a response from this Answering Respondent, this Answering Respondent is without sufficient knowledge and information to form a belief as to the truth or falsity of the allegations contained in Paragraph 17, and therefore denies these allegations.

15. This Answering Respondent denies the allegations contained in paragraph 18 of the Board's Complaint.

16. Paragraph 19 of the Board's Complaint contains legal conclusions that do not call for a response from this Answering Respondent. To the extent that these allegations call for a response from this Answering Respondent, this Answering Respondent denies these allegations.

COUNT III

NRS 630.306(1)(g)—Continual Failure to Exercise Skill or Diligence

17. Answering Paragraph 20, this Answering Respondent repeats and realleges his responses to Paragraphs 1 through 19.

18. Paragraphs 21 through 23 of the Board's Complaint contain legal conclusions that do

1 not call for a response from this Answering Respondent. To the extent that these allegations call
2 for a response from this Answering Respondent, this Answering Respondent denies these
3 allegations.

4 19. Paragraphs 1 through 4 of the Board's prayer for relief contain legal conclusions that
5 do not call for a response from this Answering Respondent. To the extent that these allegations call
6 for a response from this Answering Respondent, this Answering Respondent is without sufficient
7 knowledge and information to form a belief as to the truth or falsity of the allegations contained in
8 Paragraphs 1 through 4 of the Board's prayer, and therefore denies these allegations.

9 20. Answering Paragraphs 5 through 6 of the Board's prayer for relief, this Answering
10 Respondent is without sufficient knowledge and information as to form a belief as to the truth or
11 falsity of the allegations contained in Paragraphs 5 through 6 of the Board's prayer for relief, and
12 therefore denies these allegations.

13 **FIRST AFFIRMATIVE DEFENSE**

14 The Board's Complaint fails to state a claim on which relief may be granted.

15 **SECOND AFFIRMATIVE DEFENSE**

16 The Board's Complaint, and each cause of action therein, is barred by the doctrine of laches,
17 estoppel, and the doctrine of unclean hands.

18 **THIRD AFFIRMATIVE DEFENSE**

19 Respondent denies each and every allegation of the Board's Complaint not specifically
20 admitted or otherwise pled to herein.

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WHEREFORE, Respondent prays for judgment as follows:

1. That all charges against him be dismissed;
2. For such other and further relief as may be deemed just and proper in these premises.

DATED: September 20, 2024 WOOD, SMITH, HENNING & BERMAN LLP

By: /s/ Melanie L. Thomas
MELANIE L. THOMAS
Attorneys for Respondent Ira Michael Schneier, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on this 20th day of September 2024, a true and correct copy of **ANSWER AND NOTICE OF DEFENSE** was sent via electronic mail to the following:

William P. Shogren
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: 775-688-2559
Email: shogrenw@medboard.nv.gov

By /s/ Emma L. Gonzales

Emma L. Gonzales, an Employee of
WOOD, SMITH, HENNING & BERMAN LLP

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

FILED

3 * * * * *

OCT - 7 2024

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

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

Case No. 24-40539-1 By: 

6 **Against:**

7 **IRA MICHAEL SCHNEIER, M.D.,**

8 **Respondent.**

Early Case Conference:

October 17, 2024, at 10:00 a.m.

9
10
11 **ORDER SETTING EARLY CASE CONFERENCE**

12 **TO:** William Shogren, Esq.
13 Deputy General Counsel
14 Nevada State Board of Medical Examiners
15 9600 Gateway Drive
16 Reno, NV 89521

~and~

16 Ira Michael Schneier, M.D.
17 c/o Respondent's Attorneys
18 Melanie L. Thomas, Esq.
19 Wood, Smith, Henning & Berman LLP
20 2881 Business Park Court, Suite 200
21 Las Vegas, NV 89128-9020

22 **NOTICE IS HEREBY GIVEN** in compliance with NRS 630.339(3)¹, an Early Case
23 Conference will be conducted on October 17, 2024, beginning at the hour of 10:00 a.m.. The Early

24 ¹ Within 20 days after the filing of an answer or 20 days after the date on which an answer is due, whichever
25 is earlier, the parties shall hold an early case conference at which the parties and a hearing officer appointed by the
26 Board or a member of the Board must preside. At the early case conference, the parties shall in good faith:

27 (a) Set the earliest possible hearing date agreeable to the parties and the hearing officer, panel of the Board or the
28 Board, including the estimated duration of the hearing;

(b) Set dates:

(1) By which all documents must be exchanged;

(2) By which all prehearing motions and responses thereto must be filed;

(3) On which to hold the prehearing conference; and

(4) For any other foreseeable actions that may be required for the matter;

(c) Discuss or attempt to resolve all or any portion of the evidentiary or legal issues in the matter;

(d) Discuss the potential for settlement of the matter on terms agreeable to the parties; and

(e) Discuss and deliberate any other issues that may facilitate the timely and fair conduct of the matter.

1 Case Conference will be held via conference call. Counsel for the IC, William Shogren, Esq., will
2 initiate the conference call and add the parties to the line.

3 The scheduled Early Case Conference shall be attended by the parties in person or by any
4 party's legal counsel of record and will be conducted by the undersigned Hearing Officer to discuss
5 designate the dates for the Pre-Hearing Conference and Hearing and other procedural matters
6 established in NRS 630.339.

7 At the Pre-Hearing Conference, in accordance with NAC 630.465², each party shall provide
8 the other party with a copy of the list of witnesses they intend to call to testify, including therewith,
9 the qualifications of each witness so identified, and a summary of the testimony of each witness. If
10 a witness is not on the list of witnesses, that witness may subsequently not be allowed to testify at
11 the Hearing unless good cause is shown for omitting the witness from said list³. Likewise, all
12 evidence, except rebuttal evidence, that is not provided to each party at the Pre-Hearing Conference
13 may also not be introduced or admitted at the Hearing unless good cause is shown.

14 ///

15 ///

16 ///

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19 ² 1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the
20 physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311
21 unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the
22 Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents
23 presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the
24 Board.

25 2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications
26 and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of
27 proposed witnesses may not testify at the hearing unless good cause is shown.

28 3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may
not be introduced or admitted at the hearing unless good cause is shown.

4. Each party shall submit to the presiding member of the Board or panel or to the hearing officer conducting the
conference each issue which has been resolved by negotiation or stipulation and an estimate, to the nearest hour, of
the time required for presentation of its oral argument.

(Added to NAC by Bd. of Medical Exam'rs, eff. 1-13-94; A by R149-97, 3-30-98; R167-99, 1-19-2000; R108-01
11-29-2001)

³In identifying a patient as a witness, parties are cautioned to omit from any pleadings filed with undersigned
Hearing Officer any addresses, telephone numbers, social security numbers or other personal information regarding
that individual and to confine their submissions in this regard to the name of witness, the relevancy of any testimony
sought to be elicited from that witness and a summary of their anticipated testimony.

IT IS FURTHER ORDERED that legal counsel for the Nevada State Board of Medical Examiners and the Respondent shall keep undersigned Hearing Officer advised of each issue which has been resolved by negotiation or stipulation, if any. At the Early Case Conference, the parties must also provide an estimate, to the nearest hour, of time required for presentation of their respective cases.

IT IS SO ORDERED.

DATED this 7 day of October, 2024.


CHARLES BURCHAM, ESQ.
Tel: (775) 750-2998
Email: charlie@northernnevadaadr.com
Hearing Officer

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **ORDER SETTING EARLY CASE CONFERENCE** to the following parties:

William Shogren, Esq.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
Las Vegas, NV 89128-9020

9171 9690 0935 0255 7000 11

DATED this 4th day of October, 2024.

Signature

Mercedes Fuentes

Printed Name

Legal Assistant

Title

OCT 18 2024

NEVADA STATE BOARD OF
MEDICAL EXAMINERSBy: **BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA**

* * * * *

In the Matter of Charges and**Case No. 24-40539-1****Complaint Against:****IRA MICHAEL SCHNEIER, M.D.,****Respondent.****SCHEDULING ORDER**

**TO: William Shogren, Esq.
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521**

~and~

**Ira Michael Schneier, M.D.
c/o Respondent's Attorneys
Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
Las Vegas, NV 89128-9020**

On October 17, 2024, an Early Case Conference was held via conference call. The parties appeared via their counsel: William Shogren, Esq. on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners and Melanie L. Thomas, Esq. on behalf of Respondent Ira Michael Schneier, M.D. along with this Hearing Officer.

In compliance with 630.465, a prehearing conference will be conducted on **February 6, 2025** telephonically beginning at the hour of **10:00 a.m.** Pacific Standard Time. Counsel for the IC William Shogren, Esq., will initiate the call and add the parties to the line.

1 All parties shall exchange witness and documents intended for use at the hearing on or before
2 the pre-hearing conference. This list shall include the qualifications and anticipated testimony of the
3 witness and the Bates stamp numbers on each of the exhibits. If a witness is not included on the list
4 that witness may not be allowed to testify at the hearing unless good cause is shown for their
5 testimony. Likewise, if a document has not been listed in a prehearing conference statement, it may
6 not be admitted into evidence unless good cause is shown for its admittance.

7 All prehearing motions shall be served on all parties and this hearing officer by **February 13**
8 **2025**. Responses and Oppositions to pre-hearing motions shall be served on or before **February 24**
9 **2025**, at which time the motions shall be deemed submitted for decision. Service of prehearing
10 motions, responses and oppositions may be effectuated by U.S. Mail or by electronic mail (e-mail) to
11 all parties known email addresses and this hearing officer. Service on the Hearing Officer must be by
12 e-mail.

13 The formal hearing in this matter is hereby scheduled for **March 11, 2025** commencing at
14 the hour of **9 a.m.** Pacific Standard Time and **March 12, 2025** commencing at the hour of **9 a.m.**
15 Pacific Standard Time, and will be held at the office of the Board of Medical Examiners at 9600
16 Gateway Drive, Reno, Nevada 89521. A court reporter will take sworn testimony during the
17 formal hearing and will produce a transcript to the hearing officer and all parties at their request and
18 at their expense. (Any e-mail request to utilize video-conferencing through the Las Vegas office of
19 the Nevada State Board of Medical Examiners should be made as soon as practicable, and no later
20 than **March 4, 2025**.)

21 Once the formal hearing is concluded the hearing officer will submit to the Board a synopsis
22 of the testimony recorded by the court reporter and will make a recommendation on the veracity of
23 witnesses, if there is conflicting evidence or if credibility of witnesses is a determining factor, and
24 thereafter the Board will render its decision. *See* NAC 630.470.

25 Witnesses may appear remotely (defined as witness appearances not occurring in the Las
26 Vegas or Reno office of the Nevada board of Medical examiners), and the party or parties planning
27 on calling witnesses remotely shall identify the name of such witnesses by e-mail to counsel and the
28 Hearing Officer no later than **March 4, 2025**.

1 Stipulation to stay the above dates shall be made to the hearing officer either by email or by
2 formal, filed stipulation as soon as the parties are aware of the necessity for a stay. Any stay request
3 will require a status conference to be set unless a formal settlement agreement is being presented to
4 the Board at the next regularly held Board meeting. If a formal settlement agreement is being placed
5 on the Board meeting agenda, notification of acceptance or denial of the settlement agreement by the
6 Board shall be delivered to this hearing officer no later than five (5) days after the Board meeting by
7 the Board attorney.

8 All parties to this case are required to keep the hearing office informed of events, progress
9 and resolution of this case.

10 **IT IS SO ORDERED.**

11 DATED this 17 day of October, 2024.

12 
13 _____
14 Charles Burcham, Esq.
15 Email: charlie@northernnevadaadr.com
16 Tel: (775) 750-2998
17 *Hearing Officer*
18
19
20
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28

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **SCHEDULING ORDER** to the following parties:

William P. Shogren
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
Las Vegas, NV 89128

Certified Mail No.: 9171 9690 0935 0255 7000 80

DATED this 18th day of October, 2024.

Signature

Mercedes Fuentes

Printed Name

Legal Assistant

Title

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

3 * * * * *

FILED

FEB - 5 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

4
5 In the Matter of Charges and Complaint

Case No. 24-40539-1

By: 

6 Against:

7 IRA MICHAEL SCHNEIER, M.D.,

8 Respondent.

Prehearing Conference:

February 14, 2025 at 10:00 a.m.

9
10
11 **ORDER RE-SETTING PREHEARING CONFERENCE**

12 TO: William Shogren, Esq.
13 Deputy General Counsel
14 Nevada State Board of Medical Examiners
15 9600 Gateway Drive
16 Reno, NV 89521

~and~

16 Ira Michael Schneier, M.D.
17 c/o Respondent's Attorney
18 Melanie L. Thomas, Esq.
19 Wood, Smith, Hening & Berman
20 2881 Business Park Court, Suite 200
21 Las Vegas, NV 89128-9020

22 **NOTICE IS HEREBY GIVEN** that the prehearing conference in this matter will now
23 occur on February 14, 2025, commencing at 10 a.m., by conference call. Counsel for the IC,
24 William Shogren, will initiate the conference call and add the parties to the line.

25 **IT IS SO ORDERED.**

26 DATED this 5 day of February, 2025.

27 
Charles Burcham, Esq.

Tel: (775) 750-2998

Email: charlie@northernnevadaadr.com

Hearing Officer

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **ORDER RE-SETTING PREHEARING CONFERENCE** to the following parties:

William P. Shogren
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Hening & Berman
2881 Business Park Court, Suite 200
Las Vegas, NV 89128

9171 9690 0935 0255 7020 53

Certified Mail No.: _____

DATED this 5th day of February, 2025.

Signature

Printed Name

Title

Mercedes Fuentes

Legal Assistant

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 24-40539-1

Against:

IRA MICHAEL SCHNEIER, M.D.

Respondent.

FILED

FEB 11 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

**PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE
COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Order, filed October 18, 2024.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the Complaint against Respondent filed herein:

- a. Johnna LaRue, Deputy Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ms. LaRue, or her designee, is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

- b. Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
Las Vegas, NV 89128

Dr. Schneier is expected to testify regarding the facts and circumstances surrounding the Complaint in this case and his treatment of Patient A.

///

c. [REDACTED] M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Dr. [REDACTED] is licensed to practice medicine in the State of Nevada. Dr. [REDACTED] has conducted a medical review of this case and is expected to testify regarding his medical review of this matter and the applicable standard of care.

d. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons he may call to testify at the hearing herein.

The IC reserves the right to amend and supplement this list as required for prosecution of this case.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. Additionally, the IC of the Board reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	NSBME Allegation Letter to Dr. Schneier with Order to Produce Records, dated July 12, 2021	001 - 005
2.	Dr. Schneier's Response Letter to NSBME, dated August 29, 2022	006 - 020
3.	Patient A Medical Records; Sunrise Hospital & Medical Center	021 - 062
4.	Patient A Imaging; Sunrise Hospital & Medical Center: October 8, 2019, Lumbar Spin AP Plus Lateral December 27, 2019, MRI Lumbar Spine Plus with Contrast December 30, 2019, MRI Thoracic Spine Plus with Contrast December 31, 2019, Xray Thoracic Spine Lateral January 22, 2020, CT Thoracic Spine without Contrast January 23, 2020, Xray Thoracic Spine Lateral February 4, 2020, MRI Thoracic Spine with Contrast February 15, 2020, MRI Thoracic Spine with Contrast March 11, 2020, Xray Thoracic Spine Lateral June 1, 2020, MRI Spine Lumbar without Contrast June 4, 2020, MRI Spine Thoracic without Contrast	063

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
	June 6, 2020, CT Spine Thoracic without Contrast	
5.	Patient A Medical Records; Clinical Neurology Associates	064 - 080
6.	Patient A Medical Records; Spring Valley	081 - 088
7.	Patient A Medical Records; Desert Radiology	089 - 092
8.	Patient A Medical Records; from Khavkin Clinic	093 - 099
9.	Article - The Prevalence of Wrong Level Surgery Among Spine Surgeons	100 - 104
10.	Curriculum Vitae of [REDACTED] M.D.	105 - 109

The IC reserves the right to use any exhibits relied upon or identified by Respondent and reserves the right to amend and supplement this list of exhibits as required prior to the Prehearing Conference.

DATED this 11th day of February, 2025

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



WILLIAM P. SHOGREN

Deputy General Counsel

9600 Gateway Drive

Reno, NV 89521

Tel: (775) 688-2559

Email: shogrenw@medboard.nv.gov

Attorney for the Investigative Committee

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 11th day of February, 2025, I served a file-stamped copy of the foregoing **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**, along with a USB of Exhibits via Fed Ex Overnight Mail, postage pre-paid, to the following parties:

IRA MICHAEL SCHNEIER, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
Las Vegas, NV 89128
Respondent

Tracking No.: 7720 1257 6456

CHARLES BURCHAM, ESQ.
4255 Ross Drive
Reno, NV 89519
Hearing Officer

Tracking No.: 7720 1268 0874

With courtesy copy of the Prehearing Statement without exhibits by email to:

Melanie L. Thomas, Esq., at mthomas@wshblaw.com
Charles Burcham, Esq., at pcharlie@northernnevadaadr.com

DATED this 11th day of February, 2025.



MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

FILED

FEB 18 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: 

Melanie L. Thomas
mthomas@wshblaw.com
Nevada Bar No. 12576
WOOD, SMITH, HENNING & BERMAN LLP
2881 Business Park Court, Suite 200
Las Vegas, Nevada 89128-9020
Phone: 702.251.4100 ♦ Fax: 702.251.5405
Attorneys for Respondent Ira Michael Schneier,
M.D.

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

In the Matter of Charges and Complaint
Against:

IRA MICHAEL SCHNEIER, M.D.,

Respondent.

Case No. 24-40539-1

**RESPONDENT IRA MICHAEL
SCHNEIER, M.D.'S PREHEARING
CONFERENCE STATEMENT**

IRA MICHAEL SCHNEIER, M.D. ("Dr. Schneier"), by and through his counsel, WOOD,
SMITH, HENNING & BERMAN LLP hereby submits his Prehearing Conference Statement, in
accordance with Nevada Administrative Code 630.465, as follows:

I.

LIST OF PROPOSED WITNESSES

1. Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood Smith Henning & Berman LLP
2881 Business Park Court, Ste. 200
Las Vegas, Nevada 89128

Dr. Schneier is a board certified neurosurgeon licensed to practice medicine in the State of
Nevada and the respondent in this matter, and will testify to the facts and circumstances surrounding
the allegations contained in the Complaint.

2.  MD
c/o Melanie L. Thomas, Esq.
Wood Smith Henning & Berman LLP
2881 Business Park Court, Ste. 200
Las Vegas, Nevada 89128

Dr.  is licensed to practice medicine in the State of Nevada, and is fellowship trained
in neuroradiology. Dr.  earned his medical doctor degree at Northwestern University in

WOOD, SMITH, HENNING & BERMAN LLP
2881 BUSINESS PARK COURT, SUITE 200
LAS VEGAS, NEVADA 89128-9020
TELEPHONE 702.251.4100 ♦ FAX 702.251.5405

1 Chicago, Illinois in 1992. He completed his residency in diagnostic radiology at the William
2 Beaumont Hospital, in Royal Oak, Michigan in 1996. Dr. [REDACTED] completed a fellowship in
3 neuroradiology at the Henry Ford Hospital in Detroit, Michigan in 1998. He has been licensed in
4 the State of Nevada since April 1998. Dr. [REDACTED] has conducted a medical review of this case and
5 is expected to testify regarding his medical review of this matter, and his opinions related to the
6 facts and circumstances surrounding the allegations contained in the Complaint, as well as to any
7 other matter relevant to this proceeding.

8 3. [REDACTED] MD
9 653 N. Town Center Drive, Suite 602
Las Vegas, Nevada 89144

10 Dr. [REDACTED] is a neurosurgeon licensed to practice medicine in the State of Nevada. This
11 witness is expected to testify to his involvement with Patient A, including the treatment and care
12 rendered, and any other matter relevant to this proceeding.

13 4. [REDACTED]
14 3186 S Maryland Pkwy
Las Vegas, NV 89109

15 This witness is expected to testify to his involvement with Patient A, including the treatment
16 and care rendered by Dr. Schneier, and any other matter relevant to this proceeding.

17 5. Custodian of Records
18 Spring Valley Hospital
5400 S Rainbow Blvd.
19 Las Vegas, NV 89118

20 This witness will testify to the records related to Patient A, including the treatment and care
21 received at Spring Valley Hospital, and any other matter relevant to this proceeding.

22 6. All witnesses identified by the IC of the Board in its prehearing conference statement
23 and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list
24 of witnesses disclosed by Respondent of persons it may call to testify at the hearing herein.

25 ///

26 ///

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28 ///

II.

LIST OF PROPOSED EXHIBITS¹

Dr. Schneier lists the following exhibits that it may introduce at the hearing on the charges and in defense of the formal Complaint filed against him. Additionally, Dr. Schneier reserves the right to rely on all exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof:

1. Exhibit A – Sunrise Hospital and Medical Center Medical Records
2. Exhibit B -- Radiology Reports – Sunrise Hospital and Medical Center
3. Exhibit C – Digital Imaging (various dates)
4. Exhibit D – Any exhibits identified by the IC (not reproduced herein)
5. Exhibit E – Spring Valley Hospital Medical Center Medical Records
6. Exhibit F – [REDACTED], M.D. Medical Records
7. Exhibit G – UMC Medical Records
8. Exhibit H – UMC Medical Records - 1
9. Exhibit I – Desert Springs Medical Center Medical Records
10. Exhibit J – [REDACTED] MD/Clinical Neurology Specialists Medical Records
11. Exhibit K – [REDACTED] Medical Records
12. Exhibit L – [REDACTED] Board of Medical Examiners Licensee Lookup
13. Exhibit M – [REDACTED] Complaint [REDACTED]
14. Exhibit N - [REDACTED] Complaint [REDACTED]
15. Exhibit O - [REDACTED] Complaint [REDACTED]
16. Exhibit P – Horizon Health and Rehabilitation Medical Records
17. Exhibit Q – Dr. Schneier Curriculum Vitae
18. Dr. Schneier may use demonstrative exhibits generated from excerpts of Exhibits A-Q, for use with various witnesses to aid in their testimony, but does not necessarily plan to move for

¹ It is anticipated that these documents will be culled down to pertinent excerpts based on the testimony developed at the time of the formal hearing, but are being produced in their totality for sake of completeness and to avoid any waiver.

1 admission of those materials.

2 Dr. Schneier reserves the right to use any exhibits relied upon or identified by the IC of the
3 Board and reserves the right to amend and supplement this list of exhibits as required prior to the
4 Prehearing Conference.

5 Link: <https://wshblaw.sharefile.com/d-sf6703f1f32e94dfaa82e5f06de7418f1>

6 **Password to be sent separately via e-mail

7 DATED: February 14, 2025.

WOOD, SMITH, HENNING & BERMAN LLP

8

9

By: /s/ Melanie L. Thomas

10

MELANIE L. THOMAS

11

Attorney for Respondent Ira Michael Schneier, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that on this 14th day of February 2025, a true and correct copy of **RESPONDENT IRA MICHAEL SCHNEIER, M.D.'S PREHEARING CONFERENCE STATEMENT** was sent via electronic mail to the following:

William P. Shogren
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: 775-688-2559
Email: shogrenw@medboard.nv.gov

Mercedes Fuentes
fuentesm@medboard.nv.gov

Charlie Burcham
Hearing Officer
charlie@northernnevadaadr.com

By /s/ Melanie L. Thomas
Melanie L. Thomas of
WOOD, SMITH, HENNING & BERMAN LLP

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint

Case No. 24-40539-1

Against:

IRA MICHAEL SCHNEIER, M.D.,

Respondent.

FILED

FEB 19 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on February 11, 2025, I sent the **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS**, as well as Exhibits 1-10, via FedEx Overnight Mail to:

IRA MICHAEL SCHNEIER, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Henning & Berman
2881 Business Park Court, Ste. 200
Las Vegas, NV 89128
Tracking No: 7720 1257 6456
Respondent

CHARLES BURCHAM, ESQ.
4255 Ross Drive
Reno, NV 89519
Tracking No: 7720 1268 0874
Hearing Officer

Respondent's copy was delivered on February 12, 2025, at 10:12 a.m. *See Exhibit 1.* The Hearing Officer's Copy was delivered on February 12, 2025, at 9:54 a.m. *See Exhibit 2.*

DATED this 19th day of February, 2025.


MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521



February 19, 2025

Dear Customer,

The following is the proof-of-delivery for tracking number: 772012576456

Delivery Information:

Status:	Delivered	Delivered To:	Receptionist/Front Desk
Signed for by:	K.CHAPMAN	Delivery Location:	2881 BUSINESS PARK CT 200
Service type:	FedEx Priority Overnight		
Special Handling:	Deliver Weekday; Adult Signature Required		LAS VEGAS, NV, 89128
		Delivery date:	Feb 12, 2025 10:12

Shipping Information:

Tracking number:	772012576456	Ship Date:	Feb 11, 2025
		Weight:	0.5 LB/0.23 KG

Recipient:
Melanie L. Thomas, Esq., Wood, Smith, Henning & Berman LLP
2881 Business Park Court, Suite 200
LAS VEGAS, NV, US, 89128

Shipper:
Mercedes Fuentes, Nevada State Board of Med Exam
9600 Gateway Drive
Reno, NV, US, 89502

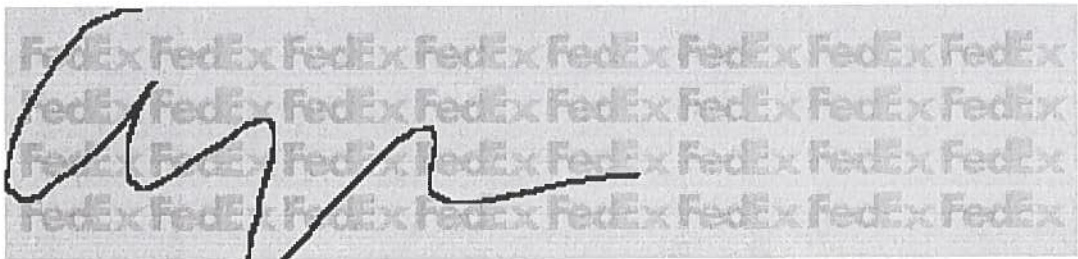


EXHIBIT 2

EXHIBIT 2



February 19, 2025

Dear Customer,

The following is the proof-of-delivery for tracking number: 772012680874

Delivery Information:

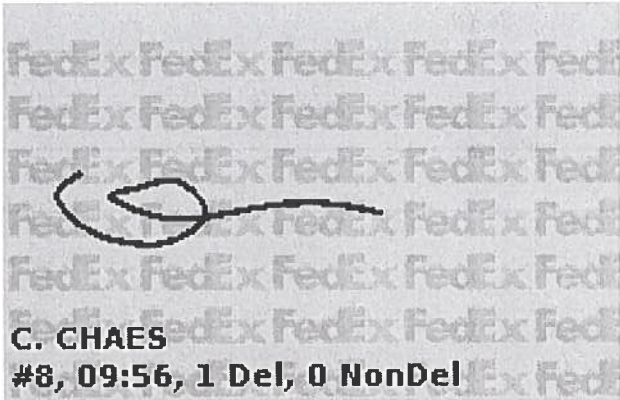
Status:	Delivered	Delivered To:	Residence
Signed for by:	C.Chaes	Delivery Location:	4255 ROSS DR
Service type:	FedEx Priority Overnight		
Special Handling:	Deliver Weekday; Residential Delivery; Adult Signature Required		RENO, NV, 89519
		Delivery date:	Feb 12, 2025 09:54

Shipping Information:

Tracking number:	772012680874	Ship Date:	Feb 11, 2025
		Weight:	0.5 LB/0.23 KG

Recipient:
CHARLES BURCHAM, ESQ.,
4255 Ross Drive
RENO, NV, US, 89519

Shipper:
Mercedes Fuentes, Nevada State Board of Med Exam
9600 Gateway Drive
Reno, NV, US, 89502



BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint
Against:
IRA MICHAEL SCHNEIER, M.D.,
Respondent.

Case No. 24-40539-1

FILED
FEB 21 2025
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
By: _____

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL
EXAMINERS' MOTION IN LIMINE TO EXCLUDE CERTAIN WITNESSES AND
EXHIBITS LISTED IN RESPONDENT'S PREHEARING CONFERENCE STATEMENT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, hereby requests leave pursuant to NRS 622A.360(2)(f) and files its Motion in Limine to Exclude Certain Witnesses and Exhibits Listed in Respondent's Prehearing Conference Statement filed on February 18, 2025.

MEMORANDUM OF POINTS AND AUTHORITIES

I. PROCEDURAL BACKGROUND

On July 30, 2024, the IC filed a formal complaint against Respondent alleging three (3) violations of NRS Chapter 630. On September 23, 2024, Respondent filed an Answer which included denials regarding all the counts in the Complaint. On October 17, 2024, an early case conference was held which set a prehearing conference date, as well as dates for a formal hearing.

On February 14, 2025, the prehearing conference, required by NRS 630.339(3)(b)(3), was held, at which time the IC had provided its Prehearing Conference Statement and complied with the provisions of NAC 630.465(2) and (3). This included listing the IC's proposed witnesses and their qualifications and a summary of the testimony of each proposed witness and providing

1 copies of documents intended to be used in prosecution of the case against Respondent.
2 Respondent submitted their Prehearing Conference Statement (Respondent's Statement) on
3 February 14, 2025. Respondent's Statement lists five (5) witnesses and discloses seventeen (17)
4 exhibits.

5 The IC does not object to the identification of Respondent's listed Witness 1, Ira Michael
6 Schneier, M.D., and Witness 2, [REDACTED], M.D. However, the IC does object to Respondent's
7 Witness 3, [REDACTED], M.D., Witness 4, [REDACTED], and Witness 5,
8 Custodian of Records for Spring Valley Hospital, from testifying at the formal hearing. Testimony
9 provided by the aforementioned witnesses will either be irrelevant, immaterial, and/or unduly
10 repetitious and would therefore be improper. Respondent also did not provide sufficient
11 information in his Statement to establish Witnesses 3 and 4's qualifications for testifying in this
12 matter. The IC requests that Witnesses 3, 4 and 5 be prohibited from testifying at the formal
13 hearing in this matter.

14 Further, the IC also objects to the admission of Respondent's Exhibits L through O.
15 Exhibit L appears to be a printout from the Board's website, concerning licensee Dr. [REDACTED].
16 Exhibits M, N, and O are copies of three separate complaints filed by the Board against Dr.
17 [REDACTED]. Respondent's exhibits L through O are irrelevant to these proceedings and the IC
18 hereby requests that they be excluded.

19 **II. RELEVANT STATUTORY PROVISIONS**

20 **A. Provisions Related to Prehearing Conference Statements.**

21 NAC 630.465(2) provides that each party shall provide to every other party a copy of the list
22 of proposed witnesses and their qualifications and a summary of the testimony of each proposed
23 witness. NAC 630.465(3) states that all evidence, except rebuttal evidence, which is not provided to
24 each party at the prehearing conference may not be introduced or admitted at the hearing unless
25 good cause is shown.

26 **B. Provisions Related to Admission of Evidence and Testimony.**

27 NRS 630.346 provides that evidence must be allowed in the administrative hearing as
28 provided by NRS 233B.123 which states that "[i]rrelevant, immaterial, or unduly repetitious

evidence **must be excluded.**” NRS 233B.123(1) (emphasis added). Evidence may be admitted unless otherwise excluded by law, only if it is the type of evidence commonly relied upon by reasonable and prudent persons in the conduct of their affairs. *Id.* The Nevada Rules of Evidence define “relevant evidence” as evidence which has any tendency to make the existence of any fact of consequence to the determination of the action more or less probable than it would be without the evidence. *See* NRS 48.015.

III. ARGUMENT

A. The Testimony of Witnesses 3 and 4 is Irrelevant, Immaterial or Unduly Repetitious to the Charges Against Respondent.

1. Witness 3

Respondent lists [REDACTED] M.D. as a witness, and states that “[t]his witness is expected to testify to his involvement with Patient A, including the treatment and care rendered, and any other matter relevant to this proceeding.” Respondent’s Statement at 2.

However, any such testimony is irrelevant as to whether Respondent violated the provisions of the MPA as alleged in Counts I through III of the Complaint. Per the Complaint, Respondent performed a laminectomy and fusion on December 31, 2019, which was intended to be performed at the T10-T11 level. Per the Complaint, Respondent performed the laminectomy at the T9-T10 level and subsequently failed to address the severe stenosis at the T10-T11 level during a second surgery performed on January 23, 2020. This is the basis for Counts I through III of the Complaint.

Per the Complaint, and the records provided prior to the prehearing conference, Dr. [REDACTED] did not treat Patient A between December 31, 2019, and January 23, 2020. Dr. [REDACTED] did not participate in the two (2) surgeries performed by Respondent on Patient A. Respondent has curiously not included any of the other several physicians listed in the parties’ exhibits who evaluated or otherwise treated Patient A, specifically after January 23, 2020. Respondent’s inclusion of Witness 3 is not relevant to the care and treatment of Patient A provided by Respondent.

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1 Any testimony regarding Patient A's treatment by any other medical provider in this context
2 is wholly unnecessary and irrelevant to the ultimate questions of fact in this case and must be
3 excluded by statute. *See* NRS 233B.123(1).

4 Additionally, Respondent's Exhibits L through O all involve Dr. [REDACTED] and his
5 disciplinary history with the Board. However, disciplinary matters against other licensees who are
6 not charged in the instant Complaint have no bearing in this hearing and are completely irrelevant as
7 to whether Respondent violated the provisions of the MPA as alleged in Counts I-III. These exhibits
8 must also be excluded pursuant to NRS 233B.123(1).

9 **2. Witness 4**

10 Respondent also lists [REDACTED] as its fourth witness. Per NAC 630.465(2), each party
11 shall provide to every other party a copy of the list of proposed witnesses and their qualifications
12 and a summary of the testimony of each proposed witness. Evidence that is not provided at the
13 time of the prehearing conference may not be introduced unless good cause is shown. *See* NAC
14 630.465(3).

15 Respondent did not provide the qualifications of Witness 4 at the prehearing conference,
16 despite stating in his Prehearing Conference Statement that they are going to testify as follows:
17 "This witness is expected to testify to his involvement with Patient A, including the treatment and
18 care rendered by Dr. Schneier, and any other matter relevant to this proceeding." Witness 4 is not a
19 Board licensee and does not appear to have been involved in Respondent's treatment and care of
20 Patient A, as ascertained by the medical records provided during the prehearing conference.
21 Respondent did not provide a curriculum vitae for Witness 4. Respondent has provided no basis for
22 why Witness 4 is qualified to testify about the treatment and care rendered by Respondent.
23 Respondent further has provided no basis for how Witness 4's testimony would be relevant in this
24 matter.

25 Respondent further cannot show good cause to amend his prehearing statement to include
26 the qualifications of Witness 4 at the formal hearing. The Nevada Supreme Court has interpreted
27 good cause as "a substantial reason ... that affords legal excuse. *See Hathaway v. State*, 119 Nev.
28 248, 252 (2003); *see also Passanisi v. Dir., Nev. Dep't of Prisons*, 105 Nev. 63, 66 (1989) (finding

1 good cause is demonstrated when an impediment external to the defense prevents compliance with
2 procedural rules). The early case conference was held October 28, 2024, and the Respondent had
3 until February 14, 2025, to produce the qualifications of witnesses intended to be called at the
4 formal hearing. Respondent received the IC's Prehearing Statement, which included its witness and
5 exhibit lists, on or about February 11, 2025, three (3) days before the prehearing conference.
6 Respondent had ample time to prepare a witness list that comports with
7 NAC 630.465(2) after receiving the IC's prehearing disclosures. Therefore, Respondent's mere
8 inadvertence to the Scheduling Order and the IC's exhibits does not constitute a sufficient basis for
9 the inclusion of witnesses whose qualifications have not been disclosed.

10 Further, identifying both Witness 3 and Witness 4 to testify to their knowledge of the same
11 facts as to Respondents' disclosed expert witness, Witness 2, is unduly repetitious and would not
12 make the ultimate facts in this case more or less probable. It is unforeseeable that calling two (2)
13 witnesses without sufficient knowledge to opine on Nevada MPA violations would add any value to
14 the proceeding. Likewise, there is no need for additional witnesses to testify to the same facts that
15 will be introduced in the testimony of the Respondent's Witness 2 when Witness 3 and Witness 4's
16 conduct in the case is not in contention in this hearing.

17 3. Witness 5

18 Lastly, Respondent lists Custodian of Records, Spring Valley Hospital, as Witness 5, and
19 states that "[t]his witness will testify to the records related to Patient A, including the treatment and
20 care received at Spring Valley Hospital, and any other matter relevant to this proceeding."

21 It is not clear why Respondent only includes the Custodian of Records for Spring Valley
22 Hospital as a witness. Respondent does not list custodians of records from the numerous other
23 facilities involved in this matter. NRS 233B.123(2) provides that "[d]ocumentary evidence may be
24 received in the form of authenticated copies or excerpts." NRS 233B.123(1) also provides that
25 "[e]vidence may be admitted . . . if it is of a type commonly relied upon by reasonable and prudent
26 persons in the conduct of their affairs."

27 NRS 52.355 does state that "[i]f during a trial or discovery proceeding the authenticity of the
28 record . . . the court may order the original documents produced," and that "[i]f the personal

1 attendance of a custodian of the medical records is required, the subpoena shall clearly state such
2 demand.”

3 However, the IC’s Exhibit 6, containing records from Spring Valley Hospital, is
4 authenticated by the signed affidavit from the ROI Specialist/Agent for the Custodian. A Board
5 investigator, who has been named as witness by the IC, will also testify as to how the Spring Valley
6 records were obtained by the Board.

7 More importantly, Respondent provided records from Spring Valley Hospital in his
8 Prehearing Conference Statement. *See* Respondent’s Exhibit E. Included in this exhibit is a similar
9 Certification of Records, from a ROI Specialist/Agent for the Custodian from Spring Valley
10 Hospital. *See* Exhibit E at 1. The specific Spring Valley Hospital records provided by the IC are
11 also found in Respondent’s records from Spring Valley. *Compare* IC’s Exhibit 6, NSBME 084-088
12 with Respondent’s Exhibit E, SCHNEIER000316-000320.

13 Both parties have disclosed the same Spring Valley Hospital records. A Custodian of
14 Records is not required to testify at the formal hearing in this matter. Pursuant to NRS 233B.123(1),
15 such testimony must be excluded as irrelevant, immaterial, and/or unduly repetitious.

16 **B. Excluding Unduly Repetitious and Irrelevant Exhibits Does Not Violate**
17 **Respondent’s Due Process.**

18 The Board must determine the continued competency of physicians for the protection of
19 public health and safety. *See* NRS 630.003. It is required to, however, balance its important public
20 protection duties with a licensee’s due process right in his or her license. It balances those duties by
21 ensuring that the procedures that guarantee due process are followed.

22 With respect to any assertion that Respondent’s Witnesses must be included to avoid any
23 violation of due process, Respondent has, as a matter of law, been afforded all due process required.
24 *Dutchess Bus. Servs., Inc.*, 124 Nev. at 711, 191 P.3d at 1166 (“Although proceedings before
25 administrative agencies may be subject to more relaxed procedural and evidentiary rules, due
26 process guarantees of fundamental fairness still apply.”). In an administrative proceeding, “it is the
27 opportunity to prepare a defense that defines due process,” and a process where a respondent is
28 apprised of the charges against him and the factual bases underlying them, and where established

1 procedural guidelines are followed, the required due process is provided. *See id.* at 711-12, 191
2 P.3d at 1166-67.

3 With respect to due process required during the investigative process, because only a Board
4 member “other than a member of an investigative committee of the Board who participates in any
5 determination regarding a formal complaint in the matter . . . may participate in an adjudication to
6 obtain the final order of the Board,” the IC has no authority to deprive Respondent of the property
7 interest he has in his medical license. (“An agency or board being tasked merely with investigatory
8 fact-finding and filing of a formal complaint, which they are statutorily prohibited from later
9 adjudicating themselves, does not implicate procedural due process protections).
10 *See Sarfo*, 134 Nev. at 713, 429 P.3d at 654 (2018)

11 Finally, the IC has complied with all established procedural guidelines in NRS and
12 NAC Chapters 630, NRS 622A, and NRS 233B, which provides for an opportunity for Respondent
13 to be heard on the allegations against him in this matter. As Respondent has been apprised of the
14 charges against him and the factual bases underlying them, all applicable standards have been
15 adhered to, and Respondent has been afforded the opportunity to prepare a defense, he has received
16 all due process to which he is entitled to in this proceeding. *See Dutchess*, 124 Nev. at 711-12, 191
17 P.3d at 1167.

18 **IV. CONCLUSION**

19 In conclusion, Respondent filed an improper Prehearing Conference Statement which
20 discloses two (2) witnesses whose testimony is immaterial, irrelevant, and/or unduly repetitious.
21 This is a straightforward matter involving the narrow question of whether Respondent violated the
22 MPA by performing a wrong level laminectomy and fusion and then failing to correct this mistake
23 during a second surgery.

24 Respondent’s counsel is attempting to confuse the core issues in this matter, by proposing
25 witnesses whose testimony is not related to the investigation or case involving Patient A and is
26 otherwise is not material and is irrelevant or repetitious.

27 ///

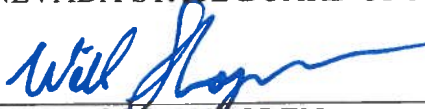
28 ///

1 Based on the foregoing, the IC respectfully requests that Respondent's identified
2 Witnesses 3 and 4 and Exhibits L through O be excluded.

3 DATED this 21st day of February, 2025.

4 INVESTIGATIVE COMMITTEE OF THE
5 NEVADA STATE BOARD OF MEDICAL EXAMINERS

6 By:



7 WILLIAM P. SHOGREN

8 Deputy General Counsel

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NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

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Attorneys for Respondent Ira Michael Schneier,
5 M.D.

6 **BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA**

7 *****

8 In the Matter of Charges and Complaint
Against:

9 IRA MICHAEL SCHNEIER, M.D.,
10 Respondent.

Case No. 24-40539-1

**RESPONDENT IRA MICHAEL
SCHNEIER, M.D.'S OPPOSITION TO
THE INVESTIGATIVE COMMITTEE'S
PREHEARING MOTION IN LIMINE**

11
12
13 IRA MICHAEL SCHNEIER, M.D. ("Dr. Schneier"), by and through his counsel, WOOD,
14 SMITH, HENNING & BERMAN LLP hereby submits his Opposition to the Investigative
15 Committee's ("IC") Prehearing Motion in Limine.

16 Preliminarily, Dr. Schneier does not contest the exclusion of the Custodian of Records for
17 Spring Valley Hospital.

18 The IC claims: "This is a straightforward matter involving the narrow question of whether
19 Respondent violated the MPA by performing a wrong level laminectomy and fusion and then failing
20 to correct his mistake during a second surgery." See Motion, at 7:21-23.

21 The IC further claims: "Respondent's counsel is attempting to confuse the core issues in this
22 matter, by proposing witnesses whose testimony is not related to the investigation or case involving
23 Patient A and is otherwise not material and is irrelevant or repetitious." See Motion, at 7:24-26.
24 The IC cannot use its investigatory privilege as a sword and a shield as it has unequivocally
25 attempted to do here—by precluding Dr. Schneier from obtaining any information related to the
26 investigation under the purported statutory protections deeming it confidential, but then attempting
27 to limit the evidence Dr. Schneier is able to use to defend against the IC's allegations by claiming
28 that evidence is "not related to the investigation." Dr. Schneier is being accused of performing a

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1 "wrong level laminectomy and fusion." The testimony of the second surgeon (Dr. [REDACTED]) and the
2 circumstances surrounding the performance of that surgery at the purported "correct" level, are
3 highly relevant to whether Dr. Schneier's surgery was performed at the "wrong level." Both Dr.
4 Schneier and Dr. [REDACTED] will testify as to their thought process and professional opinions when
5 encountering Patient A, reviewing his imaging, visualizing his anatomy in the operating room, and
6 making decisions based on their knowledge, training, and skills as neurosurgeon on what course
7 was best for Patient A's objective and subjective clinical presentation.

8 The Board counsel disingenuously claims that Dr. [REDACTED] testimony is irrelevant because
9 he was not involved with Patient A during the same time period of Dr. Schneier's involvement and
10 surgeries. However, the IC through Board counsel, has alleged Dr. Schneier violated the MPA
11 *because* he did not perform surgery at T10-T11. The IC's Complaint alleges that Dr. [REDACTED]
12 performed the T10-T11 laminectomy on June 4, 2020. *See* Complaint, at ¶ 10. The Board counsel
13 insinuates that the standard of care required surgery at T10-T11, regardless of Patient A's actual
14 pathology treated by Dr. Schneier. *Id.*, at ¶ 8.

15 Board counsel claims: "Any testimony regarding Patient A's treatment by any other medical
16 provider in this context is wholly unnecessary and irrelevant to the ultimate questions of fact inn
17 this case and must be excluded by statute." *See* Motion, at 4:1-3. Board counsel seeks to exclude
18 witnesses and documents outside of Dr. Schneier's care, yet refers to multiple dates of treatment and
19 imaging performed *after* Patient A last saw Dr. Schneier—including imaging reviewed by and
20 treatment performed by Dr. [REDACTED] prior to his surgery on Patient A. *See* Complaint, at ¶¶ 8-10.
21 Board counsel claims the treatment of any other medical provider is irrelevant, and in addition to
22 specific allegations related to other providers' care in the charging document—the IC discloses the
23 medical records of four other medical entities as exhibits in its Pre-Hearing Statement. *See* Pre-
24 Hearing Statement, at Exhibit Nos. 5-8 (of which Dr. [REDACTED] clinical chart and hospital chart
25 from Spring Valley Hospital are included). Board counsel would like to have those records accepted
26 as gospel, unchallenged, to support its conclusion that Dr. Schneier performed a wrong level
27 surgery. Dr. [REDACTED] and his surgical expertise and professional background are relevant to his
28 medical records the Board counsel intends to offer as exhibits, the T10-T11 operation that the Board

1 counsel contends was required, and Dr. Schneier's defenses in this case. Dr. Schneier is not required
2 to divulge further specifics related to his protected trial strategy, just as Board counsel hides behind
3 NRS 630.336 in refusing to disclose any specifics related to the investigation and testimony of its
4 own expert Dr. Goz.

5 It is well established that a fundamental right may not be impaired without due process of
6 law. See *Chudacoff v. Univ. Med. Ctr., of S. Nev.*, 609 F. Supp.2d 1163, 1172-73 (D.Nev. 2009);
7 *Maiola v. State*, 120 Nev. 671, 674-75, 99 P.3d 227, 229 (2004). Moreover, the Nevada Supreme
8 Court has recognized that a physician's interest in practicing medicine is a property right that must
9 be afforded due process. See *Minton v. Bd. of Med. Exam'rs*, 110 Nev. 1060, 1082, 881 P.2d 1339,
10 1354 (Nev. 1994) (overruled in part, *Nassiri v. Chiropractic Physicians' Bd. of Nev.*, 130 Nev. 245,
11 327 P.3d 487 (Nev. 2014)). In order to prepare for the adjudicatory, penal administrative proceeding
12 in this matter, Dr. Schneier should be afforded the opportunity to review the underlying complaint
13 showing the allegations actually made by Patient A, as well as the investigatory materials, including
14 the report of the Board's reviewer, and the facts contained therein, underlying the formal Complaint
15 at issue in this matter—yet, the IC hides behind NRS 630.336 to block him from doing so. The IC
16 always withholds this information from its licensees in these proceedings keeping them secret and
17 leaving the licensee (here, Dr. Schneier) to prepare defenses in the blind. NRS 630.336 is not
18 intended to exclude a professional who is the subject of a penal administrative hearing from fully
19 understanding and assessing the allegations and facts alleged against him. See *McKay v. Bd. of Cty.*
20 *Comm'rs*, 103 Nev. 490, 492, 746 P.2d 124, 125 (Nev. 1987). However, that is how this Board
21 counsel has applied it for several years now.

22 NRS 622A.330, the statute states as follows:

23 "The investigative file for the case is not discoverable **unless** the prosecutor intends
24 to present materials from the investigative file as evidence in support of the case..."
See NRS 622A.330(2). (Emphasis added).

25 Here, counsel for the Board has stated that they intend to use certain portions of the investigative
26 file—i.e., Dr. Goz's medical review and testimony relate to the same. Certainly, the Board reviewer
27 examined the materials in the investigatory file (and the facts contained) therein, and Dr. Schneier
28 and his expert should similarly be afforded the same opportunity but they are not which is why it is

1 critical that Dr. Schneier be afforded to call the witnesses necessary to respond to the testimony the
2 Board counsel intends to ambush him with at trial. It is axiomatic that if the Board intends to use
3 portions of the investigative file, then the entire file should be disclosed (especially the facts
4 contained therein) to Dr. Schneier before he is subject to an adjudicatory, penal hearing which can
5 affect his livelihood, reputation, and insurability as a physician. But, because this information is
6 withheld from Dr. Schneier, he must be able to present witnesses and documentary evidence needed
7 to overcome the undisclosed investigation by which is facing impending attack. This is particularly
8 apparent in a penal administrative hearing, such as this, where the Respondent is not permitted to
9 conduct prehearing formal discovery of evidence, such as the taking of depositions. *See* NAC
10 630.470(4).

11 With regard to [REDACTED] this witness was adequately and appropriately disclosed by
12 Dr. Schneier. Board counsel incorrectly states: "Witness 4 [...] does not appear to have been
13 involved in Respondent's treatment and care of Patient A, as ascertained by the medical records
14 provided during the prehearing conference." *See* Motion, at 4:18-20. This is absolutely untrue and
15 unequivocally false. Board counsel is attempting to force Dr. Schneier to reveal his investigation,
16 yet—hides behind an absurd statutory interpretation to wholesale foreclose Dr. Schneier from *any*
17 information related to the Board's investigation. As an officer of the court, counsel undersigned
18 represents and assures that Mr. [REDACTED] was involved in Dr. Schneier's treatment and has relevant
19 information related to the claims and defenses in this action. Mr. [REDACTED] CV is irrelevant, he is a
20 fact witness with firsthand knowledge.

21 The IC and Board counsel want Dr. Schneier to either lay out the details of his defense in a
22 manner in which the Board itself refuses to do, or they move to exclude that evidence claiming it is
23 irrelevant to their clandestine and secret investigation. Dr. Schneier has adequately identified
24 witnesses and documents relevant to his defense, and any evidentiary rulings related to the same
25 should be reserved for the time of hearing. If Dr. Schneier must accept that the Board does not have
26 to disclose its evidence and the reports of the witnesses against him in advance of the hearing, then
27 the Board should be held to the same standard with regard to the level of detail of the disclosures of
28 Dr. Schneier.

1 The IC claims: "This is a straightforward matter involving the narrow question of whether
2 Respondent violated the MPA by performing a wrong level laminectomy and fusion and then failing
3 to correct his mistake during a second surgery." *See* Motion, at 7:21-23. By disclosing subsequent
4 treatment records, and including subsequent treatment in the allegations in the formal charging
5 document, the IC and Board counsel have made the same relevant. By denying Dr. Schneier access
6 to any investigative file information, including the review performed Dr. [REDACTED] Dr. Schneier is
7 entitled to and must be permitted to prepare a defense to this withheld information based on all
8 reasonable inferences that he can gain from the inclusion of allegations and records of subsequent
9 care as evidence the Board intends to use. The Board has made this information relevant and its
10 motion should be denied in its entirety with the exception of Dr. Schneier's concession that the
11 Spring Valley Hospital Custodian of Records is not a necessary witness. This honorable Hearing
12 Officer should more appropriately respond to objections in real time at the formal hearing, in order
13 to protect Dr. Schneier's right to due process.

14 DATED: March 3, 2025.

WOOD, SMITH, HENNING & BERMAN LLP

15
16 By: /s/ Melanie L. Thomas

17 MELANIE L. THOMAS

18 Attorney for Respondent Ira Michael Schneier, M.D.
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28

CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of March 2025, a true and correct copy of **RESPONDENT IRA MICHAEL SCHNEIER, M.D.'S OPPOSITION TO THE INVESTIGATIVE COMMITTEE'S PREHEARING MOTION IN LIMINE** was sent via electronic mail to the following:

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By /s/ Melanie L. Thomas
Melanie L. Thomas of
WOOD, SMITH, HENNING & BERMAN LLP

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

3 * * * * *

4
5 **In the Matter of Charges and**
6 **Complaint Against:**
7 **IRA MICHAEL SCHNEIER, M.D.**
8 **Respondent.**

Case No. 24-40539-1

Hearing date:

To be re-set

FILED

MAR 07 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

9
10 **ORDER ON IC'S MOTION IN LIMINE**

11 On February 21, 2025, the IC filed its Motion in Limine to Exclude Certain Witnesses and
12 Exhibits Listed in Respondent's Prehearing Conference Statement (the "Motion"). On March 3,
13 2025, Respondent filed his Opposition to the Motion (the "Opposition"). Accordingly, the Motion
14 is now submitted for decision.

15 The analysis that follows will address each issue raised by the IC in the Motion in light of
16 the arguments made in same, together with the counter arguments raised by Respondent in his
17 Opposition. Initially, it is noted that fundamental due process is notice of claims and the opportunity
18 to be heard regarding the claims. The notice in this matter is the IC's Complaint filed July 30, 2024,
19 and the opportunity to be heard is the upcoming formal hearing. Further due process considerations
20 are discussed below.

21 The Motion addresses certain witnesses and documents set forth in Respondent's Prehearing
22 Statement. In particular, the IC argues that three witnesses identified by Respondent be excluded
23 from testifying: [REDACTED] M.D. ("Witness 3"); [REDACTED] ("Witness 4");
24 and Custodian of Records for Spring Valley Hospital ("Witness 5"). Additionally, the Motion seeks
25 to exclude Exhibits listed by Respondent as "L", "M", "N" and "O".

26 The Motion relies on administrative law provisions dealing with the contents of Prehearing
27 Conference Statements (*NAC 630.465(2)(3)*) and *NRS 233B.123*) which set forth the evidentiary
28 rules that apply to the upcoming hearing. Basically, evidence at the hearing must be of the type

1 commonly relied upon by reasonable and prudent persons in the conduct of their affairs. *Id.*
2 Furthermore, “irrelevant, immaterial or unduly repetitious evidence must be excluded.” *Id.*

3 It is clear that the rules of evidence are relaxed, but not ignored.

4 In the instant matter, the IC’s Complaint alleges that on December 31, 2019, Respondent
5 performed surgery on Patient A’s spine at the wrong level. In particular, it is alleged that instead of
6 performing spinal surgery at the T10-11 level (laminectomy/fusion) he operated on Patient A’s T9-
7 10 level. It is further alleged that following this surgery, Patient A continued to have problems with
8 his back, and on January 23, 2020, Respondent again operated on the T9 level, removing screws that
9 had been implanted as part of the first surgery. It is alleged that Respondent did not address the the
10 problem at T10-11 (severe stenosis) during this second procedure. Further, it is alleged that there is
11 no documentation that Patient A was advised “that the initial laminectomy was performed on the
12 wrong level, or that Patient A still required operation on the T10-11 level.” It is also alleged that
13 subsequent diagnostic tests in February 2020 and May 2020 showed continuing pathology (severe
14 stenosis) that ultimately required surgical intervention by a different surgeon in June, 2020. See,
15 generally, Complaint, paragraphs 3-10. These are the basic factual allegations of the Complaint.
16 Respondent addressed these allegations in his Answer and Notice of Defense in a detailed fashion.

17 The Complaint alleges two theories of malpractice: first for performing a wrong level
18 surgery and second, by not addressing the severe pathology (stenosis) at the T10-11 level. In the
19 instant Motion, the IC argues that “[t]his is a straightforward matter involving the narrow question
20 of whether Respondent violated the MPA by performing a wrong level laminectomy and fusion and
21 then failing to correct this mistake during a second surgery.” Motion, at 7:21-23.

22 The issue of “due process” deserves special attention, since it is discussed in both the IC’s
23 Motion and Respondent’s Opposition.

24 The IC contends that excluding witnesses and documents in this case as set forth in the
25 Motion does not violate Respondent’s due process rights. The IC cites *Dutchess Business*
26 *Services Inc. v. Nevada State Board of Pharmacy*, 124 Nev. 701 (2008) for several principles of
27 administrative law, such as (i) despite loosened procedural and evidentiary rules, “due process
28 guarantees of fundamental fairness still apply”; (ii) it is the opportunity to prepare a defense that

1 defines due process; and (iii) a process where a respondent is apprised of the charges against him
2 and the factual basis underlying them and where established procedural guidelines are followed then
3 the required due process is provided.

4 The IC then discusses the “due process required during the investigative process” and finally
5 argues that Respondent has been afforded all due process to which he is entitled to in this
6 proceeding.

7 Respondent’s discussion of due process seems to focus on access to investigative materials
8 and matters that might or might not be addressed by IC witnesses at the hearing. It also references
9 how the IC interprets and applies certain statutory provisions, chiefly NRS 630.336, so to allegedly
10 block Respondent from having access to information regarding the facts and allegations against him.
11 Since Respondent is making these arguments in the context of an *opposition* to a motion in limine,
12 it appears that such arguments are made to justify allowing witness testimony “to overcome the
13 undisclosed investigation.” Thus, this is not a direct attack on the IC’s position regarding
14 investigative materials, but rather a justification for permitting Respondent’s witnesses, Dr.
15 [REDACTED] and [REDACTED], to testify.

16 With the foregoing in mind, the following is the individual analysis of each issue raised by
17 the IC in its Motion.

18 **1. TESTIMONY OF DR. [REDACTED]**

19 The IC argues that the testimony of [REDACTED] M.D. should not be
20 allowed. After repeating the allegations contained in the Complaint, the IC contends that since Dr.
21 [REDACTED] did not treat Patient A between December 31, 2019 and January 23, 2020, and did not
22 participate in the two surgeries Respondent performed on Patient A, any testimony from him is
23 unnecessary and irrelevant. “Any testimony regarding Patient A’s treatment by any other medical
24 provider in this context is wholly unnecessary and irrelevant to the ultimate questions of fact in this
25 case and must be excluded by statute.” Motion, at 4:1-3.

26 In his opposition brief, Respondent essentially makes an offer of proof as to the scope of Dr.
27 [REDACTED] proposed testimony. Basically, the scope would include testimony about the surgery he
28

1 performed on Patient A and also his “thought process” and “professional opinions” regarding the
2 best course of treatment for Patient A’s objective and subjective clinical presentation.

3 Respondent then points out that the IC’s Complaint makes specific reference to treatment
4 Patient A received from other providers following Respondent’s second surgery on January 23,
5 2020, including the surgery that Dr. [REDACTED] performed on June 4, 2020, addressing the issue at
6 T10-11. Respondent also notes that the IC’s Pre-Hearing Statement lists medical records that “may”
7 be offered into evidence from time frames after Respondent’s last treatment of Patient A.

8 It should also be noted that in Respondent’s Prehearing Statement, he discloses what
9 appears to be an expert witness, [REDACTED] M.D.

10 It is true that the IC Complaint *specifically references* matters that occurred after the last
11 date Respondent treated Patient A. It is also true that the IC’s Prehearing Statement’s “List of
12 Exhibits” *specifically references* documents that post-date Respondent’s last treatment of Patient A.
13 This includes multiple diagnostic test results and medical records from “Khavkin Clinic.” Thus, the
14 IC clearly places these *factual* matters at issue in this case, which opens the door for a *factual*
15 response from Respondent.

16 Accordingly, the IC’s motion regarding Dr. [REDACTED] is **granted** in part, and **denied** in part.

17 If, at the hearing, the IC presents such evidence (factual matters that post date January 23,
18 2020 and specifically involving Dr. [REDACTED]) then the door is open for Respondent to address same
19 through his own disclosed *fact* witness, Dr. [REDACTED]. This falls within the “opportunity to be heard”
20 prong of due process. However, this does not mean that Dr. [REDACTED] is now an expert witness in
21 this matter. Rather, he is a percipient fact witness as to his treatment of Patient A.

22 Accordingly, and assuming that at the hearing post January 23, 2020 evidence (documents
23 or testimony) is offered by the IC and admitted, then Dr. [REDACTED] will be allowed to testify as a
24 percipient fact witness as to **his** treatment of Patient A (which can include his observations,
25 thoughts, actions and the like regarding Patient A’s medical issues and his treatment of same as a
26 treating physician), but not as an expert witness. Objections to the scope of Dr. [REDACTED] actual
27 testimony will obviously be entertained at the hearing.

1 **2. EXHIBITS "L", "M", "N" AND "O"**

2 The IC argues that Respondent's exhibits "L", "M", "N" and "O" should be excluded
3 because they all involve disciplinary matters against Dr. [REDACTED] and as such have no bearing on
4 the issues in the case, and are irrelevant. Respondent does not address these issues in the Opposition
5 brief.

6 Accordingly, the IC's motion regarding these four (4) exhibits is **granted**. These (proposed)
7 exhibits are irrelevant.

8
9 **3. TESTIMONY OF CUSTODIAN OF RECORDS, SPRING VALLEY HOSPITAL**

10 The IC objects to the testimony of the Custodian of Records, Spring Valley Hospital. In his
11 Opposition, Respondent concedes that this custodian is not a necessary witness. Accordingly, the
12 IC's motion regarding this witness is **granted**.

13
14
15 **4. TESTIMONY OF [REDACTED]**

16 The final issue raised by the IC in its Motion relates to Respondent's witness #4, [REDACTED]
17 [REDACTED]. The IC basically objects to Mr. [REDACTED] because his "qualifications" were not set forth in
18 Respondent's Prehearing Statement. It is argued that Mr. [REDACTED] is not a Board licensee and was not
19 involved in Respondent's treatment of Patient A. According to the IC, this witness should not
20 testify because there is no basis for his qualifications or showing how his testimony would be
21 relevant to these proceedings. It is also argued that the testimony of Mr. [REDACTED] would be unduly
22 repetitious given the fact that Respondent has designated an expert witness.

23 Respondent contends that it is "absolutely untrue and unequivocally false" that Mr. [REDACTED]
24 was not involved in Respondent's care and treatment of Patient A, as argued by the IC.
25 Respondent's counsel asserts: "As an officer of the court, counsel undersigned represents and
26 assures that Mr. [REDACTED] was involved in Dr. Schneier's treatment and has relevant information
27 related to the claims and defenses in this matter. Mr. [REDACTED] CV is irrelevant, *he is a fact witness*
28 *with firsthand knowledge.*" (Emphasis added.). Opposition, 4:17-20.

1
2 Respondent also contends that the IC wants Respondent to lay out his defenses in detail,
3 which the Board itself refuses to do (referencing the Board's "clandestine and secret investigation")
4 and this harkens back to Respondent's argument regarding the IC position on investigative
5 materials, discussed previously. Respondent essentially makes a "what is good for the goose is good
6 for the gander" argument in this regard in terms of the specificity of pre-hearing disclosures.

7 In Respondent's Prehearing Statement, Mr. [REDACTED] is described as follows: "This witness is
8 expected to testify to his involvement with Patient A, including the treatment and care rendered by
9 Dr. Schneier, and any other matter relevant to this proceeding." Interestingly, his address is given as
10 3186 S. Maryland Pkwy., which is the address for Sunrise Hospital and Medical Center. This would
11 indicate that Mr. [REDACTED] is somehow connected to that facility.

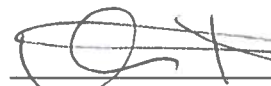
12 Respondent makes it clear, as noted and quoted above, that Mr. [REDACTED] will be offered as a
13 *fact witness*. In this regard, the designation of Mr. [REDACTED] in Respondent's Prehearing Statement is
14 adequate to preclude the granting of the IC's motion in limine regarding him. Indeed, the
15 designation of Mr. [REDACTED] is every bit as specific as the IC's designation of its investigator, who is
16 Johnna LeRue "or her designee."

17
18 Accordingly, the IC's motion in Limine as to Mr. [REDACTED] as a fact witness is **denied**.

19 That said, it needs to be made clear that the IC is certainly permitted to interpose objections
20 to Mr. [REDACTED] testimony (if offered) at the hearing, and such testimony will be limited to relevant
21 matters as a percipient fact witness.

22 **IT IS SO ORDERED.**

23
24 DATED this 7 day of March, 2025.

25
26 
Charles Burcham, Esq.

27 Tel: (775) 750-2998

Email: charlie@northernnevadaadr.com

Hearing Officer

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

3 * * * * *

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

Case No. 24-40539-1

6 **Complaint Against:**

7 **IRA MICHAEL SCHNEIER, M.D.,**

8 **Respondent.**

FILED

MAR 17 2025

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

9
10
11 **ORDER RE-SETTING HEARING**

12 **TO: William Shogren, Esq.**
13 **Deputy General Counsel**
14 **Nevada State Board of Medical Examiners**
15 **9600 Gateway Drive**
16 **Reno, NV 89521**

17 ~and~

18 **Ira Michael Schneier, M.D.**
19 **c/o Respondent's Attorney**
20 **Melanie L. Thomas, Esq.**
21 **Wood, Smith, Hening & Berman**
22 **2881 Business Park Court, Suite 200**
23 **Las Vegas, NV 89128-9020**

24 Pursuant to the agreement of counsel, the formal hearing in this matter is **re-set** to commence
25 on **May 28, 2025, at 9:00 a.m.**, and will be held at the office of the Board of Medical Examiners,
26 9600 Gateway Drive, Reno, NV 89521.

27 Counsel and the undersigned have discussed how the hearing will proceed in terms of remote
28 appearances, platforms such as Zoom and the like. The undersigned emphasizes that he will be live
at the Board office in Reno. Counsel and staff will need to work together to ensure that the hearing
proceeds in an orderly fashion and that all participants in the hearing have access to documents and
exhibits throughout the proceeding. Additionally, remote-appearing witnesses need to be on a video
platform and not simply a telephone.

1 Since the parties have submitted their Prehearing Conference Statements, the Prehearing
2 Conference has been held and the undersigned has issued the Order on IC's Motion in Limine, no
3 further conferences are scheduled at this time. Should the parties (or one party) through their counsel
4 desire any further telephone conferences prior to the formal hearing, then please email such request to
5 the undersigned.

6 Counsel are encouraged to continue to "cull down" exhibits that are intended to be offered
7 and used at the formal hearing.

8 Finally, all parties to this case are required to keep the hearing officer informed of events,
9 progress and resolution of this case.

10 Other provisions in the prior Scheduling Order not in conflict with the foregoing remain in
11 effect.

12 **IT IS SO ORDERED.**

13 DATED this 17 day of March, 2025.

14 
15 _____
16 Charles Burcham, Esq.
17 Email: charlie@northernnevadaadr.com
18 Tel: (775) 750-2998
19 Hearing Officer
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CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **ORDER RE-SETTING HEARING** to the following parties:

William P. Shogren
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Ira Michael Schneier, M.D.
c/o Melanie L. Thomas, Esq.
Wood, Smith, Hening & Berman
2881 Business Park Court, Suite 200
Las Vegas, NV 89128

9171 9690 0935 0255 7026 19

Certified Mail No.: _____

DATED this 18th day of March, 2025.



Signature

Mercedes Fuentes

Printed Name

Legal Assistant

Title