MLIM

STEVEN T. JAFFE
sjaffe@lawhjc.com
Nevada Bar No. 007035
JACOB S. SMITH
jsmith@lawhjc.com
Nevada Bar No. 010231
JACOB B. LEE
jlee@lawhjc.com
Nevada Bar No. 012428

HALL JAFFE & CLAYTON, LLP
7425 PEAK DRIVE
LAS VEGAS, NEVADA 89128
(702) 316-4111
FAX (702) 316-4114

Attorneys for Defendant
Raymond R. Khoury

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CLERK OF THE COURT

DISTRICT COURT

CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY; DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

CASE NO. A-11-636515-C
DEPT NO. XXX

DEFENDANT'S MOTION IN LIMINE NO. 1: TO LIMIT PHYSICIANS TO OPINIONS STATED IN THEIR CLINICAL RECORDS, DEPOSITIONS, AND/OR EXPERT REPORTS, IF ANY

Date of Hearing: _____

Time of Hearing: _____

Defendant, Raymond Khoury ("Khoury"), by and through his attorneys of record, Hall Jaffe & Clayton, LLP, hereby submits his Motion in Limine No. 1 for an Order, in limine limiting Plaintiff's treating physicians to opinions stated in their clinical records, depositions, and/or expert reports, if any.

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This Motion in Limine is made and based upon the pleadings and papers on file herein, the Memorandum of Points and Authorities submitted herewith, and any oral argument the Court may entertain at the hearing on this matter.

DATED this 1st day of May, 2013.

HALL JAFFE & CLAYTON, LLP

By _____

STEVEN T. JAFFE
Nevada Bar No. 007035
JACOB S. SMITH
Nevada Bar No. 010231
JACOB B. LEE
Nevada Bar No. 012428
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Defendant
Raymond R. Khoury

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NOTICE OF MOTION

TO: MARGARET G. SEASTRAND, Plaintiff; and

TO: RICHARD A. HARRIS, ESQ., her attorney of record.

YOU AND EACH OF YOU, WILL PLEASE TAKE NOTICE that the undersigned will bring the foregoing **DEFENDANT'S MOTION IN LIMINE NO. 1: TO LIMIT PHYSICIANS TO OPINIONS STATED IN THEIR CLINICAL RECORDS, DEPOSITIONS, AND/OR EXPERT REPORTS, IF ANY** on for hearing before the above-entitled Court on the 4TH day of June, 2013, at the hour of 9:00am, or as soon thereafter as counsel may be heard.

DATED this 1st day of May, 2013.

HALL JAFFE & CLAYTON, LLP

By _____

STEVEN T. JAFFE
Nevada Bar No. 007035
JACOB S. SMITH
Nevada Bar No. 010231
JACOB B. LEE
Nevada Bar No. 012428
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Defendant
Raymond R. Khoury

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AFFIDAVIT OF JACOB S. SMITH, ESQ. IN COMPLIANCE WITH EDCR 2.47

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

JACOB S. SMITH, being first duly sworn, under oath, deposes and says:

1. Affiant is an attorney licensed to practice law in the State of Nevada, and is an attorney with the law firm of HALL JAFFE & CLAYTON, LLP, counsel of record in this matter for Defendant Raymond Riad Khoury;

2. On April 23, 2013, prior to submitting Defendant's instant Motion *in Limine*, I contacted counsel for Plaintiff Margaret Seastrand to discuss the contents of the motion. Specifically, I spoke with Alison A. Brasier, Esq. of Richard Harris Law Firm, pursuant to EDCR 2.47, to discuss the content of the Motion and to make a good faith effort to resolve the issues addressed in the Motion. Ms. Brasier and I were unable to resolve the issues addressed in the Motion, thereby necessitating its filing.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

JACOB S. SMITH, ESQ.

SUBSCRIBED AND SWORN to before me
this 1 day of May, 2013.

Notary Public of and for said
COUNTY and STATE

NOTARY PUBLIC
STATE OF NEVADA
County of Clark
LISA C. RICO
No: 00-61297-1
My Appointment Expires Aug. 10, 2016

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MEMORANDUM OF POINTS AND AUTHORITIES

I. FACTUAL BACKGROUND

This case arises out of a motor vehicle accident that occurred on March 13, 2009, in Las Vegas, Nevada. Plaintiff alleges that, on that date, Mr. Khoury negligently operated a motor vehicle in a manner that caused a collision with Plaintiff's vehicle. Plaintiff further alleges that she has suffered serious and disabling injuries as a result of the collision.

Plaintiff treated with several physicians for her alleged accident-related injuries, including undergoing lumbar and cervical procedures with Dr. William Muir and a cervical procedure with Dr. Yevgenly Khavkin, as well as pain management treatment with Dr. Marjorie Belsky and Dr. Leo Langolis. However, of all Plaintiff's treating medical providers for injuries allegedly sustained in this incident, only Dr. Belsky has provided any kind of written expert witness report, when she issued a report in rebuttal to Dr. Joseph Schifini's report. *See*, Plaintiff's Rebuttal Expert Disclosures, attached hereto as ***Exhibit "A."***

Many of Plaintiff's treating physicians have not seen not seen and/or treated Plaintiff in years. For instance, Dr. Muir's last record of treatment for Ms. Seastrand is from March of 2010, over three years ago. Similarly, Dr. Belsky's last treatment of Ms. Seastrand was in December of 2009, nearly three and a half years ago. It is undisputed that these doctors have seen hundreds, if not thousands of patients since they last saw Ms. Seastrand. As set forth more fully herein, the trial testimony of Dr. Muir, Dr. Khavkin, and Dr. Langolis should be limited to the opinions stated in their clinical records, and the trial testimony of Dr. Belsky should be limited to those opinions stated in her clinical records, deposition, and rebuttal report.

On April 23, 2013, counsel for Mr. Khoury spoke with Plaintiff's counsel in a good-faith attempt to secure an agreement regarding the need to file this Motion in Limine prior to filing the same with the Clerk of the Court. After discussion, no such agreement could be reached. (*See* Affidavit of Jacob S. Smith, Esq., submitted in compliance with EDCR 2.47, as set forth above).

II. LEGAL ARGUMENT

A. Legal standard for Motions in Limine.

The Nevada Supreme Court agrees that the resolution of motions *in limine* is within the purview of the district court's discretionary power concerning rulings on the admissibility of evidence. *See, e.g.,* ***State ex. rel Dept. of Highway v. Nevada Aggregates & Asphalt Co.***, 92 Nev. 370, 551 P.2d 1095 (1976); *see*

also **EDCR 2.47** (allowing for motions *in limine* to exclude or admit evidence). "The usual purpose of motions *in limine*, is to preclude the presentation of evidence deemed inadmissible and prejudicial to the moving party." ***Kelly v. New West Federal Savings***, 49 Cal. App. 4th 659, 669-670 (1996). Indeed, motions *in limine* allow a more careful consideration of evidentiary issues than would take place during a trial. ***Id.*** Furthermore, by resolving potentially critical issues at the outset, pre-trial motions enhance the efficiency of trials and possibly promote settlements. ***Id.***

B. Testimony by Plaintiff's treating medical providers should be limited to the contents of their own clinical records, deposition testimony, and/or expert reports.

Defendants are entitled to an order, *in limine*, limiting Plaintiff's treating physicians to the facts and opinions contained in their clinical records, depositions, and/or expert reports, as required by the Nevada Rules of Civil Procedure. NRCP 16.1 (a)(2)(B) requires that an expert retained or employed specifically to provide expert testimony in a case must provide a written report, curriculum vitae, list of publications authored in the last ten years, and a list of depositions and trials in which that expert has testified as an expert for the last four years. Like all evidence, expert testimony must be relevant to the litigation and the probative value of such testimony must not be substantially outweighed by other considerations, such as "needless presentation of cumulative evidence." **NRS 48.035(2).** The admission of expert testimony lies within the sound discretion of the trial court. *See,* ***Brown v. State***, 110 Nev. 846, 852, 877 P.2d 1071, 1075 (1994).

Defendant anticipates that Plaintiff may solicit testimony from her treating physicians that extends beyond the scope of their personal medical practice and/or their own treatment of Plaintiff. There is no foundation or evidentiary basis to grant a treating physician license to testify as a specifically retained expert when they have not been disclosed as an expert and/or have not provided all necessary NRCP 16.1 disclosures. *See e.g.*, ***Albough v. United States***, slip copy, 2008 WL 686701 (S.D. GA 2008) (requiring expert disclosure in order to allow a treating physician to testify in areas outside of diagnoses, treatment, and other observations); ***Griffith v. N.E. Ill. Reg'l Commuter R.R. Corp.***, 233 F.R.D. 513, 516 (N.D. Ill. 2006) (precluding purported expert testimony of doctor based upon future care where no expert disclosure was made); ***Allen v. Parkland School Dist.***, 230 Fed. App. 189 (3rd Cir. 2008) (recognizing that doctor witness must ordinarily be disclosed as an expert witness if he or she intends to provide testimony outside of medical

treatment); ***Widder v. City of Springfield***, 108 F.3d. 1977 (6th Cir. 1997) (also recognizing general rule that physician must be disclosed as an expert in order to offer testimony outside of opinions obtained by treating individual patients); ***Hoggan v. J.B. Hunt Transp. Inc.***, 12 F.3d 1100 (7th Cir. 1993) (recognizing that where a doctor provides forensic opinion, rather than opinion developed during treatment of a patient, doctor must be properly disclosed as an expert witness); ***Wreath v. United States***, 161 F.R.D. 448 (D. Kan. 1995) (same). Accordingly, any testimony by Plaintiff's treating physicians which is beyond the scope of the information contained in their respective clinical records and depositions (and in Dr. Belsky's case, her rebuttal report) should be excluded at the time of trial.

While Plaintiff's treating medical providers may be qualified to testify to the extent of their own treatment, prognosis and observations of Plaintiff, they should not be allowed to speculate beyond that, especially where there is no such information contained in the doctors' clinical records. Almost all of the documentation provided by Plaintiff's treating physicians to date **pertains specifically to Plaintiff's past treatment**, and does not go into matters of future medical care, reasonableness of future medical treatment, or the standard of care in Clark County. In all likelihood, Plaintiff's treating physicians have no independent recollection of her, as she has not seen them in years. Accordingly, these treating physicians have no idea what the past years have been like for the Plaintiff, and have no idea of the Plaintiff's current medical or physical status. Accordingly, they are in no position to opine on Plaintiff's future care, if any, or what the future may hold for her.

C. Testimony by Plaintiff's treating physicians about future prognostications is prejudicial and speculative.

Plaintiff's medical providers must be precluded from offering opinions as to future medical care or treatment. The law is clear: a medical doctor, who has not been disclosed as an expert pursuant to NRCP 16.1 (a), may not testify in areas outside of his treatment and personal observation of the Plaintiff. *See,* ***Albough v. United States***, slip copy, 2008 WL 686701 (S.D. GA 2008) (requiring expert disclosure in order to allow a treating physician to testify in areas outside of diagnosis, treatment, and other observations of Plaintiff); ***Griffith v. N.E. Ill. Reg'l Commuter R.R.Corp.***, 233 F.R.D. 513, 516 (N.D. Ill. 2006) (precluding purported expert testimony of doctor based upon future care where no expert disclosure was made); ***Allen v. Parkland School Dist.***, 230 Fed. App. 189 (3rd Cir. 2008) (recognizing that doctor witness must

ordinarily be disclosed as an expert witness if he or she intends to provide testimony outside of medical treatment); ***Widder v. City of Springfield***, 108 F.3d. 1977 (6th Cir. 1997) (also recognizing general rule that physician must be disclosed as an expert in order to offer testimony outside of opinions obtained by treating individual patients); ***Hoggan v. J.B. Hunt Transp. Inc.***, 12 F.3d 1100 (7th Cir. 1993) (recognizing that where a doctor provides forensic opinion, rather than opinion developed during treatment of a patient, doctor must be properly disclosed as an expert witness); ***Wreath v. United States***, 161 F.R.D. 448 (D. Kan. 1995) (same).

While Plaintiff's treating physicians may be qualified to speak as to the extent of **their own** treatment, prognosis, and observations of Plaintiff, those same treating physicians should not be allowed to **speculate** about the reasonableness of Plaintiff's previously undisclosed future medical special damages, if any. Importantly, **none** of Plaintiff's treating physicians are demonstrably qualified to **reduce any alleged future medical special damages to today's dollars**, which is necessary to determine the extent of any future medical costs. Plaintiffs' alleged future medical expenses may be established by competent **expert** testimony. ***Reed v. Scott***, 820 P.2d 445, 449-450 (Okla.1991). Insofar as Plaintiff's treating physicians are permitted to testify at trial, none of them should be permitted to testify as to such topics.

To allow Plaintiff's treating physicians to make determinations regarding the same, or to somehow provide opinion testimony to confirm that Plaintiff's future cost estimates are "reasonable according to the standard in Clark County Nevada," would be to allow these treating physicians to usurp the role of expert witness accountants and/or economists. Similarly, such testimony would amount to bald damages allegations which, without proper expert testimony must be excluded. *See,* ***Central Bit Supply, Inc. v. Waldrop Drilling & Pump, Ind.,* 102 Nev. 139, 717 P.2d 35 (1986).** Such testimony would amount to a tremendous waste of the jury and this Honorable Court's time and such testimony would only serve to prejudice Defendant.

D. Testimony by Plaintiffs' treating physicians about future prognostications, permanency, or future pain and suffering, is beyond the scope of their treatment of Plaintiff.

In addition, testimony about future prognostications, permanency, or future pain and suffering is outside the scope of any of these treating physicians' treatment of Plaintiff. None of these doctors have provided an expert report in support of this anticipated expert testimony, which is otherwise far afield of

their treatment of Plaintiff. An expert report, as required by NRCP 16.1, would specifically require each expert to include "a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions." *See,* NRCP 16.1 (a)(2)(B). The chart notes prepared by Plaintiff's treating physicians do not go into matters of reasonableness of future medical treatment, or the standard of the same in Clark County. Plaintiff's treating physicians, therefore, should not be allowed to discuss any future prognostications, including any purported treatment cost estimates, outside the scope of their treatment of Plaintiffs **unless** they are otherwise qualified as experts **and** have been adequately disclosed as experts under the requirements of NRCP 16.1, which they have not. Plaintiff's treating physicians should not be able to offer such testimony because it will add nothing to the jury's understanding of the facts, it would amount to "trial by ambush," and its' prejudicial impact greatly outweigh any probative value.

III. CONCLUSION

Based on the foregoing, Defendant respectfully requests that this Court preclude any expert testimony from Plaintiff's treating physicians which falls outside the scope of their own treatment of Plaintiff and/or the contents of their sworn deposition testimony and/or their expert reports. Additionally, Plaintiff's medical providers must be precluded from speculating about the Plaintiff's future and should not be permitted to provide any future prognostications regarding the same at trial.

DATED this 1st day of May, 2013.

HALL JAFFE & CLAYTON, LLP

By _____

STEVEN T. JAFFE
Nevada Bar No. 007035
JACOB S. SMITH
Nevada Bar No. 010231
JACOB B. LEE
Nevada Bar No. 012428
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Defendant
Raymond R. Khoury

EXHIBIT "A"

DOEW
RICHARD A. HARRIS, ESQ.
Nevada Bar No. 505
JOSHUA R. HARRIS, ESQ.
Nevada Bar No. 9580
ALISON M. BRASIER, ESQ.
Nevada Bar No. 10522
RICHARD HARRIS LAW FIRM
801 South Fourth Street
Las Vegas, Nevada 89101
Phone (702) 444-4444
Fax (702) 444-4455
Attorneys for Plaintiff

RICHARD HARRIS LAW FIRM

DISTRICT COURT

CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND, Plaintiff, vs. RAYMOND RIAD KHOURY; DOES I-X, and ROE CORPORATIONS I-X, inclusive, Defendants.	CASE NO.: A-11-636515-C DEPT. NO.: XXX

PLAINTIFF'S DEISNGATION OF REBUTTAL EXPERT WITNESS

COMES NOW, Plaintiff MARGARET G. SEASTRAND, by and through her counsel of record, Joshua R. Harris and Alison M. Brasier, of the RICHARD HARRIS LAW FIRM, and hereby submits the following Designation of Rebuttal Expert Witness:

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EXPERT WITNESSES

1. MARJORIE BELSKY, M.D.
   9333 W. Sunset Road, Suite A
   Las Vegas, Nevada 89148
   Tel: 702-968-6259

Dr. Belsky will provide expert rebuttal testimony regarding pain management and will offer testimony in regards to Dr. Schiffini's expert report.

EXHIBITS

1. Rebuttal Expert Report of Marjorie Belsky, M.D. dated September 21, 2012 (3 pages);

2. Curriculum Vitae, Fee Schedule, and Testimony and Depositions of Marjorie Belsky, M.D. (12 pages);

Plaintiff reserves the right to supplement and/or amend any and all Expert Witness Disclosures and supplements thereto, as discovery is continuing.

DATED this 26th day of September, 2012.

RICHARD HARRIS LAW FIRM

By: _____
RICHARD A. HARRIS, ESQ.
Nevada Bar No. 505
JOSHUA R. HARRIS, ESQ.
Nevada Bar No. 9580
ALISON M. BRASIER, ESQ.
Nevada Bar No. 10522
801 South Fourth Street
Las Vegas, Nevada 89101
Attorneys for Plaintiff

RICHARD HARRIS LAW FIRM

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of RICHARD HARRIS LAW FIRM and that on the 20 day of September, 2012, I caused the foregoing PLAINTIFF'S DEISNGATION OF REBUTTAL EXPERT WITNESS to be served as follows:

[X] by placing a true and correct copy of the same to be deposited for mailing in the U.S. Mail at Las Vegas, Nevada, enclosed in a sealed envelope upon which first class postage was fully prepaid; and/or

[ ] pursuant to EDCR 7.26, by sending it via facsimile; and/or

[ ] by hand delivery

to the attorneys listed below:

Steven T. Jaffe, Esq.
Jacob S. Smith, Esq.
HALL JAFFE & CLAYTON, LLP
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Defendants

An employee of the RICHARD HARRIS LAW FIRM

RICHARD HARRIS LAW FIRM

Rebuttal Expert Report of Marjorie Belsky, M.D. dated September 21, 2012 (3 pages)

Marjorie Belsky M.D.
INTEGRATED PAIN SPECIALISTS

September 21, 2012

RE: SEASTRAND, MARGARET

To Whom It May Concern:

This letter is in response to Joseph Schifini's letter on August 25, 2012. Ms. Seastrand originally saw me on 05/05/2009 as 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/2009. She was rear-ended and taken to Mountain View Hospital. She continued to have ongoing pain in her neck, radiating into her right upper extremity. She also had pain in her low back, radiating at times to her lower extremities. An MRI of her low back did show disc bulges and facet arthropathy at L4-5 and L5-S1 and a tear. Her cervical MRI also showed discogenic changes at C5-6. She had also complained of numbness in her lower extremity and right upper extremities. There was decreased range of motion in her cervical and lumbar region, as well as muscular tenderness. She underwent EMG studies by Dr. Shah that did show a radiculopathy at C6 and a radiculopathy at L5.

Ultimately, I proceeded with a therapeutic injection in her low back in May 2009, which was not beneficial. She underwent a diagnostic discogram and subsequently a plasma disc decompression with Dr. Muir, as well as a spine consultation with Dr. Muir. She had a low back flare of pain following her plasma disc decompression. She had interventional pain management, which included 2 epidurals and medication; this helped to bring some of this flare under control. She underwent surgery in her low back with Dr. Grover the following year.

From this incident on 03/13/2009, she continued to have neck pain radiating into her right upper extremity. She underwent a cervical transforaminal epidural steroid injection at C5-6, which brought temporary relief. The pain went from a 6/10 to 0/10, but the pain did return. She underwent a fusion, which helped significantly with her neck pain at that time.

The first issue that Dr. Schifini addresses is his mention of prior accidents. Apparently she did have an accident between 1981 and 1983, for which she received holistic care only. In 1985 he states she describes treatment to her spine for an accident while she was stopped at a light. This did not involve MRIs or injections. Apparently, in 2004, she had a concussion as well, which would involve injury to her head. She underwent a chest x-ray and x-ray of her cervical spine in 2008, which did not show any significant injuries or fractures. Therefore, it is important to note that she was not treated for low back or neck pain since 1985, which is over 24 years prior to her current accident. Furthermore, Dr. Schifini should have an understanding that striking your head on a towel dispenser would be considered a head injury, not injury to the neck or low back, for which she is being treated for her March 13, 2009 accident. Therefore, it is a long stretch to relate her low back and neck pain in 2009 to a 1985 accident with no MRIs, no injections, no surgical treatment, and no further treatment for 24 years.

INTEGRATED PAIN SPECIALISTS [illegible]

Apparently there is also a statement from Nevada Imaging where she states she has had back pain for 26 years, but this does not ask any further questions. It does not elucidate what part of the back entails. It could be thoracic pain versus cervical versus low back pain. It does not state what type of pain, what nature, if it is intermittent, or if it is a different type of pain then her current condition. There is also no evidence of prior radiculopathy, which is now documented through EMG studies as well.

Next, Dr. Schifini discusses the diagnostic usefulness of the original low back injections, which entailed facet and lumbar epidural on 05/20/2009. Perhaps he did not understand that these were meant to be therapeutic in nature only and not diagnostic. The discography is considered the diagnostic component. He also discusses the ISIS Guidelines. ISIS is an interventional pain society, of which there are many societies. According to ISIS Guidelines, from which he is using a book that is almost 10 years old; since this was their last Guideline book. The main criteria utilized for discogenic pain would be that the pain is reproduced at a pressure of less than 15 psi above opening pressure; this did occur. Stimulation of 1 adjacent disc does not reproduce pain at all; this occurred as well. Stimulation of target disc reproduces concordant pain; this occurred. They also need to register their pain as 7/10. My standard is always at least a 7/10 in order for me to consider that disc positive, as well. Therefore, my discography clearly met all the criteria. He also discusses the use of plasma disc decompression as well and that he considers it experimental. I have done over 300 discographies involving plasma disc decompression. The very organization he discusses, ISIS, supports plasma disc decompression. I presented a poster at ISIS concerning plasma disc decompression at their 2010 international conference. There was also an entire lecture devoted to this in the ISIS summer conference on Saturday, July 21, 2012, called Co-ablation Assisted Percutaneous Disc Decompression for Contained Lumbar Disc Protrusion, 10 year Lumbar Disc Protrusion. There was also a poster presentation as well. There are other pain physicians within the Las Vegas community that perform this as well.

Next, he takes issue about monitored anesthesia care. This usually involves Versed, small amounts of Fentanyl and Propofol. Although he calls Propofol a general anesthetic agent, it was used for what is called conscious sedation where the patient can be aroused and have a conversation. He also proposes that ISIS does not support conscious sedation. He left out the paragraph where it states that if conscious sedation is used, appropriate monitoring should be utilized. Furthermore, ISIS at their most recent conference in July, stated in their Wednesday, July 18, 2012, lecture by Paul Dreyfuss on sedation, which can be found on the disk related to that day, as well as the lectures, that over 64% of physicians actually use conscious sedation for interventional pain procedures. I would also like to assert that the majority of physicians in our community use conscious sedation for pain procedures, i.e., Dr. Burkhead, Dr. Tadlock, Dr. Coppel, and Dr. Lanzkowsky, just to name a few in our immediate community.

He also discusses the cost of plasma disc decompression, stating that this was expensive at $12,000.00. In my research that was a poster presentation at ISIS concerning plasma disc decompression two-thirds of the patients felt better following this and did not go on for surgery. Therefore, I would propose that $12,000.00 for a plasma disc decompression is far less expensive alternative than a fusion, should it be beneficial. Dr. Schifini also takes issue with my billing for an epidurography. I do discuss the epiduragram itself. I have an outside billing company that monitors my billing as well. My bills for this case, and as always, have

been within the standard of the community. Dr. Schifini should be aware that anesthesia units are typically used in an operating room setting where cases are billed over time and units are utilized over time. The majority of pain physicians doing procedures has used set fees for each code and do not utilize ASA units.

Therefore, this letter addresses the fact that Ms. Seastrand does not have documentation of low back pain or neck pain in over 25 years. Ms. Seastrand had an appropriate diagnostic and therapeutic workup and that her discogram and plasma disc discography were clearly needed and warranted. Her surgeries were necessary as well. Her billing is justified within the standards of the Las Vegas community.

Please contact me for any further questions at my office at 702-968-6259. Thank you.

Sincerely,

Marjorie Belsky, MD

MB/kc

Curriculum Vitae, Fee Schedule, and Testimony and Depositions of Marjorie Belsky, M.D. (12 pages)

Marjorie Belsky, M.D.

Business Address:	9333 W. Sunset Rd. Suite A Las Vegas, NV 89148
Specialty:	Pain Medicine
Date of Birth:	January 29, 1971
Place of Birth:	Philadelphia, PA
Certifications:	Board Certified – American Board of Anesthesiology
Medical License:	Nevada License No. 11655
Staff Privileges:	Sunrise Hospital, Sahara Surgery Center, Surgery Center of Southern NV and Outpatient Surgery Center of Flamingo
Post Graduate:	University of California San Francisco Medical Center San Francisco, CA July 2004 *Pain Management Fellowship* University of California Irvine Medical Center Orange, CA June 2003 *Anesthesiology Residency* Jersey Shore Medical Center Neptune, NJ June 2000 *Preliminary Medicine Residency*
Medical Education:	Technion-Isreal Institute of Technology Haifa, Israel June 1999 *Degree: Doctor of Medicine* Faculty of Medicine

Touro College School of Health Sciences
Dix Hills, NY September 1995
Degree: Master of Arts
Interdisciplinary Biological and Physical Sciences

Undergraduate Education:

Emory University
Atlanta, GA May 1993
Degree: Bachelor of Science
Biology & Art History, Minor in Studio Art

Professional Certifications:

Nevada State Board of Medical Examiners No. 11655

American Board of Anesthesiology Certification
Pain Medicine, September 2006

American Board of Anesthesiology Certification
October 2004

ECFMG Certification
June 2009

Professional Memberships:

American Society of Interventional Pain Physicians
Active Member

International Spine Intervention Society
Active Member

Work Experience:

Integrated Pain Specialists
Private Practice
Las Vegas, NV 2006-current

Kaiser Permanente
Interventional Pain
Panorama City, CA 2005

Phoenix Pain Medicine
Interventional Pain Management Group
Owned by Mary Jo Ford, MD
Beverly Hills, CA 2004

Studio M Laser and Cosmetic Clinic
Owner and Operator 2004-2005

Rollins Research Center
Pharmacology Laboratory Technician
Emory University 1990-1991

Research Experience:

Plasma Disc Decompression: A Minimally Invasive Disc Decompression Study Authors: William Muir, MD; Marjorie Belsky, MD; Mario Tarquino, MD; Jeffrey Muir, MD, Mayo Clinic, MN

Color Coded Duplex Ultrasound Compared to CT Angiography or the Detection of Cartoid Artery Stenosis
Advisor: Diana Giatinni, MD Department of Diagnostic Radiology
Rambam Medical Center Haifa, Israel, 1997

Masters Thesis: *The Physiological Effects of Srin Nerve Gas* Touro College School of Health Sciences Dix Hills, NY 1995

Research Assistant: *Incidence of Clhamydia Pharyngitis Outbreaks and Identification of Strains Contributing to Virulence*

Presentations:

Presentation: *Plasma Disc Decompression: A Minimally Invasive Decompression S*
International Spine Intervention Society
18th Annual Scientific Meeting
Wailea, Maui Hawaii July 2010

Presentation: *Plasma Disc Decompression: A Minimally Invasive Decompression S*
American College of Spine Surgery
Contemporary Concepts in Spine Surgery
Newport Beach, CA June 2010

Presentation: *Plasma Disc Decompression: A Minimally Invasive Decompression S*
Pain Week National Conference at Red Rock
Las Vegas, NV August 2009

Ground Rounds UCSF
Intrathecal Delivery Pumps-Implantation and Clinical Application
January 2004

Presentation: *Exaberbation of Myasthenic Disease Post-Thymectomy*
Western Anesthesiology Residents Conference
San Diego, CA May 2000
And
Post Graduate Anesthesiology Conference
New York, NY December 2001

Lecture: *The Brain Breathing Circuit*
American Society of Anesthesiologist Annual Conference
New Orleans, LA October 2001

Lecture: *Color Coded Duplex Ultrasound Compared to CT Angiography the Detection of Carotid Artery Stenosis*
Annual Radiology Conference of Israel November 1998

Conferences/CME's:

California Society of Interventional Pain Physicians
Annual Comprehensive Review of Pain Management
Santa Barbara, CA June 2011

International Spine Intervention Society
18th Annual Scientific Meeting
Wailea, Maui Hawaii July 2010

Pain Week
Pain Management Conference
Las Vegas, NV August 2009

The Cleveland Clinic
Cervical Pain Conference
San Diego, CA 2008

Pain Week
Pain Management Conference
Las Vegas, NV August 2008

St. Jude Medical/ANS
Spinal Cord Stimulator Cadaver Workshop
Dallas, TX 2008

Kyphon
Balloon Kyphoplasty Training Program
Henderson, NV February 2007

American Society of Interventional Pain Physicians
Physicians Conference
St. Louis, MO 2006

Bionics
Spinal Cord Stimulator Cadaver Workshop
Valencia, CA April 2005

St. Jude Medical/ANS
Spinal Cord Stimulation Cadaver Workshop
Memphis, TN March 2005

Medtronic
Cadaver Intrathecal Implantation Course
Denver, CO October 2003

Marjorie E. Belsky, MD

Tax ID#59-3828894

Expert Retainer Fees Are as Follows:

Depositions are booked in 1 hour increments
$1,500 due one week in advance
To take place at 9333 W. Sunset Road, Suite A Las Vegas, NV 89148

Independent Medical Examinations are $1,200.00
not including any record reviews

Record Review charges will vary depending on complexity
$500.00 to $1,000.00 per inch of records

Narrative/Surgical Cost Letters $700.00

Telephone conferences and meetings are $350 per 15-minute intervals

Half Day Trial Fee (Maximum 4 hours) $7,000.00
All Day Trial Fee (8 hours) $12,000.00

Out of state trials will vary on complexity of case and travel expenses

Please note that prices are subject to change at any time.

RETAINER FEES ARE SUBJECT TO A 48 HOUR CANCELLATION

Please send written confirmations with check one week prior to trial/deposition date

Contact: Main Office: (702)968-6259

MARJORIE E. BELSKY, M.D.

Nevada State Board of Medical Examiners License No: 11655
3111 S. Maryland Parkway, Suite #200
Las Vegas, NV 89109
(702) 968-6259 Phone (702) 987-3219 Fax

TRIAL APPEARANCES

Lori Kolbert vs Michael Perry, New-Com Inc, et al — July 7, 2009
Clark County District Court, Case No: 07A535322
Department 10, Honorable Jessie Walsh
Plaintiff Attorney: Joseph Benson*
Defense Attorney: Michael Hall

Amber Hager vs Renee Olis — July 19, 2010
Clark County District Court, Case No: 08A570596
Department 4, Honorable Kathy Hardcastle
Plaintiff Attorney: Brian Nettles*
Defense Attorney: James Smedley

Shalaya Wilson vs Dennis Harkey — September 1, 2010
Clark County District Court, Case No: 08A569772
Department 22, Honorable Susan Johnson
Plaintiff Attorney: Roger Cram*
Defense Attorney: Michael Hall

Alexa Wagaska, Debra Daniel Sacha Mitchell (MINOR) vs Suzanne Miller, Brad Miller — May 31, 2011
Clark County District Court, Case No: 08A570596
Department 4, Honorable Kathy Hardcastle
Plaintiff Attorney: Roger Steggerda*
Defense Attorney: Thomas Winner

Lee Klein, Aaron Sweet vs Karen Biddle, Margie Biddle — January 12, 2012
Clark County District Court, Case No: A-10-614051-C
Department 1, Honorable Kenneth Cory
Plaintiff Attorney: R. Todd Terry*
Defense Attorney: Cecilia Ventimiglia

Eugene Moseng v. Kenneth White, Ace Cab Inc. — April 24, 2012
Clark County District Court, Case No: 08A565578
Department 16, Honorable Timothy Williams
Plaintiff Attorney: Jason Maier*
Defense Attorney: Kurt Lambeth

**Retained by attorney*

DEPOSITIONS

Kelly Olson vs Roger Dotson Clark County District Court, Case No: 07A537331	March 10, 2009
Miguel Hernandez vs Jamie Fitzgerald, Donna Fitzgerald, et al Clark County District Court, Case No: 08A565235	June 23, 2009
Archie Johnson vs Lee Eliseo Clark County District Court, Case No: 07A553636	July 20, 2009
Amber Hager vs Renee Olis Clark County District Court, Case No: 08A570596	August 11, 2009
Marta Herrera vs Desert Recreation Inc, Edgewater Hotel Corp, et al Clark County District Court, Case No: 07A546642	August 25, 2009
Larry Black vs Larry Reinagle, American Asphalt and Grading Company Clark County District Court, Case No: 08A566629	September 21, 2009
Sherry French vs Anne Boshko, Enterprise Leasing Company-West Clark County District Court, Case No: 08A569469	November 17, 2009
Luz Rangel vs Anderson Dairy, Inc. Clark County District Court, Case No: 08A575223	January 19, 2010
Leo Archambault, Carol Rosenquist vs Mylene Stachink, Sterling Auto Sales Clark Country District Court, Case No: 08A565843	February 2, 2010
Brenda Lovato, Edward Lovato vs Arianna Antauer, Novartis Pharmaceuticals Corps, et al Clark County District Court, Case No: 07A536890	February 23, 2010
Lee Norwood vs Big Lots Stores Inc. Clark County District Court, Case No: 08A561553	March 16, 2010
Hector Ruiz-Guerena v. WalMart Stores Inc, W and W Partnership Clark County District Court, Case No: 09A582939 (moved to federal court)	March 23, 2010
James Daniel vs American Family Mutual Insurance Group, American Family Mutual Insurance Company Clark County District Court, Case No: A572139	April 20, 2010
Michael Moya, Dawn Moya vs Virginia Bybee Clark County District Court, Case No: 08A574255	April 27, 2010
Isabel Gonzalez vs Sam's West Inc Clark County District Court, Case No: A-09-596762-C	May 4, 2010

Anthony Leavitt, Michelle Lee vs Dugassa Challa, Western Cab Company Clark County District Court, Case No: 09A4584024	May 11, 2010
Daniel Chavez vs John Collins, Veolia Transportation Services Inc, et al Clark County District Court, Case No: 08A575013	May 25, 2010
Rita Pacheco vs Russel Warthen Clark County District Court, Case No: 08A564591	June 1, 2010
Stephen Van Harrevelt vs Kenneth Stottler Clark County District Court, Case No: 09A582003	June 22, 2010
Mae Ilano vs Doris Murillo, Chemere Lott Clark County District Court, Case No: 08A561550	June 29, 2010
Rey Llamas vs Brian Pross Clark County District Court, Case No: 09A582111	July 6, 2010
Rosemarie Hutchinson vs Milestone Paving & Grading Clark County District Court, Case No: A-09-589920-C	July 13, 2010
Jason White vs James Blodgett Clark County District Court, Case No: 08A558690	July 20, 2010
Anthony Jones vs Jose De Hernandez Jr Clark County District Court, Case No: 08A578939	July 27, 2010
Alan Moceo vs Roberta Jones, Dale Jones Clark County District Court, Case No: 09A582737	August 10, 2010
Alexa Wagaska, Debra Daniel Sacha Mitchell (MINOR) vs Suzanne Miller, Brad Miller Clark County District Court, Case No: 08A570596	August 24, 2010
Doreen Hober, Tim Karsten vs Pearson United, Billy Johnson Washington County Fifth District Court, Case No: 09-0501597	August 31, 2010
Jodi Drexel, Bill Drexel vs John Grieder Clark County District Court, Case No: 09A587109	September 14, 2010
Billie Gonzalez vs Wal-Mart Stores, Inc. Clark County District Court, Case No: A-10-612330-C	November 16, 2010
Janet McAlindon vs Teresita Banares Clark County District Court, Case No: 08A576723	November 23, 2010
Pamela Ashley vs Richard Diskin, Deshanne Bradshaw Clark County District Court, Case No: 03A469329	February 1, 2011 March 22, 2011

Caridad Williams-Abreu vs Immanuel Williams Clark County District Court, Case No: A-09-606253-C	February 8, 2011
Tina Athow vs Wal-Mart Stores, Inc, Harry Gafford Clark County District Court, Case No: 08A560484	February 15, 2011
Cherie Dubois vs Jessica Castillo, Interior Visions by Marlies Inc, Mark Castillo, Marlies Glass, et al Clark County District Court, Case No: 09A584570	February 22, 2011
Ruby Arroyo vs James Jarrett Clark County District Court, Case No: A-10-611711-C	March 1, 2011
Marcy Mason vs Nevada CVS Pharmacy LLC Clark County District Court, Case No: 09A584238	March 8, 2011
Manuela Rodriguez vs Royal Center Associates LLC Clark County District Court, Case No: A-09-590440-C	March 15, 2011
Richard DeStefano vs George Fannin Clark County District Court, Case No: A-10-611399-C	March 29, 2011
Akilah Andrades vs American Family Mutual Insurance Company Clark County District Court, Case No: A-09-606204-C	April 5, 2011
Raymond Gallo vs Stanley Kroll, et al Clark County District Court, Case No: A-09-605644-C	April 26, 2011
Horst Pikschus vs Angela Grajeda Clark County District Court, Case No: A-10-612938-C	May 10, 2011
Victor Lajeunesse vs David Satre Clark County District Court, Case No: A-10-609879-C	May 17, 2011
Bobby Combs II vs Jery Herbst Clark County District Court, Case No: A-09-600018-C	May 24, 2011
Lani Bennett vs Gary Lacey Clark County District Court, Case No: A-09-596991-C	May 31, 2011

Latisha Watkins vs Jesus Rios Clark County District Court, Case No: A-10-616328-C	June 14, 2011
Dianne Kennedy vs Natalie McKenzie Clark County District Court, Case No: A-10-609377-C	July 5, 2011
Gregory Havens vs Tinamari Haugen Clark County District Court, Case No: A-09-606114-C	July 13, 2011
Trisha Galang vs American Family Mutual Insurance Company Clark County District Court, Case No: A-09-603504-C	July 20, 2011
Dixie McMechan vs Alpha Electrical Signs Inc Clark County District Court, Case No: A-10-610857-C	August 16, 2011
Kayli Coffman vs Catherine Steininger Clark County District Court, Case No: 08A575351	August 17, 2011
Robert Williams vs Mark Cabigon Clark County District Court, Case No: A-10-62181-C	September 7, 2011
Isau Linares, Dominga Solano vs Nicholas Carducci, Nicholas Butler Clark County District Court, Case No: A-09-588640-C	September 13, 2011
Keith Vogel, Tahney Thomas-Vogel vs Yodanys Valdes Clark County District Court, Case No: 09A584534	September 14, 2011
George Diep, Sarah Diep vs Sholina Kherani Clark County District Court, Case No: A-10-624680-C	September 20, 2011
Daniel Lind vs Lawrence Heck, Ahern Rentals Inc Clark County District Court, Case No: 08A566903	September 21, 2011
Yolanda Smith vs Marilyn Pegross Clark County District Court, Case No: A-10-610857-C	October 4, 2011
Henry Banh vs Thomas Park Clark County District Court, Case No: A-10612892-C	October 11, 2011
Isau Linares, Dominga Solano vs Nicholas Carducci Clark County District Court, Case No: A-09-588640-C	October 18, 2011
Tegan Jennings vs Miguel Gutierrez-Valdez Clark County District Court, Case No: A-10-616870-C	December 6, 2011
Helen Carpenter vs Veolia Transportation Services Inc Clark County District Court, Case No: A-09-602224-C	December 28, 2011

Melissa Kale vs Michael Gordon Clark County District Court, Case No: A-09-597206-C	January 4, 2012
Zachary Manibusan vs. Penny Berg Clark County District Court, Case No: A-10-628320-C	January 10, 2012
Crystal Politano vs. Penny Berg Clark County District Court, Case No: A-10-628320-C	January 11, 2012
Vincent Sullenberger vs Zachary King Clark County District Court, Case No: A-10-630919-C	January 17, 2012
Janice Starks vs Vern Walter Pulsipher Clark County District Court, Case No: A-10-623414-C	January 18, 2012
Robertta Nassar vs New Albertsons, Inc. Clark County District Court, Case No: A-10-615953-C	January 24, 2012
Edward Johnson vs Walmart Stores US District Court, Case No: 2:11-cv-00681-RCJ-GWF	February 1, 2012
Sabrina Langford vs Sarah Joyner Clark County District Court, Case No: A-10-617673-C	February 7, 2012
John Crowley v. Ryan Cohen Clark County District Court, Case No: A-10-617032-C	February 21, 2012
Mary Murphy v. Clement Strumillo Clark County District Court, Case No: A-10-617156-C	February 29, 2012
Salvatore Stefanelli, Michelle Hawley v. Brianna Fishman Clark County District Court, Case No: A-10-621734-C	March 6, 2012
Monica Benway, Daniel Benway v.Guadin Motor Company et al Clark County District Court, Case No: A-10-624087-C	March 13, 2012
Yesina Arce v. Robert Warnstedt Clark County District Court, Case No: A-10-616906-C	April 3, 2012
Alice Winds, Willie Winds v. Steven Hatch Clark County District Court, Case No: A-10-617648-C	April 4, 2012
Chad Tuttle	May 1, 2012

5. Harry Smith, Ph.D., M.D.
Biodynamic Research Corp.
5711 University Heights Blvd., Suite 100
San Antonio, TX 78249
(210) 691-0281

Dr. Smith is a bio-mechanical expert and will offer testimony regarding his review of Plaintiff's medical records and films, his inspection of Plaintiff's vehicle on June 21, 2012, the matters further discussed in his August 30, 2012 report, and his background and credentials. Dr. Smith reserves the right to amend and/or supplement his expert report and opinions pending review of additional records, items and testimony in this matter.

6. J. Pablo Villablanca, M.D.
UCLA Medical Center
Department of Radiological Sciences/Neuroradiology
BL-428 Center for Health Sciences
10833 Le Conte Avenue
Los Angeles, CA 90095-1721

Dr. Villablanca ia a Professor of Radiological Sciences and Chief of Diagnostic Neuroradiology at UCLA Medical Center. He will offer testimony regarding his review of Plaintiff's radiology reports and films, the matters further discussed in his August 1, 2012 report, and his background and credentials. Dr. Villablanca reserves the right to amend and/or supplement her expert report and opinions pending review of additional records, items and testimony in this matter.

Defendant reserves the right to call as witnesses all parties, any expert witnesses designated by any party, as well as any person whose identity becomes known in the course of discovery.

In addition, neither inclusion of any documents within this disclosure made pursuant to *N.R.C.P. 16.1*, nor acceptance of documents provided by any other party hereto in a disclosure made pursuant to *N.R.C.P. 16.1*, shall be deemed as a waiver by these defendants of any evidentiary rights they may have with respect to those documents, including, but not limited to, objections related to authenticity, materiality, relevance, foundation, hearsay, or any other right as may be permitted pursuant to the Nevada Rules of Evidence.

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II.

DOCUMENTS

1. Expert Report of Craig L. Greene, CPA/CFF, CFE, dated August 10, 2012;
2. Curriculum Vitae of Craig L. Greene, CPA/CFF, CFE;
3. Deposition and Trial Testimony History of Craig L. Greene, CPA/CFF, CFE;
4. Fee Schedule of Craig L. Greene, CPA/CFF, CFE;
5. Expert Report of Joseph Schifini, M.D., dated August 25, 2012;
6. Curriculum Vitae of Joseph Schifini, M.D.;
7. Testimony List of Joseph Schifini, M.D.;
8. Fee Schedule of Joseph Schifini, M.D.;
9. Loss of Earning Capacity Analysis of Staci Schonbrun, Ph.D., dated August 30, 2012;
10. Curriculum Vitae of Staci Schonbrun, Ph.D.;
11. Deposition and Trial Testimony History of Staci Schonbrun, Ph.D.;
12. Fee Schedule of Staci Schonbrun, Ph.D.;
13. Expert Report of John B. Siegler, M.D., dated July 12, 2012;
14. Curriculum Vitae of John B. Siegler, M.D.;
15. Testimony List of John B. Siegler, M.D.;
16. Fee Schedule of John B. Siegler, M.D.;
17. Expert Report of Harry L. Smith, Ph.D., M.D., dated August 30, 2012;
18. Curriculum Vitae of Harry L. Smith, Ph.D., M.D.;
19. Testimony List of Harry L. Smith, Ph.D., M.D.;
20. Fee Schedule of Harry L. Smith, Ph.D., M.D.;
21. Expert Report of J. Pablo Villablanca, M.D., dated August 1, 2012;
22. Curriculum Vitae of J. Pablo Villablanca, M.D.;
23. Deposition and Testimony List of J. Pablo Villablanca, M.D.;
24. Fee Schedule of J. Pablo Villablanca, M.D.

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Defendant specifically reserve the right to designate as an exhibit any document designated by any party, and to supplement this list as any document becomes known through the course and scope of discovery.

DATED: August 30, 2012.

HALL JAFFE & CLAYTON, LLP

By _____

STEVEN T. JAFFE
Nevada Bar No. 007035
JACOB S. SMITH
Nevada Bar No. 010231
7455 West Washington Avenue, Suite 460
Las Vegas, Nevada 89128
Attorneys for Defendant
Raymond R. Khoury

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P. 5(b), I hereby certify that service of the foregoing **DEFENDANT RAYMOND RIAD KHOURY'S DESIGNATION OF EXPERT WITNESSES** was made on August 30, 2012, by depositing a true and correct copy of the same by U.S. Mail in Las Vegas, Nevada, addressed, stamped, and mailed to the following:

Richard A. Harris, Esq.
RICHARD HARRIS LAW FIRM
801 S. Fourth Street
Las Vegas, Nevada 89101
Attorneys for Plaintiff

An Employee of
HALL JAFFE & CLAYTON, LLP

EXHIBIT 13

HJC HALL JAFFE & CLAYTON, LLP
ATTORNEYS AT LAW

7425 Peak Drive • Las Vegas, Nevada 89128
Telephone 702.316.4111 • Facsimile 702.316.4114

RILEY A. CLAYTON
STEVEN T. JAFFE [1,2]
MICHAEL R. HALL [1]
KEVIN KING [3]

ASHLIE L. SURUR
JAMES HARPER
JACOB SMITH
DAVID GLUTH
TAYLOR SELIM
KAREN BASHOR [2]
BRIANNA ISSURDUTT
JACOB B. LEE
JEREMY M. WELLAND
CHAD C. BUTTERFIELD
DANA B. KRULEWITZ
PAUL J. HOFMANN

Of Counsel
MICHAEL SHANNON
MONTE HALL [5]

1. Also licensed in Arizona
2. Also licensed in New Jersey
3. Also licensed in Wisconsin
4. Also licensed in California
5. Also licensed in Utah

April 23, 2013

Via Facsimile and Email
Richard Harris, Esq.
Allison Brasier, Esq.
RICHARD HARRIS LAW FIRM
801 S. Fourth Street
Las Vegas, Nevada 89101
Fax: 702.444.4455
Alison@richardharrislaw.com

Re: *Khoury adv.* Seastrand

Dear Ms. Brasier:

This letter will memorialize our discussion earlier today pursuant to EDCR 2.47 regarding the motions *in limine* we intend to file with the Court in the above-referenced matter. Specifically, this will serve as a summary of those motions to which you stipulated, including any specific limitations and/or conditions we discussed, as well as those motions to which the parties could not reach and agreement.

According to my notes from our conversation, we are in agreement to stipulate to the following matters:

1. to preclude references to Douglas Seastrand's position with church as irrelevant and potentially prejudicial;

2. to the inclusion of jury questionnaire questions regarding the religious identity and devotion of jurors, with leave to ask additional follow-up questions to potential jurors, as permitted by the Court, about the jurors' specific religious practices as a devout member of the Mormon church;

3. to preclude various police information, including the admission of or reference to the citation issued to Defendant, the police report, and any language referring to the vehicles and drivers as D1/V1 vs. D2/V2; this will not preclude the use of the police report to refresh the recollection of the police officers;

4. to preclude any evidence of settlement negotiations;

5. to preclude any evidence of insurance;

6. to preclude arguments regarding or reference to out of state experts;

7. to preclude arguments during voir dire and openings;

8. to mandate exchange of demonstrative exhibits one week prior to trial; this does not include power point slides, but includes any image, video, animation, or other demonstrative which might be used in a power point presentation or otherwise introduced to the jury;

9. to limit Plaintiff's employment-related losses solely to damages addressed by Dinneen, to the extent consistent with the parties' prior stipulation precluding business losses;

10. to preclude references to future surgeries;

11. to preclude references to Plaintiff's unrelated knee injury; and

12. to preclude treating doctors, designated medical experts from offering bio-mechanical opinions at trial, and to preclude other designated experts from offering opinions at trial outside those areas in which the Court has accepted them as an expert.

We will be filing the following Motions in Limine, as we could not reach a stipulated agreement on these issues:

1. Motion to limit treating physicians to opinions stated in their clinical records and depositions, unless they produced an expert report in which case limiting them to the opinions stated in expert reports as well as their clinical records and depositions;

2. Motion to Preclude any treating doctor undisclosed as a designated expert from rebutting any defense medical expert due to no reports having been disclosed;

3. Motion to admit evidence of all liens for treatment received;

4. Motion to admit evidence of amounts paid for medical treatment versus amounts billed;

5. Motion to allow introduction of liens purchased and amounts paid for liens;

6. Motion to preclude Plaintiff's experts from rebutting Defendant's experts until after Defense experts have testified;

7. Motion to preclude showing video of any surgery procedure; and

8. Motion to Preclude the Testimony of Plaintiff's Vocational Expert, Terrance Dineen, due to reliance on Dr. Gross's subsequently-altered life care plan.

We also discussed your proposed motions *in limine*. Please provide our office a summary of the motions discussed, including a list of those motions to which we stipulated and those motions which you will be filing. Once we have received this letter, we will be able to prepare a comprehensive Stipulation and Order to submit to the court.

If this does not accurately reflect your understanding of our 2.47 conference this morning, please clarify, in writing, as soon as possible.

Sincerely,

STEVEN T. JAFFE
JACOB S. SMITH

JSS/pbs

EXHIBIT 14

DISTRICT COURT

CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND, Plaintiff, vs. RAYMOND RIAD KHOURY; DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive, Defendants.	)	CASE NO.: A-10-632218-C DEPT NO.: VIII

DEPOSITION OF JOSEPH J. SCHIFINI, M.D.

Taken on Wednesday, January 16, 2013

At 10:01 A.M.

At 600 South Tonopah Drive, Suite 240

Las Vegas, Nevada

Reported by: DONNA J. ABRAHAMSEN, RPR, NV. CCR NO. 420
CA. CSR NO. 9652, WA. CCR NO. 3262

DEPOSITION OF JOSEPH J. SCHIFINI, M.D., taken at 600 South Tonopah Drive, Suite 240, Las Vegas, Nevada, on Wednesday, January 16, 2013, at 10:01 a.m., before Donna J. Abrahamsen, RPR, Certified Court Reporter, in and for the State of Nevada.

APPEARANCES:

For Plaintiffs:
RICHARD HARRIS LAW FIRM
BY: ALISON M. BRASIER, ESQ.
801 South Fourth Street
Las Vegas, Nevada 89101
(702) 444-4444

For Defendants:
HALL JAFFE & CLAYTON, LLP
BY: JACOB S. SMITH, ESQ.
7425 Peak Drive
Las Vegas, Nevada 89129
(702)316-4111

* * * * *

INDEX

JOSEPH J. SCHIFINI, M.D.

EXHIBITS

Information Requested: (None.)

LAS VEGAS, NEVADA; WEDNESDAY, JANUARY 16, 2013
10:01 A.M.

(In an off-record discussion, counsel agreed to waive the court reporter requirements under Rule 30(B)(4) under the Nevada Rules of Civil Procedure.)

JOSEPH J. SCHIFINI, M.D.,
called as a witness, being first duly sworn to tell the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. BRASIER:

Q Can you please state and spell your name for the record.

A Joseph Schifini, S-c-h-i-f-i-n-i.

Q Dr. Schifini, have you had your deposition taken enough times that we can forego the usual admonitions?

A Yes.

Q Great. I'll just remind you that your -- that you just took the same oath that you would take in a court of law, same obligation to tell the truth. Do you understand that?

A I do.

Q Okay. Before the deposition started, your office manager handed me what appears to be your file and CV and billing -- testimony list and -- and billing schedule. So I'm just going to hand these documents to you and ask if these are the most up-to-date versions of these documents.

A (Examining.)

Q I'll hand you the CV, testimony list, and the Fee Schedule.

A Yes.

MS. BRASIER: Okay. We'll go ahead and mark these collectively as Exhibit 1 to the deposition.

(Exhibit 1 marked.)

BY MS. BRASIER:

Q Also included in the packet looks like some invoices. Is this what's been billed to this file to date?

A (Examining.) Yes.

MS. BRASIER: Okay. So we'll mark the billing invoices as Exhibit 2 to the deposition.

(Exhibit 2 marked.)

BY MS. BRASIER:

Q And I've been provided with two reports that you prepared in this case: One dated August 25, 2012, and a second one dated October 15, 2012.

Are those the only two reports that you've prepared in this case?

A Yes.
MS. BRASIER: Okay. So we'll go ahead and mark the August 25th depo -- or report as Exhibit 3 and the October 15th report as Exhibit 4.
(Exhibits 3 and 4 marked.)
BY MS. BRASIER:
Q Do you have copies?
A I do.
Q Okay. Have you been asked to do any additional work on this case since you've prepared your August 15 -- October 15th report?
A No. But this morning, when meeting with Mr. Smith, I discussed that I was still missing some records in this case. Following the accident, there was a gap of two or three weeks that I didn't have records and I assume -- based on the other records I had -- that she had seen a chiropractor in between and somebody had ordered an MRI. So I'm not sure if the records are going to make a difference, but I was missing those records.
And then there was a gap between Dr. Muir recommending surgery and then a postoperative imaging study that showed she had had surgery, so I was missing the surgery records. And then there was, I think, one gap in between, so we're going to try to fill in those gaps with the records. So he assured me that I would get those, so I

assume a supplemental report will be prepared once I've had the opportunity to review those records.
Q When you say you're "missing surgery records," are you referring to the lumbar fusion, the cervical fusion, or both?
A Both.
Q And what -- what's the red folder that you brought with you today?
A It contains those two reports that we marked as Exhibits 3 and 4.
Q Okay. Other than receiving the documents listed in your report that you've reviewed, have you received any other documentation from defense counsel?
A I have not.
Q Do you have any correspondence from defense counsel?
A Other than requesting the initial reports be drafted, no.
Q Okay. Do you have a copy of that initial retention letter with you?
A I'm assuming my office manager has it with the records. So I don't know -- she usually brings those in -- it won't be in there --
Q Okay.
A So I can get those for you.

MS. BRASIER: Okay. So we'll go ahead and reserve Exhibit 5 for that -- any correspondence from defense counsel in this case.
THE WITNESS: Would you like me to step out for a second and just ask her to make a copy while we're in here doing this?
MS. BRASIER: Sure.
THE WITNESS: Okay. All right. Take a break then.
(Exhibit 5 marked.)
(Brief recess.)
BY MS. BRASIER:
Q All right. Before today's deposition, did you get a chance to speak with anyone from defense counsel's office about today's deposition?
A I did. I spoke with Mr. Smith for approximately 50 minutes before the -- the deposition this morning.
Q And what did you discuss with Mr. Smith during the 50 minutes?
A We discussed my reports and any questions that I had for him. And I informed him that we were missing some records and that I had still not received them. I made no formal request for them, but did mention that I was missing them in my reports. So I assumed I would receive them at some point and he thought they had been sent. And I

informed him they had not and so he will be correcting that.
Q All right. You said you went over questions you had for him.
Did you have other questions besides the missing records?
A No, I didn't -- I didn't really have any specific questions. There was, I -- I guess, some issue as to a potential for cervical fusion which you've now confirmed that she's had -- Miss Seastrand, I guess, has had a cervical fusion. I did not know that for certain until you had mentioned it. He thought she might have and now we know she has.
Q Did you do anything else to prepare for today's deposition?
A Other than looking at my two reports last night, no.
Q I may have asked you this already, but: Are all the documents that you've reviewed in connection with this case listed in your two reports?
A They are, yes.
Q Have you reviewed any deposition testimony other than Mrs. Seastrand's?
A No.
Q Have you reviewed any prior medical records for Mrs. Seastrand other than the October 27th, 2008, record

listed in your first report?
A Other than the one that I listed in the reports, no.
Q And the way that it's noted in your report, it looks like it was just the -- the X ray -- the actual x-ray report that you reviewed.
Did you review any of the other refer -- documents from the referring doctor?
A No. I believe it was just the -- the reports from the actual X rays, not the reason the X rays were ordered or the, kind of, the notes that would have preceded that.
Q Okay. Have you seen any records related to Mrs. Seastrand's prior motor vehicle accidents or the incident where she hit her head?
A Other than the mention through the records, I -- I don't have notes, kind of, during that timeframe to substantiate those -- those reports, but they are mentioned in her notes so I just, sort of, summarized them.
Q In your first report, you indicate that you're missing records from Dr. Lurie, Dr. Olmstead, Dr. Koka, Dr. Lenray, Dr. Rossier, Dr. Khavkin and Dr. Grover. And you just testified earlier that you still haven't received those records, is that correct?
A That is correct.
Q Okay. So it'd be fair to say you don't -- at this

point don't have any opinions regarding the treatment rendered by those doctors?
A I do not.
Q And, again, in your report, you indicate that you're missing records from March 5 to March 23rd, 2010, and that you haven't received any records since September 2010, which would be -- again be fair to say that you don't have any opinions regarding the treatment rendered during those time periods?
A That's correct.
Q And have you seen any of the records related to her lumbar fusion surgery?
A Other than the postoperative imaging study that was performed, no.
Q So at this point, do you have any opinions regarding the lumbar fusion surgery?
A Yes.
Q I guess, generally what are those? We'll probably get into them in more detail.
A Well, the -- the workup for the lumbar fusion surgery was performed in a way that didn't necessarily lead to the conclusion that a lumbar fusion surgery would have been medically indicated.
And specifically, the injections performed by Dr. Belsky in the form of bilateral L4-5 and L5-S1

transforaminal epidural injections, along with bilateral L4-5 facet injections, produced a decreased pain according to the nursing notes -- not Dr. Belsky's notes -- of an eight out of ten to a seven out of ten as reported by Dr. -- Miss Seastrand. The motion segments and most everything that moves in the lumbar spine would have been anesthetized with those injections, assuming Dr. Belsky performed them correctly, and therefore, discogenic pain became a possibility rather than a probability.
The indication, then, for the lumbar discography was not present. The indication for plasma disk depression which ultimately failed was not present. And the indication for the ultimate spine surgery seemed to be based on the failure of the previous treatment provided to Miss Seastrand, which was used as the excuse for the fusion so therefore, the fusion was not necessary either.
Q Do you have any opinions regarding the success of the lumbar fusion surgery?
A Not necessarily. I mean, it's just Miss Seastrand, I believe, reported some improvement with the -- with the surgery so that's the only record I have reflecting any information regarding the success or lack of success of the surgery.
Q Have you seen any records related to the cervical fusion surgery?

A I have not.
Q Do you have any opinions as to whether the cervical fusion was necessary?
A I haven't seen the records so I don't -- I don't know what the indications reported by the doctors who were involved, and I'm assuming it was Dr. Grover and Khavkin that may have been involved in that surgery, based on the -- the fact that I was missing records from their offices that were mentioned later in -- in the reporting. So I don't have any opinions because I'm not sure exactly what they used as the indications for the surgery.
Q Have you seen any subrosa video of Mrs. Seastrand?
A No.
Q Based on the records that you've listed, it looks like you're missing records from the date of the accident through April 3rd, 2009, is that correct?
A Let me just check here. (Examining.) Yeah. I may have had a Traffic Accident Report from the date, but as far as medical records, I don't have any from March 13th, 2009, through April 3rd, 2009.
Q That would include the ambulance records and the ER visit from the date of the accident?
A I may have had the ambulance records if they're listed. If they're not listed, I did not have access to them. I cannot recall specifically.

Q Okay. In reviewing the records in this case, is it important for you to know what Mrs. Seastrand's initial pain complaints were? And by "initial," I mean date of accident.

A I think that's important information to be aware of.

Q And why is that important in your analysis?

A The pain complaints initially give some clue as to what the patient is experiencing and what they may continue to experience following the accident or injury. The other piece of information that's important to note is the examination by the emergency personnel -- whether that's the ambulance drivers or the emergency room physicians or QuickCare physician or whatever, you know, whoever saw the patient. It looks like she went to Mountain View Hospital, so I'm assuming it was an emergency room physician. So not only were the complaints important to know initially, but the examination of those body parts that she was complaining of pain.

Q Is it also important for you to know when the initial onset of certain symptoms occurred, such as radicular pain?

A It is, yes.

Q Okay. Why is that important in your analysis?

A If radicular symptoms occurred and they are found

I may be somebody who's seeing a person for a defense forensic review or IME.

Q In the instances where you're not a treating physician, what percentage of cases are you retained by the defense versus by the plaintiff's side?

MR. SMITH: Let me just object to the form.

You can go ahead and answer.

THE WITNESS: When I'm not a treating physician and I'm just reviewing records, the great majority is going to be defense. If I haven't had any interaction with the patient, I would say probably 80 percent defense and 20 percent plaintiff.

BY MS. BRASIER:

Q And you would agree with me that regardless of who retains you, you should be objective in your reporting, correct?

A That's correct.

Q All right. Are you -- do you have any qualifications as a biomechanical expert?

A No.

Q In this case, have you reviewed any of the actual x-ray, MRI or CT films taken of Mrs. Seastrand or -- or just the reports?

A If I did review them, they would be listed as CDs or films in the -- in the medical records, and I don't see

to be in a dermatomal pattern, it may indicate that there's some nerve irritation in a -- in a particular region of the body, so it would be important to note when those occurred. I mean, if they occurred, you know, within a day or two of the accident, it's more significant than if they occurred, you know, three-and-a-half-months later. So the timing of which may be important.

Q Currently, how much of your time is spent doing clinical work versus medical legal work?

A Probably 95 percent is clinical -- no, 90 to 95 percent is probably clinical and 5 to 10 percent, depending on the month, is forensic or medical legal work.

Q Okay. And the forensic or medical legal work that you do, is it all in the context of personal injury cases, or do you do any other type of medical legal work?

A Most of the patients and -- and -- and, sort of, circumstances I do my clinical work has to do with the industrial injury system or workers' compensation. That's probably 75 or 80 percent of my work. So there is -- I guess, some of my medical legal work is kind of combined with my -- with my clinical practice, but those oftentimes end up in some sort of personal injury -- whether it's car accident, trip-and-fall, product defect -- lawsuit. And depending on the situation, I may be a treating physician, I may be a treating physician under the work comp setting, or

them listed in that fashion. So I believe it was just the reports that I had access to.

Q Okay. In your clinical practice, is it your standard to review the actual films?

A If they're available, yes.

Q Okay. And why -- why is it important to you to review the actual films rather than relying on the reports?

A Well, it depends on the particular radiologist whose read them. Specifically, if I've known the radiologist to be reliable and read films in a similar fashion that I read them versus a radiologist that I've had to call on a couple of occasions, you know, to reread the films or look at something different than -- than what I'm necessarily seeing, and oftentimes it has to do with either the presence of an annular tear or annular fissure or a far lateral disk herniation or protrusion.

Those are the most common things radiologists miss because they're just reviewing the films, and they're not necessarily sitting in front of the patient listening to their symptoms and -- and reviewing the films with that knowledge.

Q In this case, the radiologist who read Mrs. Seastrand's films, do you have any opinion as to -- or experience as to whether or not you feel their readings are reliable?

A I -- I didn't have any problems with the readings of the -- the films. As I recall, the radiologists were people that I've reviewed films from before and found to be reliable. So I -- I didn't have any problems or issues.

Q In this case, you didn't perform an actual physical examination on Mrs. Seastrand, is that right?

A That is correct.

Q In your clinical practice, do you physically examine all of your patients?

A I -- I do because it's expected of me.

Q What can you -- what kind of information can you gather from a physical examination that you can't simply from reviewing records?

A Well, you may find a new finding that previous physicians examining patients didn't -- didn't have the opportunity to document, but, you know, oftentimes you're just confirming what the previous physician found on examination.

You do get the opportunity to perform additional testing that may not have been performed previously by physicians and they may or may not have felt it was necessary or their exam may have been brief in nature. So it just depends on the -- on the situation.

There may be things that you find by repeat exams or serial exams that have changed. You may add new

examinations or testing to the -- the process which may provide additional information. The physical examination oftentimes doesn't lead to significant changes. Most of the information comes from the history.

Q All right. You indicated before -- we're going into the prior record that you reviewed that it was -- that you believed it was just the x-ray reports, is that correct?

A That is correct.

Q Okay. Do you have any indication as to why she was sent for the X rays in October of 2008?

A I could speculate, but I don't have any specific reasons. As I recall looking at the -- the actual record itself, I don't believe there was an indication of why she went for the X rays. For example, going for a chest X ray -- was it a screening chest X ray because she had a positive tuberculosis test?

You know, sometimes it will say something like that or suspect pneumonia. She had an X ray on that date of her cervical spine. I don't recall it specifically saying "neck pain," although that's the most common reason that a cervical X ray would be ordered. But ordering it with a chest X ray and a cervical spine X ray, could I combine the two? Maybe they felt she was having radicular symptoms down her arm and wanted to make sure she didn't have a cervical rib. That's the only reason I could think those two would

be ordered together. I -- I simply don't know at this moment.

Q Do you know when the last time Mrs. Seastrand sought treatment for any kind of neck pain?

A Well, if we assume that the X ray on 10/27/08 was taken for the complaint of neck pain, somewhere in that timeframe.

MR. SMITH: You're still talking prior to the accident, right?

MS. BRASIER: Yes, prior to the accident.

THE WITNESS: Same answer.

BY MS. BRASIER:

Q Okay. I'm going to show you a record dated October 27th, 2008, from Dr. Kermani who ordered the X rays. I know that you haven't seen this before, but I'll just show this to you for your review and ask you if it changes your opinions that you just testified to.

A Okay. (Examining.) Okay. I've reviewed this, and as far as the opinions go, he doesn't specifically mention any neck pain. He mentions shooting pain down the left arm and numbness and tingling bilaterally in both arms, but then he goes on to say, "She has 00:24 no numbness bilaterally."

So I'm not sure exactly what that -- what that means or what code word that is, but sounds like she's

having bilateral arm symptoms with a shooting pain down her left arm and he's ordering the X rays most likely to rule out any obvious issues in her neck or neural foraminal narrowing or things that may explain the symptoms she's having.

Q When is the last time prior to this accident that Mrs. Seastrand sought treatment for low back pain?

A I don't have any evidence that -- that she sought treatment of low back pain as far as medical records. They're just mentions of prior accidents affecting her neck and low back.

(Interruption in proceedings.)

BY MS. BRASIER:

Q Okay. On page 3 of your August report, the bottom of that second paragraph --

A Okay.

Q -- you reference that while Mrs. Seastrand was undergoing MRI studies in April of 2009, that she indicated that she had back pain for 26 years. Do you see that?

A I do.

Q Do you have any indication or knowledge as to what type of back pain she was referencing?

A No.

Q Do you have any indication or knowledge as to how often she experienced low back pain prior to our accident?

A No.
Q Do you have any indication or knowledge as to the pain levels that she experienced when she had prior low back pain?
A No.
Q In reviewing her deposition transcript, do you have any recollection of how she described her prior low back pain?
A I think she minimized the amount of pain that she had and that she had pain related to an accident that occurred in the 80's is my recollection and that she was treated for a while and the pain somehow resolved, which doesn't necessarily explain her comment about the 26 years. But that was, I think, my recollection of what her attempted explanation was.
Q Do you recall her testifying that she would have intermittent backaches prior to this accident?
A I believe that's her testimony -- that she has, you know, kind of the normal level of back pain that -- that most people have and her pain kind of waxes and wanes, comes and goes, is intermittent, something of that nature.
Q Do you have any reason not to believe her testimony?
A Yes.
Q Okay. And what basis do you have?

A Her reference that she's had back pain for 26 years which would be unusual if she just had the normal amount of back pain that -- that most people have. The specific reference that "I've had back pain for 26 years," indicates that it occurs more often than occasionally.
Q You've never had the opportunity to speak with Mrs. Seastrand and ask her about what she meant when she wrote "26 years," is that correct?
A I mean, her answer is going to be her answer based on the knowledge of the fact that I would know this information. So her answer's going to be the same as it was that she swore under oath. I'm quite certain of it. But -- so I don't know that her answer's going to be different. My interpretation of her answer, though, is -- is different than I think she's implied in her -- in her deposition testimony.
Q Okay. My question was: You haven't had the opportunity to speak with Mrs. Seastrand and ask her what she meant when she wrote "26 years"?
A No, I have not. And I apologize if I didn't answer your question.
Q On page 7 of your August report, you discuss her prior accidents and -- and episodes of head injury, and after that, you note "All these accidents and/or injuries required treatment for complaints of headache, neck pain,

shoulder pain, and low back pain." Do you see that?
A Yes.
Q Are you indicating that -- that in each of these four incidents, she had all of those symptoms or that that's a summary of symptoms that she's complained of over the years?
A Most likely it's a summary of things that she's complained of over those years of the accidents, I believe. Throughout the record, she mentioned that she had treatment for these conditions cumulatively.
Q Did you have any -- any knowledge as to what specific complaints are related to what specific accident or incident?
A No, I believe there -- there was some reference to which pain was associated with what in -- in the original descriptions of the accident which are found on page 2 of my August 25th, 2012 report, so we can go through those or we can just refer to that for your -- the answer to your question. It's up to you.
Q Okay. We can refer to what you've listed on page 2. In that summary, there is that information that you've taken -- I guess, where did you get that information?
A I would assume that's from various places throughout the records and her deposition testimony of -- of histories that were taken or information -- historical

recollections that's were provided by Miss Seastrand.
Q Okay. You would agree with me that degenerative changes -- changes in the spine can be asymptomatic, correct?
A Sure.
Q Would you also agree with me that those changes can become symptomatic after a traumatic event?
A Typically, degenerative changes are possible to become traumatic after a single event, but usually they become symptomatic after multiple traumatic events rather than following one single traumatic event. Although it is certainly possible, I don't have any peer-reviewed medical literature which would support that theory.
Q When that happens -- when an asymptomatic change becomes symptomatic following either one or multiple traumatic events, will that -- will there necessarily be an acute finding on MRI or X ray?
A Typically there would be because then you would see some sort of change in the disk. It will probably change in appearance from what it used to be. And based on your question, we would have had to have some advance knowledge of the previous degenerative changes to compare the new now symptomatic degenerative changes to.
So typically there would be some change, whether it would be truly considered a traumatic change with

bleeding and edema and -- and that sort of thing, it's -- it's kind of hard to say. Certainly that's probable that -- that those findings would be necessary if that became symptomatic.

Q Aside from a fracture, what would you consider to be an acute finding on MRI or X ray of the spine?

A Bony contusions of the vertebrae, edema, bleeding, contusions of the spinal cord or nerves. Those types of things would be considered acute findings.

Q Would you consider annular tears to be acute findings?

A They can be. But oftentimes and the most common context we see annular tears are not necessarily with acute findings, but they're more the natural degenerative changes that are present in the nucleus. As the nucleus degenerates, small annular tears are formed which is how the nucleus expands and gets larger. So sometimes all we're seeing is the normal degeneration of the nucleus which is misinterpreted as an annular tear.

Annular tears truly represent high-intensity zones where the signal changes are much brighter than the surrounding spinal fluid on the weighted images of -- of the MRI scan. So oftentimes the presence of a -- an annular tear doesn't necessarily indicate a traumatic event. It's more consistent when there's an actual high-intensity zone

that's present.

Q In Dr. Orrison's reading of the April 2009 lumbar MRI, he noted "posterior annular tears at L4-5 and L5-1."

Do you have any reason to dispute those findings that he noted?

A No. Dr. Orrison's a well-respected neuro radiologist. So I have no reason to discount his findings of an annular tear, but I don't recall him mentioning high-intensity zones which would be more likely associated with a traumatic event.

Q On page 8 of your report, in the second paragraph, you indicate that there was what -- what you call "an early ordering of the cervical and lumbar MRIs on April 3rd, 2009."

Why do you consider that to be early to order that kind of imaging?

A Most people get better. So typically, unless there's something worrisome that has been expressed, you know, by the patient or on an exam finding, ordering an MRI that early is really not going to be that helpful. You end up treating oftentimes incidental findings. If he -- if they would have waited for anywhere between 8 and 12 weeks -- probably closer to 12 weeks -- it would have been a more appropriate timeframe to order this unless, of course, there was something worrisome that's present in the

notes that I do not have access to.

Q And that was going to be my follow-up question: You don't know what type of symptoms she was reporting or what the findings were prior to the MRI, is that correct?

A No, I do not.

Q Are you aware of any records or information indicating Mrs. Seastrand had radicular pain to her lower extremities prior to this?

A I am not.

Q Would you agree with me that patients with soft tissue injuries usually do not have persistent radicular symptoms?

A Radicular symptoms are usually not thought to be related to soft tissue injuries, although they can be. Especially if you talk to chiropractors, they feel that soft tissue injuries can cause radicular symptoms, and I assume that's possible, it's not -- not likely.

Q You've indicated that Mrs. Seastrand's injury should have resolved within four to eight weeks, is that correct?

A Yes.

Q Okay. If she was still experiencing symptoms after eight weeks, what -- what's your explanation for those ongoing symptoms?

A I'll replace your word "symptoms" with subjective

complaints, and I will indicate to you that Miss Seastrand is a litigant and she has secondary gain issues and reasons to have persistent symptoms that are unrelated to any medical conditions.

Q All right. If we take it out of the litigation context, if Mrs. Seastrand was patient coming to see you in your clinical practice and after eight weeks she still had subjective complaints, what would you recommend for her? What would you do for her?

A If she came to me after eight weeks, she still had subjective complaints of, what?

Q Well, the same subjective complaints that she has in this case, eight out of ten low back pain.

A I would ask her about her previous history of 26 years of low back pain and find out how that was different than the 26 previous years had been for her.

Q Just so I'm clear. When you say "four to eight weeks," is that four to eight weeks that her symptoms related to the accident should have resolved in four to eight weeks or her symptoms regardless of whether or not they're related to the accident should have resolved in four to eight weeks? If that makes sense.

A I think it probably does. I have to think about it for a minute. I -- I was specifically referring to the soft tissue injuries or musculoligamentous injuries which

may have been related to the accident. Certainly she could have had some exacerbation of preexisting conditions as a result of -- of this impact. So those conditions related to the accident were specifically what I was referring to. If she continued to have symptoms following that, I -- I have no evidence that I can point to objectively that would relate them back to the accidents of March 2009.

Q Do you believe that Mrs. Seastrand's preexisting injuries made her more susceptible to injuries following this accident?

A Well, it's interesting that you discuss preexisting injuries and conditions and things like that because it doesn't seem like any of your experts have even acknowledged that she had any previous injuries. So if you're asking my opinion hypothetically, I -- I would -- I would say that because she had a head start to something, theoretically makes you more susceptible to injury, but I don't know of any specific literature that I could refer you to that would support that.

It seems to be a common theme in medicine that if you have a head start you're -- you're going to, you know, get closer or -- or have something happen sooner than it would have happened normally, but I don't have anything to support that.

MS. BRASIER: Can we go off the record real quick.

(Brief recess.)

MS. BRASIER: Back on the record.

Q On page 7 of your report, your August report, the last sentence of that first paragraph there says "Treatment beyond May 13th, 2009, should be considered unrelated to the events of March 13th, 2009." Do you see that?

A Yes.

Q All right. We have already established that aside from the MRI reports and it looks like one record from Dr. Belsky, you haven't seen any medical records from the date of the accident through May 13th, 2009, is that correct?

A That's correct.

Q Okay.

MR. SMITH: Hold on. I believe it's through April 3rd, 2009.

THE WITNESS: Oh, yes, it is.

MS. BRASIER: Well, I said, "Aside from the MRI and that one Belsky note."

THE WITNESS: He's correct. It sounds like you're correct, too.

BY MS. BRASIER:

Q So based on that absence of -- of, you know, almost a month's worth of treatment and reporting of symptoms, what kind of support do you have to -- for your

opinion that anything past May 13th should -- is unrelated to this accident?

A Well, when she actually did have records that I could review, there was nothing significant on either her cervical or lumbar MRI which would necessarily support her ongoing complaints of pain. Based on the mechanism of injury, it is likely that she had soft tissue or musculoligamentous injuries as a result of this.

And then, you know, although I -- I did not have access to the care provided to her in between and -- and the symptoms that she was complaining about, I did have access to the symptoms that occurred afterwards which, again, couldn't necessarily be supported by the objective data that was present.

The injections, the MRIs didn't necessarily fit with the symptoms that she was describing later. So whatever she was describing before had either improved or worsened to the point where I knew about it later, and I still couldn't support it even with whatever she was complaining about later. So it didn't seem like treatment beyond that first evaluation by Dr. Belsky was -- was reasonable to pursue.

Q Do you believe that the referral to Dr. Belsky was reasonable and related to the accident?

A It -- it may have been. Again, I don't have

access to the other records. I'm assuming medical comanagement was being provided by -- I believe there was a Dr. Litchfield who works at Compass Care. There was a Dr. Koka who works at Primary Care Consultants that I saw mention of that she had seen during the -- the timeframe.

I did not have the chance to review the records. So my assumption is that she was getting medical comanagement in addition to the chiropractic care from those other physicians. Certainly a consultation of Dr. Belsky was reasonable. I don't have any problem with the -- the referral to her. The plan, though, I have some issues with as I'm sure we'll get into. But I don't have any problem with the fact that the patient was referred to Dr. Belsky for her opinion.

Q You've already testified that you're not a biomechanical expert, is that correct?

A That is correct.

Q Are you --

A I haven't changed since you last asked the question.

Q -- are you going to offer any opinions regarding whether or not the forces Mrs. Seastrand experienced in this case were sufficient to cause injury?

A I will not be offering any opinions in reference to those.

Q Will you be offering any opinions that Mrs. Seastrand is malingering?
A No.
Q Will you be offering any opinions that Mrs. Seastrand is exhibiting secondary gain behaviors?
A Yes.
Q And what's that based on?
A Based on the -- my review of the records. I listed out the subjective complaints far outweigh the objective findings. There appeared to be omissions in her records or minimization of her prior conditions, and then she is a litigant in this particular issue.
The omissions specifically have to do with her longstanding history of low back pain which she did report to the radiology department but failed to report to any other treating physician that I have had the opportunity to review the records.
Q You -- one of the factors you just listed is that "Mrs. Seastrand is a litigant in this case" --
A That could be said of anyone involved in cases. It's not specific to her, you know, but it's one of the -- the medical legal context definitions of secondary gain is that there's some sort of pending lawsuit or that she's involved in a lawsuit, but again, I don't hold that against her. It's just a fact.

Q Going along with the secondary gain behavior, is it your opinion that Mrs. Seastrand is intentionally exaggerating her symptoms?
A That wouldn't be the definition of malingering. And I wasn't going to label her as a malingerer because she -- you know, whether it's intentional or unintentional, I don't know but she just appears to be minimizing and/or omitting specific information, but I have no reason to believe that she's doing it intentionally.
Q Do you have any training or experience as a psychologist or psychiatrist?
A Other than the psychiatry rotations that I've done in medical school for 8 or 12 weeks, no.
Q Have you performed any testing on Mrs. Seastrand to determine if she's exhibiting secondary gain behavior?
A Other than reviewing her records, which is not necessarily a form of testing, no.
Q You reviewed the records.
Have any of the other treating physicians or designated experts in this case indicated that Mrs. Seastrand is exhibiting secondary gain behavior?
A Not in the records I've reviewed, no.
Q Okay. You said that she's minimized her prior -- her prior conditions.
What prior medical conditions are you referring to?

A Specifically her low back pain which she felt enough to reflect that it had been present for 26 years, but indicated that she was only experiencing it, you know, every once in a while in her deposition testimony.
Q All right. Your report details your criticism of Dr. Belsky's performance of the lumbar discogram.
Explain to me how the discogram should have been performed if you were performing it.
A Okay. Am I performing it for Dr. Muir or am I performing it in preparation for plasma disk decompression or -- because there's -- part of the criticism was that she performed it in preparation for plasma disk decompression with the surgeon sitting in the doctor's lounge waiting to come in and complete the procedure. So am I performing it like I normally do, like everyone else in the world does, or am I performing it like Dr. Belsky does and what she did wrong in that particular circumstance?
Q Tell me, if Mrs. Seastrand was a client of yours, how would you have performed that lumbar discogram?
A Okay. Well, first of all, a surgeon wouldn't have been waiting in the wings to come in and -- and perform that procedure immediately afterwards. I like to work independent of the -- the surgeons. So a surgeon would have made a referral to me typically for a discogram.

I would have taken a history, examined Mrs. Seastrand and discussed with her the risk, the benefit, the options and the alternatives to her in reference to the procedure. We would have obtained authorization, if necessary, and taken her to a particular facility to perform the lumbar discography.
If I was concerned -- or if I were concerned that her problem areas were at L4-5 and/or L5-S1, it would have been appropriate to perform the discography at L3-4, L4-5 and L5-S1 using L3-4 as an appropriate control level to validate the study. The needles would have been placed under fluoroscopy with the patient under sedation with a medicine called Versed which is an anxiolytic or antianxiety-type medicine that's.
Reversible. It's safe. It does not induce unconsciousness at usual doses and is -- it has a wide margin of -- of -- of safety associated with it to the point where if a patient appears to be oversedated and cannot converse with you, you can actually reverse the medication.
The three needles would have been placed. All three of those needles would have been of the same size. Those would have been placed in the nucleus of the -- of the disks under direct guidance with x-ray studies. And then testing would have taken place in random order.
Oftentimes it's recommended that you start with

the suspected control disk. So in her case, I would have likely started with the level of L3-4 and would have documented several things: One is the opening pressure of the discography. The second thing that we would document is the pressure at which the patient experienced pain. And the third thing that we would document is the response by the patient because she would be awake to give me a response. And then I would document the volume that I injected into the disk. I would then proceed with the next disk in the same fashion and then the third disk in the same fashion. The needles would then be removed.

If I were concerned at all that there was an annular tear in the disk -- which appeared to be a concern of Dr. Orrison when he read the studies -- that would have been documented on the actual discography reporting. I would not have injected any analgesic substance into the disk because what you're then doing is potentially spilling out local anesthetic into the epidural space and creating an epidural rather than anesthetizing the disk. The needles would have been removed.

A report would have been generated. The patient may or may not have gone for a CT scan after the study to demonstrate what the disk looked like coming from the -- the birds eye point of view. That report, the fluoroscopic image, and the CT scan would then be forwarded to the

surgeon for a potential surgical planning.

Q You said, "A CT scan may or may not follow."

Are there instances where you don't order a CT scan following a discogram?

A Yeah, if the surgeon doesn't find them useful. There's three surgeons in town who do not order CT scans following their discography: Dr. Bassewitz, Dr. Dunn, and Dr. Perry. All of the other surgeons that I've worked with appreciate the fact that you order a CT scan afterwards. So depending on who I'm doing the discography for.

Q When you perform a discogram, do you administer the anesthesia yourself, or do you have a separate anesthesiologist who works with you?

A No. I -- I don't use another anesthesiologist to do that. The nurse in the room who's already being paid as part of a facility fee administers the Versed.

Q Do you know any doctors other than Dr. Muir who performs plasma disc decompression in Las Vegas?

A No.

Q Does ISIS support the use of plasma disc decompressions to treat pain?

A I'm not sure of ISIS's position on plasma disc decompression. I'm sure Dr. Belsky will inform you again next time you talk to her that she did a poster presentation at ISIS in Hawaii in 2010 where they reported up to

70 percent success rates with plasma disc decompression. And I will remind Dr. Belsky -- because I'm sure she'll read this deposition -- that ISIS sometimes invites people to discuss controversial topics and do a poster presentation which may stimulate an interesting discussion regarding that.

And if there is, in fact, a 70 percent success rate, I must only be seeing the 30 percent of the people who have failed the procedure as I have not seen one person actually benefit from plasma disc decompression, whether it be the cervical or lumbar spine.

Q Correct me if I'm wrong.

Did you say you've never seen any patient ever have the success with a PDD?

A It depends on your definition of "success." I mean, long-lasting success beyond, you know, a few months of reported relief, no.

Q You characterized the anesthesia used by Dr. Belsky during the discogram as being -- as "deep sedation." Define "deep sedation" for me.

A Patient being unconscious without a breathing tube.

Q Do you know the amount or strengths of the anesthetics used during the discogram?

A I'm sure I can get that information for you.

(Examining.) It was 1 milligram of Versed used, 50 milligrams of Fentanyl used and 200 milligrams of Propofol used.

Q Now, under monitoring by an anesthesiologist, can those -- can the doses of those medications be used for conscious sedation?

A Versed and Fentanyl, yes. Propofol at that dose, no.

Q Do you know any other pain management specialists other than Dr. Belsky who use Propofol when performing discograms?

A I do.

Q Who are those other physicians?

A Dr. Rossier; Dr. Chuman, G-h-u-m-a-n; Dr. Leon; Dr. Prater; Dr. Kidwell; Dr. Bien. I'm sure there's others, but those are the ones that I can think of right at the moment. Oh, Dr. Lanzkowsky.

Q At the end of your August report, you indicate that Mrs. Seastrand's future is "guarded."

What do you mean when you use the term "guarded"?

A Well, I meant I don't have the rest of the records to know did she die during the operation? I assume she didn't because she ultimately went on and had a CAT scan -- or an MRI. Was she paralyzed? I mean, I don't -- I don't know. I didn't get the end of the story, so that's what I

mean -- I just don't know what's going to happen next. I'll be excited to find out.

Q Do you have any opinions as to whether or not Dr. Belsky is a competent physician?

A I assume she is. She's a board certified anesthesiologist, I believe, with a fellowship in pain management.

Q Will you be providing any testimony that Dr. Belsky should not have performed pain management injections on Mrs. Seastrand?

A No.

Q I know you take issue with how the discogram was performed, but will you be providing any testimony that Dr. Belsky should not have performed a discogram on Mrs. Seastrand?

A No. I mean, Dr. Belsky at that point was Dr. Muir's technician, so she was performing the discography in preparation of a plasma disc decompression which was already predetermined to be performed at L4-5 and L5-S1 based on the presence of the 17-gauge ArthroCare needles that were placed at those levels. So she was essentially Dr. Muir's technician to perform them.

I'm not sure why Dr. Muir can't place the needles himself and why he needs Dr. Belsky to do it, but -- because he does discography apparently. But, you know, that's a

question for Dr. Muir. But, no, I don't have any fault with her. She was working as -- as his "hands" at that point.

Q Do you have any opinion as to whether or not the lumbar fusion was medically necessary?

A I'm not sure if it was medically necessary or medically indicated.

Q When you say you're "not sure," does that mean because you haven't -- you don't think the right workup was performed or you don't think that it was medically necessary?

A I don't think it was medically necessary based on the workup that was performed. The objective data didn't necessarily lead to lumbar fusion being a reasonable offering to Miss Seastrand at that point other than her persistent subjective complaints which seem to have motivated the fusion to be performed.

Q Do you have any opinion as to whether or not cervical fusion was medically necessary?

A I -- I don't because I didn't know until today that it was actually performed.

Q Do you know Dr. Muir's reputation in the community?

A I do.

Q Do you believe he's a competent physician?

A He appears to be. He's a board certified

orthopedic spine surgeon. I believe I have seen his CV where he's done a fellowship in spine surgery in Utah and moved to Las Vegas -- or moved back to Las Vegas and started working with Dr. John Thalgott and then left Dr. Thalgott's office and went on his own. So as far as I understand, he has a reasonable reputation for being a competent spine surgeon.

Q What about Dr. Khavkin?

A Dr. Khavkin, I met him one time. He's a neurosurgeon, and he has an excellent reputation in town. He was a professor of neurosurgery after graduating residency, as I recall, and sort of started his practice in an academic setting and then came and joined Dr. Grover's practice.

Q All right. Let's look at your October report.

A Okay.

Q On the second page of that report, about a quarter of the way down the page, there's a sentence that reads, "Although minor accidents can cause injury, this remains possible, but in this instance, I do not feel it was probable." What's your basis for that statement?

A I mean, you know, Dr. -- I was basically referring to Dr. Gross's comment that, you know, minor accidents can cause major injuries and major accidents may not cause any injury, and although that is true in general, usually the

more severe the accident, the more severe the injury.

He commented that that is not something that's instructed in medical school -- and I'm not sure if he knows about every medical school in the country -- but I went to a different medical school than he did and perhaps that was discussed in my school and maybe not his school. But you would assume that the severity of the accident would be more likely associated with a worsened injury.

A minor accident is more likely to cause minor injuries. A major accident is likely to cause major injuries. So you don't have to be a biomechanical engineer to understand that concept. He seemed to take issue with it. I believe the word "minor" was referred to as the amount of property damage in her traffic accident report why it's in quotes.

I can't recall exactly where I had the reference of "minor." He may actually have used the word "minor" in his report. I just simply cannot recall. But he seemed to have a problem with my assumption that major accidents most likely would lead to major injuries and minor accidents most likely would lead to minor injuries.

Q Have you -- in your clinical practice, have you ever treated patients involved in what's been categorized as a minor accident that have had more than just soft tissue injuries?

A I have.
Q Okay. Do you have any opinions about Dr. Gross's competency as a physician?
A No. There appears to be some question as to whether or not he's actually a fellowship-trained spine surgeon as he asserts based on another report I read from another defense expert in a different case who was questioning his credentials.
I don't have any specific evidence that I -- I have seen that would state otherwise. I know Dr. Gross and I went to the same residency at UC Irvine. I did not know him there. I recognize his face when I have seen his picture, but I did not know him specifically. I know he went to a good residency for neurosurgery.
I don't know what he did after -- after that as far as fellowship goes. So there seems to be some question, but as far as I understand, he went to a good residency program, graduated from that accredited program and is fully capable of performing neurosurgery and spine surgery on patients.
Q Who was the other defense expert who questioned Dr. Gross's credentials?
A I believe it was Dr. Derek Duke.
Q Outside of the context of this case or maybe even inside the context of this case, have you ever spoken with

Dr. Belsky about why she uses Propofol during her discograms?
A She seems to defer to her husband, Dr. Tarquino, for that answer. She does not specifically answer it other than she commonly quotes -- and I haven't spoke with her, but I have seen other reports of her -- but she commonly quotes guidelines and I've asked in depositions before -- not to her personally -- but I'll ask again in this deposition if she has the guidelines from the American Society of Interventional Pain Physicians supporting the use of Propofol for these diagnostic procedures, I would love to see it. She says that it exists. I've not seen it.
Most pain physicians prescribe or subscribe to the -- the guidelines of the International Spine Intervention Society -- or ISIS -- guidelines which specifically, you know, I guess, discourages the use of Propofol due to its propensity to cause unconsciousness during these injections. And although Dr. Belsky may have performed thousands of these procedures and she's performing them appropriately under x-ray guidance, the biggest safety factor in the procedure room is the patients being awake and responsive to what she's doing to them, and if you render a patient unconscious, they are unable to do that and you've gotten rid of your biggest safety factor in experience.
Q So Dr. Belsky indicates that Mrs. Seastrand was

able to respond during the discogram and reported concurrent pain at L5-S1. Do you have reason to -- to dispute that?
A Based on the amount of Propofol used, yes.
Q Have you ever discussed with Dr. Tarquino the use of Propofol during a discogram?
A I've never met Dr. Tarquino, no.
Q Are you going to offer any opinions that any of the treatment rendered in this case fell below the standard of care?
A No. That was not my task.
Q Are you going to offer any testimony that the physicians in this case performed unnecessary procedures for the purposes of building up the damages in this case?
A No. That was not my task.
Q Do you have any opinions as to what treatment Mrs. Seastrand may need in the future?
A I'm not sure what treatment she's had to date other than the mention of the cervical fusion. I know she's had a lumbar fusion, but I -- I don't know that she's going to need future treatment at this point based on what I've -- what I've seen. But my opinion stands that treatment beyond a couple of months following this accident is unrelated to the accident. So whatever treatment she needs is still considered unrelated to the accident of March 13th, 2009.
Q Have all of the opinions that you've provided

today been to a reasonable degree of medical probability?
A Yes.
MS. BRASIER: Okay. I don't have any further questions for you.
THE WITNESS: While we're here, you -- you off the record agreed to pay for an extra half hour. The only reason I'm mentioning this on the record is because your office specifically had a problem with a payment to us regarding the scheduling of a four-hour deposition. So I just wanted to make sure that, you know, you've agreed on the record to pay because I don't want to have any issues with your office like we had recently.
MS. BRASIER: Yes. We'll -- we'll pay you for the additional half an hour that you were nice enough to stay here and -- and provide me with, and if you'll just send an invoice, either through defense counsel or directly to my office, we'll get you paid.
THE WITNESS: We will.
MR. SMITH: I don't have anything.
MS. BRASIER: Off the record real quick.
(Brief recess.)
BY MS. BRASIER:
Q In the initial retention letter from Hall, Jaffe & Clayton to you in this case, on page 3 of that letter it indicates "We would prefer that you withhold forming any

final conclusion and authoring a final report. Once you've had an opportunity to review the materials, please contact me to discuss your preliminary opinions."

Do you remember doing so in this case?

A No. But oftentimes that request is made of me and I -- I typically think it's inappropriate for me to be hired to write a report and then have to speak with a -- an attorney in between. If they call and ask a question, that's fine, but I'm not going to specifically call them before I, sort of, put pen to paper and -- and discuss with them what my report might say so that they can just, you know, discount what -- what my opinions are just because they may or may not like them.

Q And would it be fair to say you didn't offer any draft reports prior to authoring the report dated October 25, 2012?

A I think that's a safe assumption based on my prior answer.

Q Do you have any idea how many times you've been retained by Mr. Jaffe's firm?

A Well, I've been in practice since 1997. It would be difficult to estimate. I -- I would say somewhere in the neighborhood of five to ten times.

Q And in any of those five to ten times, have you ever complied with this request to speak with the attorney

before drafting your final report?

A I don't think I've ever spoken with Mr. Jaffe in reference to a report. I -- I've spoken with him on a couple of occasions for unrelated issues. But no, I don't think I've -- again, I use those letters to dictate and come up with a list of records. I don't really read what the instructions are at the very bottom of the letter. So oftentimes, when I'm dictating something, I'll take that letter and fax it on to the transcriptionist so they can -- so I don't have to dictate the list, they can just type it in. So that's, sort of, what I use them for.

MS. BRASIER: Do you have any questions?

MR. SMITH: I do have a couple of questions.

EXAMINATION

BY MR. SMITH:

Q Doctor, there was a little discussion about whether Miss Seastrand's testimony and complaints of back pain prior to the subject accident were -- I think it was described as "normal back pain" that somebody experiences. Do you recall that?

A I -- I think that was my word, yes.

Q If I represent to you that on April 20th, 2009 -- and you've already testified that you don't have these records -- there are records from her chiropractor where she

indicates that she had neck pain prior to the motor vehicle accident at a three of ten, two to three times per month and low back pain prior to the motor vehicle accident at a four of ten, one to two times per month.

Is it your opinion that type of neck and back pain -- and we'll just do the neck first and then I'll ask you about the back -- is that type of neck pain, three of ten, two to three times per month, considered nor -- normal by the description that you gave or the definition that you gave?

A No. Again, I -- I just, you know, to be fair, I didn't have access to that record before you're asking me the question, and I'm assuming that it's accurate information that you're providing me. And I would call her neck pain chronic neck pain and her back pain chronic neck pain. I don't think that's the normal amount of back pain that "I slept wrong and I have pain every three or four months because, you know, my pillow slipped away from me."

Q Fair enough.

So just to make sure the neck pain that I just described, assuming that it's accurate, and the back pain complaints that I described, assuming they're accurate, you would not categorize those as normal back pain?

A Not normal amounts. Normal amounts for patients who have chronic neck and back pain, yes. But not normal

amounts for patients who are supposedly asymptomatic.

Q Fair enough.

MS. BRASIER: Jake, I'm sorry. I missed it. What rec -- what record were you referencing?

MR. SMITH: I'm referencing -- just a second. February -- sorry. March 20th, 2009, Neck and Back Clinic with Benjamin Lurie. I believe they have been disclosed as Neck and Back Clinic, NBCL-0006 to 00020.

MS. BRASIER: Thank you.

THE WITNESS: I think in your original question, you said something about April, so is it really March?

MR. SMITH: Sorry. If I said "April," I meant March, March 20th, 2009.

THE WITNESS: Okay.

MR. SMITH: In that window of documents that you didn't have.

THE WITNESS: Okay. Correct. I just wanted to be clear as well.

MR. SMITH: That's all I've got.

FURTHER EXAMINATION

BY MS. BRASIER:

Q Would you like to read and review your deposition, or do you want to waive?

A I can waive this one.

MS. BRASIER: Okay. Thanks..
(The deposition concluded at 11:24 A.M.)

CERTIFICATE OF DEPONENT

PAGE LINE CHANGE

* * * * *

I, JOSEPH J. SCHIFINI, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition.

JOSEPH J. SCHIFINI, M.D.
Deponent

STATE OF NEVADA)
) ss
COUNTY OF CLARK)

I, DONNA J. ABRAHAMSEN, a Certified Court Reporter, do hereby certify:

That prior to being examined, the witness in the foregoing proceedings was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth;

That said proceedings were taken before me at the time and place therein set forth and were taken down by me in shorthand and thereafter transcribed into typewriting under my direction and supervision;

I further certify that I am neither counsel for, nor related to any party to said proceedings, nor in anywise interested in the outcome thereof.

In witness whereof, I have hereunto subscribed my name.

Dated: _____, 2013

DONNA J. ABRAHAMSEN, RPR
NV CCR NO. 420, CA CSR NO. 9652
WA. CCR NO. 3262

EXHIBIT 15

Rev 04/10

CURRICULUM VITAE

Joseph John Schifini, M.D.

Personal Data:

Birth date:	June 16, 1967
Birthplace:	Hawthorne, California
Medical Licensure:	Nevada – 8071 California – G80849 DEA – BS5160659 Pharmacy – NV – CS8551
Board Certification:	American Board of Anesthesiology Certified 04/99 American Academy of Pain Management Certified 11/99 American Board of Pain Medicine Certified 02/08

Practice History:

2/99	-	Present	Joseph J. Schifini, M.D., Ltd. Las Vegas Pain Control Associates 600 S. Tonopah Drive, Suite #240 Las Vegas, NV 89106
10/98	-	8/99	Summit Anesthesia Pain Relief Associates (Chief of Pain Management Division) 2200 Rancho Drive, Suite 116 Las Vegas, NV 89102
7/97	-	10/98	Pain Institute of Nevada 4500 West Oakey Blvd. Las Vegas, NV 89102

Current Hospital Affiliations:

9/97	-	Present	Sunrise Hospital Medical Center 3186 South Maryland Pkwy. Las Vegas, NV 89109 Status: Active
12/97	-	Present	University Medical Center 1800 West Charleston Blvd. Las Vegas, NV 89102 Status: Active

Current Hospital Affiliations (cont.)

1/98	-	Present	St. Rose Dominican Hospital 102 East Lake Mead Drive Henderson, NV 89015 Status: Courtesy
			Valley Hospital Medical Center 620 Shadow Lane Las Vegas, NV 89106 Status: Active
9/00	-	Present	Siena Hospital Medical Center 3001 St. Rose Parkway Henderson, NV 89052 Status: Courtesy

Education:

7/94	-	6/97	University of California, Irvine Medical Ctr Orange, California Anesthesiology Residency & Chief Resident-Anesthesiology
7/93	-	6/94	University of Nevada School of Medicine Las Vegas, Nevada Internship - Internal Medicine
1989	-	1993	University of Nevada School of Medicine Reno, Nevada Doctor of Medicine
1985	-	1989	University of Nevada, Las Vegas Las Vegas, Nevada BS-Biology and Minor-Chemistry

Academic Positions:

8/97	-	Present	University of Nevada School of Medicine Assistant Clinical Professor Department of Anesthesiology
7/06	-	Present	Touro University Assistant Clinical Professor

Memberships/Professional Affiliations:

American Society of Anesthesiology
Nevada State Society of Anesthesiology
International Spine Intervention Society
American Academy of Pain Management

Medical Committee Memberships:

6/09 - Present Medical Executive Committee – HCA/Columbia Las Vegas Surgery Center

Awards:

January 1991, Best Presenter Award for "Effects of Caffeine on Human Lower Esophageal Sphincter and Esophageal Body Dynamics". Presented at the Second Annual George G. Bierkemper Student Research Convocation. University of Nevada School of Medicine. Reno, NV.

May 1991, University of Nevada School of Medicine Department of Physiology Research Grants awarded for "Effects of Caffeine on Human Lower Esophageal Sphincter and "Esophageal Body Dynamics" and Effects of Somatostatin Analogue on the Normal Human Esophagus".

Presentations:

Jan. 1991	Second Annual George G. Bierkemper Student Research Convocation Reno, Nevada "Effects of Caffeine on Human Lower Esophageal Sphincter and Esophageal Body Dynamics".
Feb. 1991	Nineteenth Annual Western Student Medical Research Forum Carmel, California "Effects of Caffeine on Human Lower Esophageal Sphincter and Esophageal Body Dynamics".
Sept. 1992	Seventh Biennial American Motility Society's International Symposium Lake Tahoe, California "Caffeine Stimulates the Normal Human Esophagus"
June 1997	Eleventh Annual Low Back Pain Conference Las Vegas, Nevada "Epidural and Selective Nerve Root Injections"
June 1998	Twelfth Annual Low Back Pain Conference Las Vegas, Nevada "Facet and other Spinal Injections"
June 2000	Fourteenth Annual Low Back Pain Conference Las Vegas, Nevada "Spinal Injections" and "Opiates"
June 2002	Sixteenth Annual Low Back Pain Conference Las Vegas, Nevada "Facet and other Spinal Injections"
June 2003	Seventeenth Annual Low Back Pain Conference Las Vegas, Nevada "Spinal Injections" and "Opiates"
February 2004	American College of Physicians Governors Conference Las Vegas, Nevada "Pain Management"

Presentations: (cont'd.)

March 2010	Kaiser Permanente Advanced Spinal Medicine Conference for Sacral Region Pain Oakland, California "Diagnostic Injections for Sacral Pain"
March 2010	Kaiser Permanente Advanced Spinal Medicine Conference for Sacral Region Pain Oakland, California "Validity of Diagnostic Blocks"
April 2010	S.I. Bone Cadaver Lab Las Vegas, Nevada "Sacroiliac Joint Pain"

Instructional Courses Attended:

Aug 1996	Radiofrequency Techniques in the Management of Chronic Pain.
May 1999	IntraDiscal Electrothermal Therapy.

Articles in Publication:

Gunshefski, L.A., Rifley, W.J., Slattery, D.E., Schifini, J.J., Hartsuck, M.E., Little, A.G. "Somatostatin Stimulation of the Normal Esophagus". AM J Surgery, 163:59-62. Jan 1992.

Abstracts:

Hartsuck, M., Slattery, D., Schifini, J., Gunshefski, L., Little, A. "Nicotine Inhibits Esophageal Function in Smokers and Nonsmokers". Clinical Research, 39(1):p115A. Feb. 1991.

Slattery, D.E., Schifini, J.J., Hartsuck, M.E., Gunshefski, L.A., Little, A.G. "Effects of Somatostatin Analogue on the Normal Human Esophagus". Clinical Research, 39(1):p19A. Feb. 1991.

Schifini, J., Hartsuck, M., Slattery, D., Gunshefski, L., Little, A. "Effects of Caffeine on Human Lower Esophageal Sphincter and Esophageal Body Dynamics". Clinical Research, 39(1):p115A. Feb. 1991.

Slattery, D.E., Hartsuck, M.E., Schifini, J.J., Little, A.G. "Nicotine and Esophageal Motor Function". Gastroenterology, 103(4):p1412. Oct. 1992.

Schifini, J.J., Slattery, D.E., Hartsuck, M.E., Little, A.G. "Caffeine Stimulates the Normal Human Esophagus". Gastroenterology, 103(4):p1411. Oct. 1992.

EXHIBIT 16

John B. Siegler MD

2510 Wigwam Parkway, Suite 201
Henderson, NV 89074
Phone: (702) 457-7463
Fax: (702) 878-7463

EDUCATION

Residency - July 1998 – June 2001
Department of Physical Medicine and Rehabilitation
Rehabilitation Institute of Chicago
Northwestern University Medical School
Chicago, Illinois

Internship - July 1997 – June 1998
Departments of Internal Medicine, Neurology and
Physical Medicine and Rehabilitation
Northwestern University Medical School
Chicago, Illinois

Medical School - August 1993 – July 1997
Northwestern University Medical School
Chicago, Illinois

Undergraduate - September 1989 – July 1993
Bachelor of Arts
College of Arts and Sciences
Northwestern University
Evanston, Illinois

CERTIFICATION & LICENSURE

- Diplomate, American Board of Pain Medicine
- Board Certified, American Board of Electrodiagnostic Medicine
- Board Certified, American Board of Physical Medicine & Rehabilitation
- Board Certified Independent Medical Examiner
- Nevada State Board of Medical Examiners License: 10534.
- Basic and Advanced Cardiac Life Support.

EMPLOYMENT HISTORY

Private Practice – March 2004 - present
Spine and Rehabilitation Specialists
Las Vegas, Nevada

Independent Contractor – August 2003 – April 2007
Concentra Medical Centers
Las Vegas, Nevada

Private Practice – August 2001 – August 2003
Physical Medicine Associates of Northwest Ohio, Inc.
Lima, Ohio

Pain Education and Rehabilitation Center – August 2001 – August 2003
Medical Director
St. Rita's Medical Center
Lima, Ohio

APPOINTMENTS

Touro University Nevada College of Osteopathic Medicine
Adjunct Assistant Professor Pain Management/Rehabilitation
Las Vegas, NV

Summerlin Hospital
Medical Staff Privileges
Las Vegas, Nevada

Sunrise Hospital
Medical Staff Privileges
Las Vegas, Nevada

Institute of Orthopedic Surgery
Medical Staff Privileges
Las Vegas, NV

Las Vegas Surgery Center
Medical Staff Privileges
Las Vegas, NV

PUBLICATIONS AND PAPERS

- Harden NR, Bruehl S, Siegler JB, Cole P, "Pain, Psychological Status, Functional Recovery in Chronic Pain Patients on Daily Opiods; a Case Comparison." *Journal of Back and Musculoskeletal Rehabilitation*; vol 9; 1997, p101-108.

PRESENTATIONS

- Siegler J, Brenman EK, Bruehl S, Saltz S, Harden NR, "Time Series Analysis of Stress, Anger, Anxiety, and Depression as They Relate to Chronic Pain" Poster presented at the 61st Annual AAPM&R Assembly, November 1999.

- Rosenfeld PJ, Siegler JB, "Detection of deception using P300 stimulus evoked potentials." Poster presented at the 1992 annual meeting of Psychophysiologists, June 1992.

RESEARCH ACTIVITIES

- Study Coordinator at the Rehabilitation Institute of Chicago in a multi-center study. Rowbotham M, Harden N, Stacy B, Bernstein P, Magnus-Miller L, "Gabapentin for the Treatment of Postherpetic Neuralgia: a Randomized Controlled Trial", JAMA 1998:280:1837-42.

- Research Assistant, Northwestern University Psychophysiology Laboratory – Recording and Analyzing Stimulus Evoked Potential on Electroencephalograms 1992, 1993.

HONORS AND AWARDS

- S.T.A.T. (Superior Talent And Teamwork) award, elected by the ancillary staff of St. Rita's Medical Center, July 2002

- Scholl Recognition Award for rehabilitation research, June 2001

- Graduated with departmental honors in Psychology from Northwestern University, June 1993

LECTURES

- "Spasticity and Traumatic Brain Injury", Nevada Traumatic Brain Injury Council's Traumatic Brain Injury Conference – October 2007
- "Pain in the Acute Care Setting", Sunrise Hospital Grand Rounds – August 2007
- "Workers Compensation and Disability", University of Nevada School of Medicine Family Practice Residency – May 2007
- "The Evaluation of the Patient with Low Back Pain", University of Nevada School of Medicine Family Practice Residency – May 2007
- "Low Back Pain", Nevada Attorney for Injured Workers – July 2006
- "Evaluation and Treatment of Concussion", Concentra Medical Center Physician Meeting – January 2006
- "Trigger Point Injections", University of Nevada School of Medicine Family Practice Residency – October 2005
- "The Evaluation of the Patient with Low Back Pain", University of Nevada School of Medicine Family Practice Residency – August 2005
- "The Orthopedic Examination of the Shoulder", Western Occupation Health Conference – September 2004
- "Practice and Pitfalls of Prescribing Opioids", Lima Area Family Practice Physicians – September 2002
- "The Chronic Pain Patient: Diagnosis and Treatment Strategies", St. Rita's Nursing Education Forum – December 2001
- Use of Botulinum Toxin in the Treatment of Spasticity", Lima Area Stroke Support Group – November 2001
- "Gait: Biomechanics, Kinetics, and Abnormalities", Resident Lecture Series – February 2001
- "Electrodiagnostic Medicine: Principles and Procedures", Medical Student Lecture – May 2000
- "Reflex Sympathetic Dystrophy", Summer Extern Lecture Series – August 1999

- "Thromboembolism: Physiology and Prevention", Summer Extern Lecture Series – July 1999

ADDITIONAL EDUCATION

- International Spinal Injection Society Workshop on Fluoroscopically Guided Disc Stimulation, Philadelphia, November 2005
- International Spinal Injection Society Workshop on Fluoroscopically Guided Cervical Pain Procedures, Philadelphia, October 2005
- Completion of The American Board of Independent Medical Examiners training course in the study of AMA Guides to Evaluation of Permanent Impairment, October 2003
- International Spinal Injection Society Workshop on Fluoroscopically Guided Thoracic Pain Procedures, Philadelphia, July 2003
- Workshop on the Use of Botulinum Toxin in the Treatment of Myofascial Pain, Chicago, September 2002
- Workshop on Botulinum Toxin in Headache, Cleveland, August 2002
- International Spinal Injection Society Workshop on Fluoroscopically Guided Lumbar Pain Procedures, San Francisco, January 2002
- Lower and Upper Limb Orthotics and Prosthetic Course for Physicians, Rehabilitation Institute of Chicago, April 2000

COMMITTEES/POSITIONS

- Chairman, Physician Taskforce on Pain, St. Rita's Medical Center
  August 2002- August 2003
- Medical Care Improvement Committee, Rehabilitation Institute of Chicago
  January 1999- June 2001
- Physician Users Group – Computer Information System, Rehabilitation of Chicago
  November 1998-June 2001
- President, American Medical Association Student Section, Northwestern Branch:
  May 1994 –May 1995.
- Delegate to the Chicago Medical Society Student Section from Northwestern University Medical School: September 1993 – September 1995.

PROFESSIONAL ACTIVITIES

- Bastille Day Five-Kilometer Run, Physician Volunteer, 2000
- Chase Corporate Challenge, Physician Volunteer, 1999
- High School Sports Physical Examiner, 1997, 1998, 1999
- Ravinia Music Festival, Event Medical Coverage for Performing Artists, 1998

posterior facet joint synovitis at L4-5. 6) Moderate bilateral neural foraminal narrowing at L4-5. 7) No significant central spinal canal stenosis in the lumbar spine.

05/05/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Recommend set of lumbar epidural steroid injections at the levels where the MRI shows pathology to alleviate some of the presenting complaints and findings L4 and L5 TFESI bilaterally and consider lumbar facets L4-5 B/L. After this C5-6 on the right TFESI. Ultram and Flexeril.

05/20/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Transforaminal epidural at L4-5 and L5-S1 bilaterally with L4-5 bilateral facet injections and epidurogram with fluoroscopic guidance. **Preoperative Dx:** 1) Lumbar disc bulge. 2) Lumbar radiculopathy. 3) Lumbar facet pain. **Postoperative Dx:** Same. ***The same procedure was repeated on the left.*** **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 7/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Versed 1mg; Fentanyl 50mcg; and Propofol 100mg. Arouses to name, responsive to verbal stimuli in PACU.

08/04/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including

cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Recommend C5-6 on the right TFESI. 2) Tylenol #4. 3) Send for surgical consult.

08/24/09 **William Muir, M.D. – Initial Visit – Chief Complaints:** Neck and back pain. **History of Injury:** Patient was involved in an MVA on 03/13/09. She was rear-ended by another vehicle. She had a similar injury 23 years ago. **Pain Score:** 7/10 cervical, 10/10 lumbar. **ROM:** Lumbar spine ROM 10% of normal and painful. Extension 5% of normal and painful, lateral flexion 10% of normal and painful. **Impression:** 1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal of normal lordotic curve. 3) Probable in internal disc disruption syndrome. 4) Mild degenerative disc changes L4-5 and L5-S1. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Lumbar IDD/IDDS. 3) Lumbar radiculitis. **Plan:** 1) Naprosyn. 2) Continue Tylenol #4. 3) Pending cervical injection. 4) Discogram/plasma disc decompression L4-5, and L5-S1. 5) Return for evaluation of the cervical spine.

08/26/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure;** 1) Transforaminal epidural injection at C5-6 on the right with epidurogram and fluoroscopic guidance. **Preoperative Dx:** 1) Cervical disc bulge. 2) Cervical radiculopathy. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 6/10. **Post Procedure Pain Score:** 0/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Versed 1mg; Fentanyl 50mcg. Propofol 100mg. No response to verbal or tactile stimuli.

08/28/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that resulted in significant improvement regarding her cervical spine. **Pain Score:** 5/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation

60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 3) Probable in internal disc disruption syndrome L4-5. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Naprosyn. 2) Continue Tylenol #4 for pain. 3) Pending L4-5, L5-S1 plasma disc decompression. 4) Obtain medical records from recent injection in the cervical spine. 5) Return in one month.

09/16/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Discogram at L3-4, L4-5, and L5-S1 with fluoroscopic guidance and discographic interpretation. The L3-4 disc was negative OP 30psi → 81psi. The L4-5 disc was positive OP 25psi →40psi →75psi 17g ArthroCare cannula inserted. The L5-S1 disc was positive OP 15psi →25psi →40psi 17g ArthroCare cannula inserted. Analgesic discography performed at L4-5 and L5-S1 prior to Plasma Disc Decompression.

09/16/09 **William Muir, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** Lumbar plasma disc decompression surgery, L4-S1. **Pre Procedure Dx:** Discogenic pain L4-5. **Post Procedure Dx:** Same. **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 6/10. **Anesthesia:** Versed 1mg; Fentanyl 50mcg and Propofol 200mg.

09/22/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Neurontin. 2) Valium. 3) Flector patches. 4) Follow up in one week.

09/22/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. **Pain Score:** 9/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 3) Probable in internal disc disruption syndrome L4-5. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Follow up with Dr. Belsky. 2) Continue present medication therapy. 3) Follow up in one week.

09/29/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 9-10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Prescriptions for pain from Dr. Tarquino. Start Medrol Dosepak after results from lab work. 2) CBC and Sed rate to rule out infection

associated with injection. 3) May need new MRI and possible right L5 selective nerve root block. 4) Follow up in one week.

10/06/09 **Mario Tarquino, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Neurontin. 2) Valium. 3) Ultram. 4) Follow up in one week.

10/06/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1)

Continue present meds. 2) Pending MRI scan. 3) Medrol Dosepak. 4) Return after MRI.

10/13/09 **Mario Tarquino, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Increase Neurontin. 2) Schedule her for caudal to relieve some of her pain. 3) Add Lortab. 4) Follow up in one week.

10/13/09 **Sonny A. Patidar, M.D. – Las Vegas Radiology – MRI of the Lumbar Spine Without Contrast – Findings:** There is straightening of the lumbar lordosis. Mild disc desiccation is noted at L4-5 and L5-S1. The vertebral body heights are maintained. The conus medullaris ends at L1-2. T12-L1: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L1-2: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L2-3: No significant disc bulge or protrusion. The neural foramin are patent, and the exiting nerve roots are normal. L3-4: There is a minimal 1 to 2 mm disc protrusion that abuts the thecal sac. The neural foramina are patent, and the exiting nerve roots are normal. L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing. **Impression:** 1) L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. 2) L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing.

10/16/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Pending right sided selective nerve root block by Dr. Belsky. 3) Return in two weeks.

10/21/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Lumbar caudal epidural with epidurogram and fluoroscopic guidance. **Preoperative Dx:** Lumbar disc bulge. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 5/10. **Anesthesia:** Versed 1mg; Fentanyl 100mcg; Propofol 100mg.

11/02/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion

and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Ultram. 2) Neurontin. 3) Add Lortab. 4) Follow up in four weeks.

11/02/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Toradol. 3) TENS unit for home use. 4) Return in two weeks.

11/17/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 8-10/10, low back and buttocks, 4/10 right leg pain. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion

50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Prescription for Tramadol and Ibuprofen. 3) Return in one month. 4) EMG of the right upper extremity.

11/20/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **Pain Score:** 4/10. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Utram. 2) Neurontin. 3) Repeat caudal. 4) Follow up in four weeks.

12/09/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Lumbar caudal epidural with dye study and fluoroscopic guidance. **Preoperative Dx:** 1) Lumbar disc bulge. 2) Lumbar radiculopathy. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 5/10. **Post Procedure Pain Score:** 0/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Propofol 100mg, Fentanyl 50mcg, and Versed 1mg. Drowsy but arousable.

12/10/09 **Russell J. Shah, M.D. – Upper Extremity EMG/NCV Study – Impression:** Subacute C6 radiculopathy with minimal active denervating potentials. Please note the patient did have a steroid treatment in the neck area and active axonal denervating potentials may not be as reflective given the indicated therapeutic intervention.

12/15/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **Pain Score:** Lumbar pain 5/10. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Ultram ER. 2) Neurontin. 3) Follow up in four weeks.

12/15/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient is here for follow up with Dr. Muir. Patient is status post plasma disc decompression at the L4-5 and S1 done on September 16, 2009. Subsequently, she developed a severe right L5 radiculitis which was intolerable. She had 2 epidural steroids by Dr. Belsky and was provided temporary relief. Due to the severity of the right leg pain, the neck problems were somewhat ignored. Nevertheless, the neck pain and arm pain have worsened. Initially after her epidural injection, she had some relief but that has worn off. She describes neck pain and arm pain as quite severe. **Pain Score:** 8/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the

foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) ACDF at C5-6 in January. 3) EMG right lower extremity from Dr. Shah. 4) Return in one month.

2010

01/07/10 **Russell J. Shah, M.D. – Lower Extremity EMG/NCV Study – Impression:** Mild subacute bilateral L5 radiculopathies.

01/20/10 **Jose Ramon Troche, PA-C - William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here for preoperative follow up. The patient is scheduled for cervical fusion at the C5 to C6 with spinal cord monitoring on January 25, 2010. She continues to have significant cervical spine pain with increased symptomatology. She is also complaining of significant lumbar spine pain as well. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) ACDF at C5-6. 3) Preoperative history and physical completed today. 4) Avoid high impact activities. 5) Keflex. 6) Follow up one week after surgery. 7) Go to Summerlin Hospital to preregister. 8) No PT for six weeks.

01/22/10 **Rajashree Vyas, M.D. – Summerlin Hospital Medical Center – X-ray: Chest Two Views – Impression:** Normal chest.

01/25/10 **William Muir, M.D. – Summerlin Hospital Medical Center – Pre-Op History and Physical – Chief Complaint/History of Present Illness:** Neck pain and lumbar spine pain as well. She is here for neck pain which is severe pain, constant radiating to both upper extremities. **Clinical Impression:** Cervical spine C5-6 with a herniated nucleus pulposus and a C6 radiculopathy. **Plan:** Proposed surgery by Dr. Muir is anterior cervical interbody fusion with spinal cord monitoring at C5-6 with instrumentation.

01/25/10 **William Muir, M.D. – Summerlin Hospital Medical Center – Operative Report – Procedure:** 1) Anterior approach to the cervical spine. 2) Decompression diskectomy C5-6. 3) Anterior cage placement, C5-6. 4) Anterior fusion C5-6. 5) Anterior plating C5-6. 6) Spinal cord monitoring. 7) Closure. **Preoperative Dx:** Herniated nucleus pulposus, C5-6. **Postoperative Dx:** Same.

01/26/10 **Enad S. Soumi, M.D. – Summerlin Hospital Medical Center – History and Physical** – Patient presents with neck pain. She is a 48-year-old female who was admitted for surgical intervention 01/25/10. **Assessment:** 1) Right upper extremity numbness and pain status post C5-6 diskectomy. The pain is resolved. The patient is doing very well, hemodynamically stable, with no neurological deficit. 2) Lower back pain. 3) Mild leukocytosis. No sings of infection. Hold IV antibiotics for now.

01/27/10 **Enad S. Soumi, M.D. – Summerlin Hospital Medical Center – Discharge Summary – Admitting Dx:** 1) Neck pain. 2) Lower back pain. **Discharge Dx:** 1) Neck pain, resolved, status post decompression, diskectomy on C5-6 with anterior cage placement, anterior fusion of C5 and C6. 2) Lower back pain. Patient did well, kept overnight for postop monitoring.

02/02/10 **Jose Ramon Troche, PA-C - William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here for postoperative follow up appointment. The patient is status post anterior cervical interbody fusion at the C5 to C6 that was done on January 25, 2010. She is approximately 90% overall improved since her surgical intervention. She has mild difficulties in sleeping secondary to some incisional pain. The patient states that her lumbar sine pain continues to be quite significant at this time. She would like to proceed with lumbar spine surgery within the next six weeks. **Pain Score:** 5/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Avoid high impact activities. 3) Keflex. 4) Follow up in two weeks. 5) No PT for six weeks. 6) Valium.

02/16/10 **William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here today for postoperative appointment. The patient is status post anterior cervical interbody fusion at C5 to C6 that was done on January 25, 2010. Approximately two weeks out from surgery the patient stated she was 90% improved since her surgical intervention. Unfortunately, in the past three days she was experiencing some posterior cervical and shoulder region stabbing pain and discomfort which Lortab and Valium is helping. **Pain Score:** 7-10/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Avoid high impact activities. 3) Follow up in two weeks. 4) No PT for six weeks. 5) Continue Valium.

03/05/10 **William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here today for postoperative appointment. The patient is status post anterior cervical interbody fusion at C5 to C6 that was done on January 25, 2010. She does have some discomfort at night in the shoulder region stabbing pain which Lortab and Valium help at night time. **Pain Score:** 5-7/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Bilateral L5 radiculitis. 5) Status post C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal of normal lordotic curve. 6) Status post right to C6 and possibly C7 radiculopathy/radiculitis. 7) ACDF C5-6, 01/25/10 with good outcome to date. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc site without myelopathy. 8) Lumbar radiculitis. **Plan:** 1) Anterior posterior lumbar fusion L4-S1. 2) Avoid high impact activities. 3) Follow up in one month. 4) No PT for the neck until April. 5) Continue Valium and Neurontin.

04/02/10 **Leo P. Langlois, M.D. – Pain Medicine Consultation – Chief Complaints:** 1) Back pain. 2) Extremity pain. **History:** Patient is a 48-year-old who was involved in an MVA in March 2009. She has a history of previous surgery/procedure: ACDF. **Pain Score:** 9/10. She is here for a second opinion. **ROM:** Limited Rom of the lumbar spine. Painfully limited at end ROM in all directions of the cervical spine. **Assessment:** 1) Degenerative disc. 2) Neuralgia, neuritis, radiculitis. 3) HNP/disc protrusion/extrusion. 4) Postlaminectomy, cervical. **Plan:** Start Ultram ER. EMG/NCS ordered. Refer to neurosurgeon Dr. Conner for evaluation for surgical options, for disc replacement.

04/14/10 **Leo P. Langlois, M.D. – EMG/NCV Studies – Impression:** Normal electrodiagnostic study. No electrodiagnostic evidence of right or left lower extremity radiculopathy or myopathy was noted.

04/29/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic – Chief Complaint:** Low back pain and numbness in her legs. **History of Present Illness:** Patient is a 48-year-old lady with a longstanding history of neck and low back problems. Her chief complaint at this point in the lower back pain and numbness in her legs. She states that most of her pain is in the lower back and gets very severe on an almost daily basis. **Impression/Recommendations:** Consider surgical treatment consisting of L4-5 and L5-S1 interbody fusion.

05/07/10 **Kelly R. Gardner, M.D. – X-ray: Chest Two Views – Impression:** No acute cardiopulmonary disease.

05/12/10 **Eddy Luh, M.D. – St. Rose Dominican Hospital – Operative Report – Procedure:** 1) Retroperitoneal exposure and mobilization of the aorta, iliac artery and vein and lumbosacral spine. 2) Diskectomy, lumbar interbody fusion of the L4-5, L5-S1 intervertebral disk space. 3) Placement of Gore-Tex lumbosacral patch. **Preoperative Dx:** Diskogenic back pain. **Postoperative Dx:** Same.

05/12/10 **Yevgeniy Khavkin, M.D. – St. Rose Dominican Hospital – Operative Report – Procedure Performed:** 1) Anterior lumbar approach for L4-5 and L5-S1 discectomy with placement of the interbody cage device by Stryker at the L4-5 and L5-S1 levels with an L4-5 interbody fusion using vitoss and BMP followed by the placement of anterior lumbar instrumentation from L4 to S1 using a Stryker Thor plate. 2) Use of interpretation of intraoperative fluoroscopy. **Preoperative Dx:** L4-5 and L5-S1 disk compromise. **Postoperative Dx:** Same.

05/12/10 **Jaswinder S. Grover, M.D. – Nevada Spine Clinic** – Patient returns status post ALIF L4-S1. **Plan:** Advance activities, stabilization and strengthening.

05/14/10 **Kelly Noel, PA-C – Jaswinder Grover, M.D. – St. Rose Dominican Hospital – Discharge Summary – Admission Dx:** 1) Intractable back pain. 2) Lower extremity radiculopathy. **History of Present Illness:** Patient is a 48-year-old female with a long standing history of significant intractable low back pain with radiation to the gluteal region lower extremity with numbness, tingling, paresthesias.. **Plan:** Transfer to JRU on May 13 and discharged on May 14, 2010.

06/08/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up after the L4-5, L5-S1 anterior lumbar interbody fusion with anterior lumbar instrumentation, performed on May 12, 2010. The patient states significant improvement in her lower back pain. She is requiring a minimum amount of pain meds at this point. **X-rays:** Show unchanged position of the plate with the top of the plate slightly displaced ventrally, but with no change since the previous imaging. **Plan:** Continue current management.

06/29/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up after the L4-5, L5-S1 anterior lumbar interbody fusion with anterior lumbar instrumentation, performed on May 12, 2010. The patient states that her pain has been getting better each day. **Plan:** Continue treatment. Follow up in two weeks.

08/19/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up after the L4-5, L5-S1 anterior lumbar interbody fusion with anterior lumbar instrumentation, performed on May 12, 2010. The patient states about five weeks ago she strained her back trying to pick up a child and since that time had been complaining of pain in the lower back and the right buttock area. **Plan:** If she continues to experience symptoms, would like her to undergo CT of the lumbar spine.

09/23/10 **Lawrence Bogle, M.D. – Las Vegas Radiology – CT Lumbar Spine Unenhanced With CT Reconstructions – Findings:** Spinal alignment: Normal lordosis, no significant listhesis. Paraspinal soft tissue: Normal. T12 to L5: Normal height without compression fracture. Anterior fixation at L4, L5 and S1 vertebral bodies are noted. T12/L1: AP dimension of central canal measures 15 mm. L1/L2: AP dimension of central canal measures 15 mm. L2/L3: AP dimension of central canal measures 15.2 mm. L3/L4: Disc: 2 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 13.7 mm. Right neural foramen: Mild stenosis due to disc bulge. Left neural foramen: Mild stenosis due to disc bulge. L4/L5: Disc: Postoperative changes are noted in anterior portion of disc.

Central canal: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. Right neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: Postoperative changes are noted in anterior portion of disc. 3 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) Interval anterior fixation of L4, L5 and S1 vertebral bodies, postoperative changes at L4-5 and L5-S1 intervertebral discs. 2) L3/L4: 2 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis. 3. L4/L5: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There is moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis.

09/23/10 **Laurie Seltzer, D.O. – Las Vegas Radiology – Bilateral Screening Mammography – Impression:** Bilateral mammography reveals no evidence of malignant change. Recommend annual screening. Bi-Rads 2, benign.

09/30/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up after an anterior L4-5, L5-S1 interbody fusion. She has been feeling much better over the last several weeks. She is experiencing no pain when she is walking and denies any numbness. She underwent CT of the lumbar spine that showed a changed position of the anterior lumbar plate with the superior portion of it being slightly displaced anteriorly with the cages being in an adequate position within the disc space. **Plan:** Discussed the possibility of reinforcing her construct with a posterior lumbar instrumentation with pedicle screws and rods versus continuation of the observant conservative treatment at this point.

12/14/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up. She continues to have fairly substantial relief of her lower back pain compared to the preoperative state. **X-rays:** Unchanged position of the instrumentation and interbody cages. **Plan:** Initiate PT. Follow up around May of 2011.

2011

01/05/11 **Rosemary Liu, PT – MattSmith Physical Therapy – Dx:** Spine lumbago. **History of Injury:** Patient complains of neck and back pain which started 03/13/09 when she was involved in a car accident (ear-ended). Patient is status post two lumbar surgeries and two neck surgeries and still has pain and weakness in her lumbar spine and lower extremities. **Pain Score:** 7/10. **ROM:** Lumbar extension 5, flexion 35, left rotation 25,

right rotation 25, left side bending 20, right side bending 20 degrees. **Treatment Plan:** AAROM, AROM, client education, HEP, joint mobilization techniques, manual ROM, manual therapy techniques, neuromuscular re-education, postural stabilization training, neutral principle training, proprioceptive/closed kinetic chain activities, soft tissue mobilization techniques, stretching/flexibility activities, therapeutic activities, therapeutic exercises, aerobic conditioning, cryotherapy, functional stimulation, interferential stimulation, moist hot packs and TENS. Patient treated: 01/05/11, 01/07/11, 01/10/11, 01/11/11, 01/13/11, 01/20/11, 01/24/11, 01/27/11, and 01/31/11. **(9 visits).**

01/14/11 **Yevgeniy Khavkin, M.D. – Nevada Spine Clinic** – Ms Seastrand has been treated for significant lumbar disc pathology at L4-5 and L5-S1. She has undergone anterior interbody fusion and reconstruction across these levels and has overall appreciated significant improvement from her preoperative condition. Over the course of follow up I have identified evidence of some withdrawal of the anterior lumbar plate that has been used intraoperatively for fixation across the L4-5 and L5-S1 levels. Such an operative undertaking is indicated in an effort to provide greater structural support and to enhance the likelihood of a long term successful outcome as it relates to the interbody fusion and reconstruction at L4-5 and L5-S1.

01/20/11 **Leo P. Langlois, M.D.** – Patient is a 49-year-old female who presents with complains of lower back pain in the midline, aggravated by standing, sitting, walking, exercise, movement, partially relieved with rest/relaxation, oral pain meds. **Pain Score:** 5/10. **Assessment:** 1) Postlaminectomy lumbar. 2) Postlaminectomy cervical. 3) Degenerative disc disease. 4) Neuralgia, neuritis, radiculitis. 5) HNP/disc protrusion, extrusion. **Plan:** Start Flector Patch. Continue to receive meds from prescribing practitioner. Continue PT.

02/10/11 **Wendy Goken, Legal Coordinator – Nevada Spine Clinic** – Patient is a candidate for surgical treatment in the form of a posterior lumbar fusion stabilization and reconstruction L4-S1. The estimated costs are: Surgeon's fees - $22,000; Asst. Surgeon's Fees $6,000; Anesthesia fee: $4,200; Hospitalization fee center equipment fees $84,000; postoperative rehab and medical management $6,000.

06/02/11 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic** – Patient returns in follow up. **X-rays:** Appear stable. **Plan:** We will evaluate the condition of her lumbar fusion.

11/02/11 **James A. Cooper, M.D. – Las Vegas Radiology – CT Lumbar Spine Without Contrast – Findings:** T12 to L5: Status post L4-S1 anterior lumbar interbody fusion (ALIF). The alignment is anatomic. The

interbody space graft at L4-5 is displaced forward by approximately 12 mm. This result in displacement of the anterior fusion plate as well. However, there is still solid osseous incorporation across this fusion construct. Similar findings are present at L5-S1, with anterior displacement by approximately 5 mm. This fusion is at most only minimally incorporated. T12/L1: 1.4 mm posterocentral and right paracentral protrusion. AP dimension of central canal measures 16.3 mm. L1/L2: AP dimension of central canal measures 16 mm. L2/L3: 1.5 mm disc bulge. AP dimension of central canal measures 15 mm. L3/4: AP dimension of central canal measures 13.7 mm. L4-5: Disc: ALIF. Central canal: 10.5 mm central canal stenosis due to 4 mm diffuse disc bulge. Right neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: ALIF 3 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) L4-S1 ALIF with solid osseous incorporation at L4-5. 2) L4/5: 10.5 mm central canal stenosis due to 4 mm diffuse disc bulge. Mild to moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge. There is mild bilateral neural foraminal stenosis. No significant interval change since prior study.

11/17/11 **Yevgeniy Khavkin, M.D. – Nevada Spine Clinic** – Patient presents in follow up after L4-5, L5-S1 anterior lumbar interbody fusion, which was performed in May of 2010. She reports significant improvement in her symptoms. She denies having any back pain other than when she is occasionally bending forward forcefully. Her incision appears to be well healed. **Plan:** She has made a wonderful recovery after the surgery and will continue with the current management.

Diagnostic Imaging Records Prior to DOL of 03/13/09

2008

10/27/08 **S. Robert Hurtwitz, M.D. – Michael A. Baron, M.D. – X-ray: Chest – Impression:** 1) Normal examination. **X-ray: Cervical Spine – Impression:** 1) Mild rightward flexion of spine compatible with muscle spasm. 2) Spondylolytic changes of mild degree at C5-6.

Diagnostic Imaging Records Following DOL of 03/13/09

2009

03/13/09 **David P. Groczyca, M.D. – MountainView Hospital – X-ray: Cervical Spine Five Views – Impression:** Negative study.

03/13/09 **Lindsey C. Blake, M.D. – MountainView Hospital – CT Brain Without IV Contrast – Impression:** 1) Negative brain. 2) No significant change.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Cervical Spine Without – Findings:** There is straightening of the cervical lordosis. Vertebral body heights are well preserved. Marrow signal intensity throughout the cervical region is normal, except for subtle findings related to chronic degenerative disc disease at C5-6 in the endplates. The foramen magnum and craniovertebral junction are normal. The C1-2 joint is normal. The C2-3, C3-4, and C4-5 discs are normal. The C5-6 disc space narrowing and endplate signal intensity changes are seen, consistent with chronic degenerative disc disease. There is also posterior protruding disc and osteophyte in the midline with indentation on the ventral thecal sac. This is a broad-based indentation and there is some mild bilateral foraminal encroachment. The C6-7, C7-T1 and T1-2 discs are normal. The cervical cord is normal in caliber and signal intensity. **Impression:** 1) Moderate chronic disc degenerative changes at C5-6 with posterior protruding disc osteophyte complex and broad indentation on the ventral thecal sac. Associated mild bilateral neural foraminal narrowing. 2) Straightening of the cervical lordosis.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Lumbar Spine Without – Impression:** 1) Evidence for lumbar strain. 2) Posterior annular tears at L4-5 and L5-S1 intervertebral discs. 3) Bilateral posterolateral disc bulges at L4-5. 4) Central disc protrusion at L5-S1. 5) Posterior facet joint arthropathy L3-4 through L5-S1 bilaterally, with left posterior facet joint synovitis at L4-5. 6) Moderate bilateral neural foraminal narrowing at L4-5. 7) No significant central spinal canal stenosis in the lumbar spine.

10/13/09 **Sonny A. Patidar, M.D. – Las Vegas Radiology – MRI of the Lumbar Spine Without Contrast – Findings:** There is straightening of the lumbar lordosis. Mild disc desiccation is noted at L4-5 and L5-S1. The vertebral body heights are maintained. The conus medullaris ends at L1-2. T12-L1: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L1-2: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L2-3: No significant disc bulge or protrusion. The neural foramin

are patent, and the exiting nerve roots are normal. L3-4: There is a minimal 1 to 2 mm disc protrusion that abuts the thecal sac. The neural foramina are patent, and the exiting nerve roots are normal. L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing. **Impression:** 1) L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. 2) L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing.

12/10/09 **Russell J. Shah, M.D. – Upper Extremity EMG/NCV Study – Impression:** Subacute C6 radiculopathy with minimal active denervating potentials. Please note the patient did have a steroid treatment in the neck area and active axonal denervating potentials may not be as reflective given the indicated therapeutic intervention.

2010

01/07/10 **Russell J. Shah, M.D. – Lower Extremity EMG/NCV Study – Impression:** Mild subacute bilateral L5 radiculopathies.

01/22/10 **Rajashree Vyas, M.D. – Summerlin Hospital Medical Center – X-ray: Chest Two Views – Impression:** Normal chest.

04/14/10 **Leo P. Langlois, M.D. – EMG/NCV Studies – Impression:** Normal electrodiagnostic study. No electrodiagnostic evidence of right or left lower extremity radiculopathy or myopathy was noted.

05/07/10 **Kelly R. Gardner, M.D. – X-ray: Chest Two Views – Impression:** No acute cardiopulmonary disease.

06/08/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic - X-rays:** Show unchanged position of the plate with the top of the plate slightly displaced ventrally, but with no change since the previous imaging.

09/23/10 **Lawrence Bogle, M.D. – Las Vegas Radiology – CT Lumbar Spine Unenhanced With CT Reconstructions – Findings:** Spinal alignment: Normal lordosis, no significant listhesis. Paraspinal soft tissue: Normal. T12 to L5: Normal height without compression fracture. Anterior fixation at L4, L5 and S1 vertebral bodies are noted. T12/L1: AP dimension of central canal measures 15 mm. L1/L2: AP dimension of central canal measures 15 mm. L2/L3: AP dimension of central canal measures 15.2 mm. L3/L4: Disc: 2 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 13.7 mm. Right neural foramen: Mild stenosis

due to disc bulge. Left neural foramen: Mild stenosis due to disc bulge. L4/L5: Disc: Postoperative changes are noted in anterior portion of disc. Central canal: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. Right neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: Postoperative changes are noted in anterior portion of disc. 3 mm diffuse disc bulge.. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) Interval anterior fixation of L4, L5 and S1 vertebral bodies, postoperative changes at L4-5 and L5-S1 intervertebral discs. 2) L3/L4: 2 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis. 3. L4/L5: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There is moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis.

09/23/10 **Laurie Seltzer, D.O. – Las Vegas Radiology – Bilateral Screening Mammography – Impression:** Bilateral mammography reveals no evidence of malignant change. Recommend annual screening. Bi-Rads 2, benign.

12/14/10 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic – X-rays:** Unchanged position of the instrumentation and interbody cages.

2011

06/02/11 **Yevgeniy A. Khavkin, M.D. – Nevada Spine Clinic – X-rays:** Appear stable.

11/02/11 **James A. Cooper, M.D. – Las Vegas Radiology – CT Lumbar Spine Without Contrast – Findings:** T12 to L5: Status post L4-S1 anterior lumbar interbody fusion (ALIF). The alignment is anatomic. The interbody space graft at L4-5 is displaced forward by approximately 12 mm. This result in displacement of the anterior fusion plate as well. However, there is still solid osseous incorporation across this fusion construct. Similar findings are present at L5-S1, with anterior displacement by approximately 5 mm. This fusion is at most only minimally incorporated. T12/L1: 1.4 mm posterocentral and right paracentral protrusion. AP dimension of central canal measures 16.3 mm. L1/L2: AP dimension of central canal measures 16 mm. L2/L3: 1.5 mm disc bulge. AP dimension of central canal measures 15 mm. L3/4: AP dimension of central canal measures 13.7 mm. L4-5: Disc: ALIF. Central canal: 10.5 mm central canal stenosis due to 4 mm diffuse disc bulge. Right neural foramen: Mild to moderate stenosis due to disc bulge and

facet joint arthrosis. Left neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: ALIF 3 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild to moderate stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) L4-S1 ALIF with solid osseous incorporation at L4-5. 2) L4/5: 10.5 mm central canal stenosis due to 4 mm diffuse disc bulge. Mild to moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge. There is mild bilateral neural foraminal stenosis. No significant interval change since prior study.

EXHIBIT 8

www.controlpain.com
JOSEPH J. SCHIFINI, M.D., LTD
Diplomate of the American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

April 3, 2013

Steven T. Jaffe, Esq.
Hall Jaffe & Clayton, LLP
7455 West Washington Avenue, Suite 460
Las Vegas, Nevada 89128

RE: Khoury adv. Seastrand
Claimant: Margaret Seastrand
DOL: March 13, 2009

Dear Mr. Jaffe:

This letter will serve to summarize my opinions/conclusions following my review of additional medical records in reference to Ms. Seastrand. You have provided me with additional records with an accompanying letter dated March 27, 2013. You have asked me to review these records as a medical expert and provide additional opinions, if necessary, following my review. I have also had the opportunity to review my previously authored reports in this matter from August 25, 2012, October 15, 2012, and February 25, 2013. I saw no need to update my more formal record review. Below, you will find a listing of the category of records reviewed in preparation of this document.

1. Deposition of Jeffrey D. Gross, M.D., taken March 18, 2013

After having the opportunity to review my previously authored reports in this matter as well as the recent deposition testimony provided by Dr. Jeffrey Gross, I have had no significant changes to my previously held opinions. During his deposition testimony, Dr. Gross admitted that modifications to his life care plan regarding Ms. Seastrand were necessary and that significant reductions in potential charges should be instituted.

600 S. Tonopah Drive, Suite #240, Las Vegas, NV 89106 ▫ (702) 870-0011 ▫ Fax (702) 870-1144

Dr. Gross admitted that he was reliant on patient history from his August 28, 2012 evaluation to determine the level of prior complaints to Ms. Seastrand. Dr. Gross's main source of information regarding the level of discomfort from Ms. Seastrand is obtained directly from the patient, which may or may not be consistent with her true presentation prior to the March 13, 2009 date of loss. Dr. Gross should have noted that Ms. Seastrand did undergo a cervical x-ray on October 27, 2008 for complaints of discomfort in this area, which showed spondylolytic changes of mild degree at C5-6, which indicates that she actually did have complaints of pain before the accident; which were likely more than the "occasional stiff neck" described to him on August 28, 2012. Lack of documentation of prior complaints, symptoms, diagnostic testing, and/or treatment does not necessarily equate to the absence of complaints, symptoms, diagnostic testing, or treatment. This simple concept seems to have escaped Dr. Gross during his analysis. As stated above, I have had no other changes to my previously expressed opinions in this matter.

I, Joseph J. Schifini, M.D., do hereby affirm that I am a physician licensed to practice the full scope of medicine and surgery in Nevada and California; that I have an unrestricted license to prescribe every class of medication issued by the FDA; that I am Board Certified by the American Board of Anesthesiology and the American Board of Pain Medicine, and that I am a Diplomate of the American Academy of Pain Management.

I do further affirm that my opinions are derived from a review of the records provided and based on multiple factors including my experience in addition to my knowledge and familiarity with current evidence based medicine. The opinions/conclusions presented above are based on the records reviewed and/or performance of a history and physical examination, and may or may not be supplemented or changed upon presentation of additional materials not presently available for review. The opinions above were derived only after reviewing the entirety of the records submitted and/or examining the patient. No assumptions of validity or invalidity were made prior to an actual review of the materials provided.

Unless noted otherwise, all presented opinions are rendered to a reasonable degree of medical probability on a more likely than not basis. The derived opinions expressed herein are the author's alone and have not been modified or skewed on the basis of any prejudice, financial consideration, or secondary influence other than an analysis of the available data, including provided medical records, photographs, radiographs, video surveillance, history and physical examination, etc. The opinions stated above would remain the same based upon the evidence provided regardless of the parties involved or the agent or agency requesting this review and/or examination.

If further clarification of these opinions is necessary, please do not hesitate to contact me.

Sincerely,

JOSEPH J. SCHIFINI, M.D. JJS/bjs

c: 0403-640

EXHIBIT 9

DISTRICT COURT
CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY; DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

Case No. A-11-636515-C

VIDEOTAPED DEPOSITION OF OFFICER TODD CONN
Taken on Monday, July 30, 2012
At 9:10 o'clock a.m.
At 7455 West Washington Avenue, Suite 460
Las Vegas, Nevada 89128

Reported by: Ann Salisbury, RPR, CCR 185

APPEARANCES:

For the Plaintiff: ALISON BRASIER, ESQ.
RICHARD HARRIS, ESQ.
Richard Harris Law Firm
801 South Fourth Street
Las Vegas, Nevada 89101
(702)444-4444

For Defendant Raymond Riad Khoury: JACOB S. SMITH, ESQ.
Hall Jaffe & Clayton, LLP
7455 West Washington Avenue
Suite 460
Las Vegas, Nevada 89128
(702)316-4111

The Videographer: TOM BURTNEY
Certified Legal Videography
(702)873-2029

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EXHIBITS

(Original exhibits attached to original transcript.)

THE VIDEOGRAPHER: This begins the videotaped deposition of Todd Conn. Today's date is July 30, 2012, and the time is 9:10 a.m. This deposition is taking place at the law offices of Hall Jaffe & Clayton, 7455 West Washington Avenue, Suite 460, in Las Vegas, Nevada. This case is in the District Court, Clark County, Nevada, entitled Margaret G. Seastrand versus Raymond Riad Khoury, et al., Case No. A-11-636515-C.

I am Tom Burtney with Certified Legal Videography, and the court reporter is Ann Salisbury with Manning, Hall & Salisbury.

Will counsel please identify yourselves and then the reporter will administer the oath.

MR. SMITH: Jacob Smith for the defendant.

MS. BRASIER: Alison Brasier for the plaintiff.

MR. HARRIS: Richard Harris for the plaintiff.

Thereupon–

TODD CONN

was called as a witness by Defendant Raymond Riad Khoury, and having been first duly sworn, testified as follows.

. . .

. . .

DIRECT EXAMINATION

BY MR. SMITH:

Q. All right. Officer, my name is Jacob Smith. Well, first of all, let me just have you state and spell your name for the record.

A. My name is Todd, T-o-d-d, Conn, C-o-n-n.

Q. Okay. And, Mr. Conn, would you prefer that I call you Officer, Mr. Conn, Todd?

A. You can call me Todd, that's fine.

Q. All right. Todd, and you can call me Jake. And I'm sure we can be casual here with Alison and Richard as well.

Have you ever had your deposition taken before?

A. Yes, I have.

Q. Approximately how many times?

A. I believe three times.

Q. Okay. And was that – were those three instances also dealing with your duties as an officer?

A. All of them were, yes.

Q. Okay. So outside of your duties as an officer, you've never had your deposition taken?

A. No, I have not.

Q. Okay. What is your work address, Todd?

A. 400 South Martin Luther King, Las Vegas,

Nevada, 89106.
Q. And what is the best number to contact you on?
A. (702) 499-4277.
Q. And is that --
A. That's my cell phone.
Q. That's your cell, okay.
Now, when was the last time you had your deposition taken?
A. Approximately six months ago I had a deposition.
Q. Okay. So you're fairly familiar with the process?
A. Yes.
Q. I'm going to run down just some ground rules that you're probably already aware of, but I just want to make sure that we have the -- we have them on the record and that you understand exactly, you know, what we're trying to do here today.
Obviously this is a deposition, and the oath that the court reporter just gave to you holds -- holds with it the same penalties of perjury as if it were offered in a court of law. So, you know, that means that even though we're not here in a formal setting, we're here informally today, we're seeking your best and, you know, truthful responses to any questions that

we ask, okay?
Obviously we do have the video here today, but at the same time the -- the written record is primarily what we'll use in the future as this case proceeds forward. So I'll ask that you give any responses verbally so that we have that on the written record.
Throughout the course of the deposition, you may give a nod of the head or a shake of the head, and I may follow that up and just by saying, "Is that a yes or is that a no," just to make sure we have an audible response on the record, okay?
A. Okay.
Q. If at any time during this deposition I ask a question that you don't understand or that you're not certain about, ask me to clarify. If -- if you answer a question, I'm going to presume that you understood it, okay?
A. Okay.
Q. If I ask -- and it's certain to happen. I'm going to ask a question that's confusing. If it's confusing and you don't know how to respond or you don't know exactly what I'm saying, make -- make sure that I clarify the question.
Now, we're here to discuss an accident that happened over three years ago. So I understand that,

you know, you, as an officer, see, you know, dozens of traffic accidents on a regular basis and, you know, you may not recall exactly specific events. I'm going to ask you for your best recollection, and if you can't remember, you know, then that's a perfectly acceptable response, okay?
A. Okay.
Q. Now, I'll use the Traffic Accident Report and some other documents to attempt to refresh your recollection, but I don't want you to remember anything that you can't actually remember; does that make sense?
A. Absolutely.
Q. Throughout the course of the deposition, there may be some objections lodged. What I'll ask you to do is if somebody lodges an objection, counsel or myself offers an objection, just wait till the objection is lodged and then you can respond to the question. If the objection distracts you and you can't remember the question, we can just ask the court reporter to read back the question, okay?
A. Okay.
Q. Now, once the deposition's concluded, you'll have an opportunity to review the deposition and make any changes. I would just caution you that any changes that are substantive in nature, you know, may -- may

weigh on your credibility at a later date. In other words, if, for example, we -- your testimony today was that the light was red and then you later scratch that out and change it to green, that's a substantive change that would allow us to comment on -- on your credibility at a later point. However, if you're just correcting a misspelling or a name or something, you know, minor like that, then that's certainly not a big deal. You'll have the opportunity to review your deposition transcript and -- and make any of those changes once the deposition is completed. Do you understand?
A. I understand.
Q. Now, have you had any drugs or alcohol in the last 24 hours that would affect your ability to respond?
A. No, I have not.
Q. Now, did you speak with anyone in preparation for your deposition today?
A. No, I have not.
Q. Did you meet with anyone in preparation for your deposition?
A. No, I have not.
Q. And did you review any documents in preparation for your deposition today?
A. I did look at my accident report prior to coming here.

Q. Okay. And now I know that the subpoena that we served was a subpoena duces tecum that listed documents. I notice that you didn't have any documents here with you today. Was –

A. Department policy. I cannot disseminate information. And so therefore I don't bring any documents with me because they could be called into the court. And because I cannot disseminate that information without prior approval from the department, I do not bring any.

Q. Okay. So it's your testimony that the reason you didn't any bring documents in response to the subpoena is pursuant to a department policy?

A. Correct.

MR. SMITH: Okay. What I'm going to do today, then, is – I have a copy of the Traffic Accident Report from this incident. And I'll give you a copy of that, Counsel, as well, and we'll mark that as Exhibit A.

(Plaintiff's Exhibit A marked for identification.)

MR. SMITH: And we may go through and -- and review some of the information in that. We don't necessarily need to get to it right now.

I also have a civil subpoena, a copy of the subpoena duces tecum that I'd like to mark as Exhibit B.

(Defendant's Exhibit B marked for identification.)

Q. (BY MR. SMITH) Take a look at that Exhibit B, if you wouldn't mind, the subpoena. Is that similar to the subpoena that was served on you?

A. Yes, sir, it is.

Q. Okay. Talk to me a little bit about your background and training as a police officer.

Well, just to begin with, what is your official position?

A. Currently my official position is a Police Officer II assigned to the airport.

Q. And how long have you been in that capacity as a Police Officer II at the airport?

A. Approximately four weeks.

Q. Okay. So prior to being a Police Officer II at the airport, what was your position?

A. I was assigned to the Las Vegas Metropolitan Police Department's Traffic Bureau as an accident investigator.

Q. And how long were you an accident investigator with the Traffic Bureau?

A. Approximately four years.

Q. So that was a position you held when this accident occurred back in March of 2009?

A. Correct.

Q. What – well, let's – let's go briefly through your educational history. Did you graduate from high school?

A. Yes, I did.

Q. What year did you graduate?

A. 1995.

Q. And from where?

A. Green Valley High School.

Q. And after high school did you – did you attend any college?

A. I attended UNLV and Clark County Community College of Southern Nevada.

Q. Okay. And did you receive any degrees from either of those schools?

A. No, I did not.

Q. Approximately how -- how much education or, you know, how many years –

A. I attended college for approximately three and a half years.

Q. Okay. And when did you go to the police academy?

A. On September 17th, 2003.

Q. And how long is the police academy?

A. It actually varies on years, not always

consistent. I believe that for mine it was a 23-week academy. But it's been anywhere as low as 18 to as high as almost 26 depending on what they decide is curriculum.

Q. Okay. And what kind of training do you receive in the academy?

A. You receive basic law, which includes city/county ordinances, along with the Nevada Revised Statute. You're also going to be trained in self-defense, marksmanship. Those are your basic primary studies that are required for post certification obviously. There's – on top of that you're going to have -- I'm trying to think of some other good classes they give you there. Along with your general law, I mean you have specific courses on DUIs, felony arrests, misdemeanor arrest. Those are all part of the curriculum. Diversity training. There's quite a few.

Q. Okay. So after you graduated from the police academy – and you said it was 23 long -- or 23 weeks long, so you graduated sometime in early 2004?

A. Correct, February.

Q. February of 2004.

Have you received any other specific training for your job since graduating from the academy?

A. Thousands upon thousands of hours specifically

of being a police officer.
Q. And maybe to narrow it down a little bit, what -- you testified that you were an accident investigator. What training specifically did you receive for your position as an accident investigator?
A. Once upon being promoted to the Traffic Bureau, you attend a training course, which includes riding skills. Along with those riding skills are traffic investigation, basic traffic investigation, which is your primary learning for accidents when you get to Traffic. On top of those, though, you can become radar certified, which I was already radar certified upon getting there. You can become -- take HGN, allow you to investigate DUIs, utilizing HGN as your skills along with other determining factors.
Q. And what does HGN stand for?
A. Horizontal gaze nystagmus. It's a technique used to determine whether somebody is impaired due to the small movements of the muscles in the eye.
But I also took advanced accident investigation while I was there. Only course I didn't take prior was vehicle dynamics.
Q. Okay. And as part of the advanced accident investigation, what types of -- I mean what types of training or education do you receive in that

certification?
A. Basically we're looking more into roadway evidence, the types of ways that vehicles move during a collision based upon their center of gravity. So rotational forces, seeing where the impact can direct a vehicle so that when an officer shows up we're able to actually basically reverse all the steps to determine how we got from A to Z. So we're going to be looking at tread depths, things of that nature, sitting in the car pumping the brakes, ensuring that the brakes feel like they have a resistance to them, they don't automatically drop to the floorboard. We're also going to look at the types of damage actually on the intrusion portions to the vehicle because that's going to give us a little bit on where center of gravity caused that vehicle to rotate, et cetera. Looking at seatbelts, air bags, that's a little bit more on the advanced end of -- of your training.
Q. Okay. Is it safe to classify that advanced training as kind of accident reconstruction training?
A. It's not reconstruction because you have to have vehicle dynamics in order to be able to do accident reconstruction. It's -- it's -- vehicle dynamics is much more heavy on the use of physics in order to use mathematical calculations to determine very true

estimates of speed and -- and rotational force, et cetera.
Q. And the vehicle dynamics training, that's the one that you said that you didn't receive?
A. I did not take. That's what you would need prior to becoming a fatal detective.
Q. Fair enough.
Have you ever testified in court?
A. Yes, I have.
Q. Approximately how many times? Let me -- let me strike that. Let me -- let me go this way.
Have you ever testified about an accident investigation in court?
A. Only in a deposition, not actually in a courtroom.
Q. Okay. So your testimony in court, was that related to criminal -- criminal investigations?
A. It would be DUIs mostly as a result of accidents, but the accident isn't the primary portion of my being there.
Q. Fair enough.
When was the last time you testified in court? Approximately.
A. Approximately three to four months ago.
Q. And how many times have you testified in

court?
A. Not a hundred but, you know, more than 50.
Q. Fair enough.
So fair -- fair to say that you've seen the inside of a courtroom a number of times?
A. Yes, I have.
Q. All right. I want to talk a little bit about the accident that we're here to discuss today. As I explained initially, I represent Raymond Khoury who is a defendant in a lawsuit that's been brought by Margaret Seastrand. The subject of that lawsuit is the accident that happened on March 13th, 2009.
Now, you mentioned that you reviewed the accident reconstruction report before you -- before your deposition, correct?
A. Correct.
Q. When did you review that?
A. I reviewed that last night.
Q. Okay. Did that -- as you read through that -- well, let me just ask you, do you -- do you remember anything specific about this accident itself? Do you remember appearing at the scene?
A. Yes, I do.
Q. Okay. What did you do when you first arrived at the scene?

A. When I first arrived at the scene, the first thing I do is view both vehicles just from an outside perspective so I have a general idea of the location where I'm at. I look at my streets, look at the exact location, place where vehicles are facing.

At that time I then immediately walk up to the first driver that I come in contact with, which tends normally to be the one closest to me. I ask them if they're okay, if they need medical assistance. Depending on what their response is depends on where I go from there. If this vehicle -- the first vehicle I come into contact with says that I need medical attention, I'm going to advise dispatch to send me an ambulance and get that going. If they tell me that they're fine, I ask them to do me a favor and prep their paperwork for me, get their driver's license, insurance and registration ready so that I can take a report for them.

I then move on to the next vehicle, ask them the same question, whether or not they're okay, do they need medical attention. And depending upon their response, I take the appropriate action.

Q. Okay. And so it sounds like you kind of just explained your normal procedure --

A. Correct.

Q. -- in approaching an accident, correct?

A. Correct.

Q. Do you specifically remember, when you arrived at that scene on March 13th, 2009, who you spoke with first?

A. I spoke with Mr. Khoury first. Officer Bob Holland spoke with Mrs. Seastrand first.

Q. Okay. Do you remember where you were when the call came in to appear at that accident?

A. No, I do not.

Q. Okay. And do you know -- explain to me the process of -- of having two officers there. Do you know --

A. At that time Officer Bob Holland, who was a fatal detective prior to becoming a -- just an accident investigator at that time, he was actually training me in accident investigation, so I was riding with him basically kind of in what we call a solo beat status. So I was the primary investigator. I was doing the investigation. Bob was basically overseeing and writing down on a report how my performances were at that time.

Q. Okay. So you were the primary investigating officer --

A. Correct.

Q. -- is that safe to say?

A. Yes.

Q. But you mentioned that you spoke with Mr. Khoury and at the same time Officer --

A. Bob went to go speak to Mrs. Seastrand first.

Q. Do you remember what -- do you remember the substance of your discussion with Mr. Khoury?

A. Basically it started out just how -- whether or not he was injured or not and then to get the paperwork ready. As soon as that left, I went up to go see Bob and Mrs. Seastrand. I didn't continue the investigation questions until I knew -- Bob advised me that she had complaints of injury and we were going to request medical.

Q. Okay. So did Mr. Khoury complain of any injuries?

A. No, he did not.

Q. And at that point then, you know, of him not complaining of any injuries, you moved on to discuss the situation with Ms. Seastrand?

A. Correct. I didn't actually ask her the -- the details right then and there. I knew that she was going to go by ambulance so I did end up questioning her first, okay, because she's probably going to be put in an ambulance, taken away. I want to get my story out of her as -- as quickly as I can. So my first primary

investigative questions were to Mrs. Seastrand.

Q. Okay. Then let's -- let's kind of try and walk through it chronologically. You mention that you talked with Mr. Khoury. You confirmed that he wasn't injured. And then you moved over, confirmed that Ms. Seastrand was injured, but at that point that's not when you did your investigation or your questioning of her. You --

A. I end up asking where her paperwork is. I grab it for her. I'm trying to find out questions that I need her specifically there on scene for. So I gather her paperwork together, her driver's license. I then ask for things like phone numbers immediately, whether or not she was wearing her seatbelt when she was involved in the collision. I try to get some of the primary stuff that I know I'm going to need for the accident report.

So at that time, after I get that basic information, then I ask her, Okay, in your own words, tell me what happened. She states that she was stopped eastbound Craig, right of three travel lanes, approaching Rancho. While she's stopped there, she's looking left, to her left, okay, watching for her southbound traffic to see if it's safe to make a turning movement. That's when she feels an impact onto the back

of her vehicle. That's the extent of it.

So I ask her if she has any injuries. She tells me yes, she does. She has neck and back pain but that it was aggravated due to a prior injury that she received years ago.

Q. Did she offer any specifics as to what type of – as to how she sustained the prior injury?

A. No, she did not.

Q. Is there anything else you remember from your conversation with Ms. Seastrand?

A. I remember asking her whether or not her vehicle was moved. She couldn't remember. I immediately turned to look. There was no roadway evidence. This wasn't a vehicle accident in which broken pieces of plastic or tire marks were left on scene. There was none of that roadway evidence to be left to give me an exact area of initial contact.

So when you look in my report, you'll see that there's an estimation of approximately 23 feet west of, and that is based upon where the vehicles were. But neither driver could tell me whether or not they had moved it after the collision, so we didn't know how many feet either vehicle had moved itself. There was no – no push marks on Mrs. Seastrand's car from the collision where – where Mr. Khoury's vehicle could have pushed

it. And I would have seen drag marks left on the roadway. There was none of that evidence to determine that.

Q. Did either Mister – well, did – did either – either of the parties say that they had moved their vehicle since the accident?

A. No.

Q. But they were just not sure?

A. They weren't sure, correct.

Q. Okay. So after you took the statement from Mrs. Seastrand, then what did you do next?

A. I asked Mr. Khoury his events of the accident. He stated that he was also in the far right of three travel lanes approaching Rancho on Craig, that he was looking left at well – as well to southbound traffic to see if vehicles were approaching. At that time he assumes the roadway's clear and that Mrs. Seastrand is going to make a right-hand turn. So he's rolling forward as he is looking left. He is not looking forward. And that's when his vehicle contacts the rear of Mrs. Seastrand's vehicle.

Q. Did either of the parties give any estimations as to the speed of travel?

A. Mr. Khoury stated that he was looking left. He was – he couldn't give me an exact estimation of

speed but that he was rolling is his recollection at the time, looking left to make his right-hand turn. So not that he was on an approach – for instance, let's say it didn't appear that he was traveling if it was posted – I can't even recall what the speed limit was. It should be in my documentation, but I believe that section of the roadway there is 35. It wasn't as if he was going 35 miles an hour to make a right-hand turn. He had slowed down, knew that Ms. Seastrand was in front of him and was looking left to make a right-hand turn. And just as he had slowed down – he assumes that she's going to make the right-hand turn – he accelerates, and that's when he ended up striking her.

Q. Okay. After – after you gathered Mr. Khoury's statements, then what did you do?

A. Then I go and I looked at both vehicles, okay? I already knew that we had no roadway evidence to speak of for me to determine area of initial contact. But I took a look at the rear bumper –

Q. Let me just stop you right there. When you say "no roadway evidence", are you talking no skid marks?

A. Correct. No tire marks, no – and we'll just leave it as tire marks. So whether that be braking marks or acceleration marks, there was no marks of any

type of that. There's also no pieces of plastic from either vehicle to be laying in the roadway. These are all items that I'm going to use to determine an area of initial contact. Sometimes there's broken glass, oil, fluids, what have you. There's none of that on the roadway.

Q. Okay. So after you spoke with Mr. Khoury, then what?

A. Then I went and looked at the vehicles. Upon looking at the rear of Mrs. Seastrand's car, there was actually a puncture hole caused by a forward tow hook on Mr. Khoury's vehicle. When I went and looked at Mr. Khoury's vehicle to match the damage, I could see that it had minor scrapes to the paint where it punctured itself through and that there was a four-inch crack that's actually housed within – it's got a little housing in which the hook kind of sets recessed. And you could see where on the plastic portion of his bumper there's approximately a four-inch crack.

Q. Did you take any photographs of the damage to the vehicles?

A. No, I did not.

Q. Okay. Once you inspected the damage to the vehicles, then what did you do?

A. And then I completed my – my portion of the

accident investigation on Form 5 and gave both parties copies of their accidents.

Q. Now, did you -- were you able to complete the Form 5 before Ms. Seastrand was taken from the scene?

A. I can't recall whether or not I went down to the hospital to give her the Form 5 or if I gave it to her on scene.

Q. And so would your normal procedure be to, if that's completed, give it -- before they leave the scene, give it to them while they're there?

A. Yes, if I can complete it beforehand, I will give it to them right there and give them their driver's license back. I prefer that they have all their documentation for medical and insurance purposes. And it helps for the ambulance when they have all their paperwork and all the information that they need.

Q. But if you're not able to complete it before it's taken from the scene --

A. I'll meet them at the hospital.

Q. Okay. At what point -- well, strike that.

Was the ambulance called to the scene by you?

A. By Officer Holland.

Q. And at what point throughout this investigation did the ambulance arrive?

A. I don't recall the time.

Q. Do you recall approximately how long the investigation took from the time that you, you know, arrived at the scene until you left the scene?

A. I do not. I could get a close approximation by looking at the time stamp on Mr. Khoury's citation because that's the last part of evidence to -- to go in there. And so that gets a time stamp when I start the citation. It's normally a couple minutes thereafter that we have a close of the investigation. Because I only write the citation at the end of it.

Q. Okay. Is there anything on the Traffic Accident Report itself that indicates the time when the investigation was concluded?

A. There is not, no. Only in CAD records for the police department.

Q. But is -- what -- what on this -- is there something on here that indicates when the investigation commenced or when you arrived at the scene?

A. Yes. There's -- there's an actual time of call on here, there's a time of my en route, and there's also my arrival time on the documentation.

Q. Okay. Will you go ahead and look at that -- we're looking at the Traffic Accident Report that's Exhibit A -- and identify those times for me?

A. Okay. The time of call was 10:27. Let's see

if I can find all my en route and arrival times. Because unfortunately documentation is different than what it is on our -- here we are. Time Notified 10:29 a.m. and time of arrival was 10:38 a.m.

Q. And what is -- what is the Time Notified?

A. Time Notified is the time in which Metro com dispatch contacts me on the radio, advises me that there's a collision, and I tell her that I'll be en route.

Q. Okay. So at 10:27 is when Metro received a call saying that an accident had happened, 10:29 is when you received contact from Metro dispatching you to the scene --

A. Correct.

Q. -- and 10:38 is the time that you arrived at the scene of the accident?

A. Correct.

Q. Fair enough.

Did you take any steps to secure the scene once you got there?

A. This isn't an accident of the nature in which I'm going to take crime scene photos or do a diagram. There was no evidence at the time to lead to believe that it needed to be treated as a substantial injury or as a fatal scene. So our standard procedure is to just

document by measuring, okay, in which I'll take out my measuring wheel and measure AIC, distance traveled afterwards. But there was no evidence of that nature in order for me to even document. So I made a rough estimation based upon where the vehicles were at the scene to come up with approximately 23 feet west of the intersection there as -- as my approximate area of which the accident occurred.

Q. And do you remember what information you used to base that estimation on?

A. Basically from both Mr. Khoury's statements and Mrs. Seastrand's statements about where the accident occurred at and where they were in relationship to the intersection.

Q. Now, did the vehicles remain in the intersection while you filled out the traffic report or at some point were they moved out of the intersection?

A. They weren't actually moved out of the intersection or taken onto private property. They were left in the roadway.

Q. And were any steps taken to, like, direct traffic around the vehicles or anything like that?

A. Other than my motor's lights to show that there was an accident, no.

Q. Are you aware, is there a 911 tape of the call

to Metro?
A. I do not know if there is. I would assume so since there was a call reporting a time of collision. It wasn't something that we rolled up on, so there should be an audio of somebody making some sort of call reporting an accident.
Q. But that's not something you ever listen to?
A. Never.
Q. Is that something that you would normally listen to?
A. Never.
Q. Okay. Do you remember any details about -- and I know I kind of already asked this, but I want to just make sure -- where you were when you got the call or which direction you approached the intersection from?
A. I know that I approached from – from west to east. I can't recall where we were at. I want to say Starbucks because that was Bob's favorite place, but I can't say for certain.
Q. So you approached from west to east, eastbound on Craig then?
A. Correct.
Q. Throughout the course of the investigation, did you have any conversations with Bob, the other officer that was there, about the accident itself?

A. Yes, I did.
Q. And what was the nature of those conversations? What was discussed?
A. Bob would ask me, What do you see as far as is there any roadway evidence, you know, where do you think the accident took place? He was basically my – my mentor at the time, and so he would provide insights to me and be like, Okay, well, do you see tire marks? No, I don't. Okay, well, I don't see any either. Well, but know if you look in the light sometimes and take a different perspective and walk on the other side of the vehicle, you may be able to see those. Those types of conversations were had between me and Officer Holland during -- -
Q. So kind of a mentor training –
A. Correct.
Q. – questioning conversation?
A. Yes. He had multiple years as a fatal investigator, and he tried to give me some of those insights that he learned in being a fatal officer and tips on what to look for on scenes.
Q. Did you and Officer -- what's his last name?
A. Holland –
Q. Holland?
A. – H-o-l-l-a-n-d.

Q. Did you and Officer Holland have any conversations about the -- the statements given by either of the parties?
A. Yes.
Q. And what specifically did you discuss?
A. Bob actually advised me that when Mrs. Seastrand advised that she had prior injuries, that that is something that I should document into my report because it could be called upon later. And that's why it was actually written into my Narrative.
Q. Okay. Anything else?
A. I believe that's it.
Q. Were there any attempts made to determine Mr. Khoury's speed at the time of impact?
A. There's no roadway evidence. I couldn't do a slide-to-stop measurement. So there was nothing for me. I cannot do a crush damage even though there was very little to have to begin with. You can – can – if you have a general idea of the vehicles' weights and momentum and the amount of intrusion into a vehicle, it can be determined that way. But that is only performed by Fatal Details. We do not do that.
Q. And when you say that's only performed by Fatal Details, that's only something that you would get into if there was a fatality in the accident?

A. Or a – or an injury of substantial nature in which somebody -- you know, severed limb, brain injuries, spinal cord going to be severed, you're going to be a paraplegic, very serious injuries.
Q. So at some point a determination was made that this accident was not severe enough to merit that investigation?
A. Correct. This is what we call a claimed-injury-only accident.
Q. Just to humor me for a bit just because I want to make sure that I understand, you know, what factors are considered when – when the investigation takes place. If -- if it had been determined that a more in-depth investigation was needed, even in the absence of the, you know, roadway evidence as you stated, was that the type of investigation that you could have performed, or would somebody else have been called out to perform that?
A. No, once we determine it's a serious accident, like where we have a substantial – not serious but substantial injury, we would actually close down the roadways, I would contact Fatal Detail to respond out to the scene, our ID technicians come out, and then the accident investigation is actually handed over to the Fatal Detail. It's not an investigation which I would

do. I would assist them in documenting by completing a diagram and providing my statements onto the information that I received prior to their arrival. But that's about it.

Q. Okay. And what -- what training do you receive or what information do you use to determine whether it's a substantial injury or not?

A. Basically we're going to be looking for blood, open gashes, things of that nature. If the complaint of injury is, I can't move my lower legs, I can know that there's probably some severe spine damage. Just general information. I also go based upon the information provided me -- to me by medical staff that arrive on scene and go, Hey, that's, you know, a lot of injury, they're complaining of chest pain, torn aortas, you know, broken ribs that could have punctured lungs or livers. These are all things that we can see by the amount of force during the initial collision, along with statements of their injuries that they're telling us, and we make an assumption based upon the totality of the circumstances there.

Q. Fair enough.

I want to look a little bit at the description of the accident that's given in the Traffic Accident Report --

A. Okay.

Q. -- and just ask you a few questions about that.

What I'll do is I'll just read a portion of it into the record, and then we can discuss that, if that's all right.

A. Okay.

Q. Or in fact I can have you do that.

Will you read the first sentence of the description?

A. "Seastrand who was the sole occupant of maroon 2002 van was stopped in the far right eastbound lane at Craig approaching Rancho Drive," period.

Q. Okay. Go ahead and read the next sentence as well.

A. "Seastrand states the -- she then felt her vehicle being impacted," period.

Q. Okay. So these two statements, what information -- strike that.

Was there any information, other than your conversation with Ms. Seastrand, that was used to -- to kind of formulate those sentences?

A. No, other than her recollection -- my -- my statements about vehicles, when I mention Ms. Seastrand, will be Mrs. Seastrand's statements to me. When I

mention Mr. Khoury, it'll be Mr. Khoury's statements to me. After I list these two initials -- vehicles, what they're driving, what their direction is, what they saw, then I'll go down later and state, well, Khoury states that he saw this prior to the collision or Mrs. Seastrand states that she saw this prior to the collision. It will always say what the person either saw or stated. I will not include, you know, Mr. Khoury's statements as fact for what Mrs. Seastrand said. I will not mix the two.

Q. Fair enough.

And it's safe to say then that if there were external physical evidence that were -- that was involved in this description, that would be identified specifically as well?

A. Correct. If there had been, let's say for instance, tire marks, I would measure the distance of tire marks that were left on scene and I would include that stating that I was left with, you know, for example, 14 feet of two-wheel tire marks that were 14, you know, feet in length prior to impact, or it could be, you know, pre-impact or I can have post-impact. So it could be a vehicle pushed leaving me 14 feet of tire marks or it could be pre-impact braking marks prior to that. I'm specific on leaving those exact in the

Narratives.

Q. Fair enough.

And there was nothing in that -- of that nature in this instance, correct?

A. Nothing at all.

Q. So the next sentence, then, "Seastrand claimed injury to her neck and back." And, "Las Vegas Fire Department Rescue Unit 9 responded and transported to MountainView Hospital."

The first sentence, "Seastrand claimed injury to her neck and back," that's again a statement made by her?

A. Correct.

Q. And then "Las Vegas Fire Department Rescue Unit 9 responded and transported to MountainView Hospital," that's just -- I mean is that -- I mean is that just based on your observation that they showed up and took her?

A. They showed up. I document the -- the vehicle number that I seen that shows up. It would have been AMR. I'd ask for their unit number. And then I ask them where they're taking her. Because if I do have to drop off paperwork, i.e., the accident report, driver's license, registration, insurance, et cetera, I have to be able to go down there. If I need a medical release

form or anything of that nature, I go down there –
Q. Fair enough.
A. – and fill out that paperwork.
Q. Okay. Will you read the next – next few sentences? And if it gets lengthy, I may stop you and interrupt you.
A. Okay.
Q. But starting with "I then".
A. I then made contact with Khoury who is the sole occupant of a white 2007 Infiniti SUV, period. Khoury states that he was traveling in the far right eastbound lane of Craig approaching Rancho Drive, period. Khoury states that he observed the Honda in front of him and anticipated that it was going to make a southbound right turn at the intersection, period. The Infiniti then moved forward and struck the front of its bumper against the rear bumper of the Honda, period.
Q. Okay. Stopping right there, is all of that statement that you just – that you just read, is all of that based on Mr. Khoury's statements to you?
A. Correct.
Q. And was there any other information relied upon in crafting that –
A. I take his statement as it is. And then if there's anything that contradicts it, I'll put that in

later on. If it matches exactly what was said by both parties, which in this instance it did – both parties' statements were true to what I had left of the vehicles and damage on vehicles, that both their statements seemed to be true – I leave it as is.
Q. Fair enough.
Then starting at the Infiniti – oh, sorry, did we already read that?
A. Let's see here. The Infiniti, that's it. Let's see, moved forward, struck the front of its bumper against the rear of the bumper of the Honda, period. That's where we ended.
Q. All right. Pick up there, then.
A. "Both occupants were properly secured." This means that both of them were wearing seatbelts.
Q. Okay.
A. "And no air bags were deployed on either vehicle." That goes for forward and side impact air bags. They were not deployed.
Let's see. "The rear of the Honda had a small hole in the rear bumper which was caused by a forward tow hook on the Infiniti's front bumper." And I – it's the evidence that I looked at on both vehicles when I actually went and inspected it. You could see the housing in which the tow hook was on the bumper. You

could see this four-inch crack. That's where I documented this information on both vehicles, by looking at it.
Q. Were there any measurements taken as you –
A. No, it's an approximation.
Q. Okay. Let's see –
A. And then the last sentence, it's just – just says the front bumper of the Infiniti had an approximate four-inch crack in the bumper next to the tow hook, period.
Q. Okay. What I'm going to do is – I know that no – no photographs were taken by you at the scene.
A. Correct.
Q. I'm going to introduce to you a few photos.
MR. SMITH: And I apologize – and we'll mark those – what exhibit are we on? D or C?
THE REPORTER: C.
MR. SMITH: We'll mark those as Exhibit C.
(Defendant's Exhibit C marked for identification.)
Q. (BY MR. SMITH) If you would look through those and specifically – generally do those photographs correspond with the damages that are described in the description of the accident on the Traffic Accident Report?

A. Yes, it does.
Q. And seeing – seeing the damage to these vehicles in the photos, does that – is that an accurate representation of what you recollect –
A. Yes, it is.
Q. – from the – the damage that you observed on – at the date of the accident?
A. Yes, it is.
Q. Is there anything in – well, let's look at the first photo, 0001.
A. Okay.
Q. Is there anything in there that looks noticeably different from your recollection of the damage to the vehicle on the date of the incident?
A. No.
Q. Okay. And similarly, on page 004 and 005, the photographs of Mr. Khoury's vehicle – so, yeah, sorry, there's Bates numbers on the bottom of those pages.
A. 04?
Q. Yeah, 004 and 005, same question. Anything noticeably different from the – in the damage reflected in those photographs from your recollection of the incident?
A. No, you can see the four-inch crack that I described along with the housing holding the tow hook.

Q. Fair enough.
Now, I want to take a look at the last two sentences -- or maybe it's just the last sentence of the Narrative/Description. Starting with "Seastrand", would you read that?
A. "Seastrand told officers that she had prior neck and back injuries caused by a previous vehicle accident years before," period. And then it goes on with, "The injuries claimed by Seastrand are not consistent with being caused during this collision."
Q. Looking at that last sentence there, "The injuries claimed by Seastrand are not consistent with being caused during this collision," is that -- what was the basis that you used for including that in the Narrative?
A. She was complaining of severe neck and back injury when she got into the -- into the ambulance, so much so that -- by the minimal amounts of damage caused to both vehicles and no roadway markings whatsoever, I know that Mr. Khoury didn't come in at a high rate of speed, slam on his brakes, and smash into the back of Mrs. Seastrand. That was impossible. Didn't happen. I know that this is a low-speed-impact collision because I don't have bits of vehicles left in my roadway, I don't have any tire marks, I don't show her vehicle being

pushed whatsoever. So it's not as if she had her brakes on and her vehicle was pushed out into the middle of the intersection. It would have left me some sort of roadway marking indicating it.
Because of all those factors and the totality of those factors, I can determine that this was a small-speed collision. And her stating that she was properly secured with a seatbelt, she shouldn't have had any major whiplash, any major spine compressions, anything of that nature, because the speeds were just so slow.
Q. Is there -- strike that.
Were there any witness statements taken as part of the investigation?
A. No, there were not.
Q. Were there any -- were there any witnesses to the accident itself?
A. I don't believe there were any, but I'm not a hundred percent sure. I'd have to look on my witness box. It would be marked if it was on here.
Q. Okay. Do you want to go ahead and take a look through that --
A. I'll take a look.
Q. -- see what you can find?
A. No witnesses.

Q. Okay. And just -- just because you didn't bring your own, is this traffic incident report that we're looking at, is it representative of the copy that you inspected or that you reviewed prior to your deposition?
A. Correct. There's only six pages. All six pages are here.
Q. Were there any differences in the way you inspected or approached the inspection of this accident than you normally would approach an accident inspection?
A. No.
Q. Safe to say that you followed the standard procedure that you would have followed for any accident inspection?
A. Correct.
Q. Is there any pertinent information to the inspection that was not included on the Traffic Accident Report?
A. No.
Q. And you'd agree with me that it's important to include all pertinent information in the accident report so that it can be relied upon at a later time --
A. Yes, sir.
Q. -- or a statement?
MR. SMITH: I don't think I have any more

questions for now.
MS. BRASIER: I have some questions, but can we take a break real quick?
MR. SMITH: Sure.
THE VIDEOGRAPHER: Going off record. The time is 9:59 a.m.
(Recess taken.)
THE VIDEOGRAPHER: Back on the record. The time is 10:09 a.m.
CROSS-EXAMINATION
BY MS. BRASIER:
Q. Officer Conn, my name is Alison Brasier, and off the record I introduced myself. I represent Mrs. Seastrand in this case. I'm going to try to -- try to keep a logical order to my questions.
A. Okay.
Q. But a lot of it's going to be follow-up to what Mr. Smith has already asked you, so bear with me as we kind of jump around and fill in some of the gaps.
At the beginning of the deposition, you -- you indicated to us that you graduated the academy beginning of 2004 and that you began your assignment in the Traffic Bureau in 2008; is that right?
A. Let's see. Correct, in 2008 -- the end of 2008 I was taken on to Traffic.

Q. What assignment did you have from 2004 until you started with Traffic in 2008?

A. I actually had quite a few positions. I was a basic patrol officer. I was an officer within Bolden Area Command Problem Solving Unit.

THE REPORTER: I'm sorry, repeat that. Within –

THE WITNESS: Bolden Area Command Problem Solving Unit.

I was also assigned as an A-2 detective to the Robbery Bureau for a period of time doing robbery decoy and robbery decoy saturation. And I was also a field training officer.

Q. (BY MS. BRASIER) All right. During your initial training in the academy back in 2003, what kind of courses, if any, did you have regarding accident investigation?

A. Little to none. Basically they give you a dollar amount and tell you that if there's an injury call Traffic, if it's over $750 call Traffic. If it's a minor fender-bender, no injuries, no visible damage, just a paint scuff, that we could do an accident exchange of information for people to assist them, and that is all.

Q. Okay. Then when you got assigned to the

Traffic Bureau, you got into some more detailed training; is that right?

A. Much more in-depth training, yes.

Q. Okay. And one of the courses you listed, or I guess areas of training, was basic traffic investigation.

A. Correct.

Q. Can you describe for me what that course entails?

A. Basic accident investigation tells you to look for general signs that say, for instance, in the interior of vehicle items that have been moved around, whether or not seatbelts are in locked positions, air bags, to see if you have blood on air bags, and also give you general descriptions of tire marks left on scene, such as braking, acceleration, and yaw marks. But it doesn't -- doesn't get into details of how to reconstruct speeds or anything like that. That's why it's just basic accident investigation. General questions to ask, the information that's required to be included into your Form 5 accident investigation form. And that's basically what it consists of.

Q. And when you – you've been referring to the Form 5. Is that the Traffic Accident Report?

A. Correct. That is the Form 5 Traffic – State

of Nevada Traffic Accident Report.

Q. Okay. So give me a little bit more explanation as to what kind of training you were provided with on the information that needs to be contained in your Traffic Accident Report.

A. Okay. Well, you're always going to have an area -- we had to learn where – what starts an intersection, what continues to be the actual roadway, what's private property. So you need to be able to distinguish between all those, whether or not an accident occurred actually in the middle of the intersection or occurred on the roadway. This one here, for instance, occurred within the roadway because it's technically west of the intersection. So we look at the number of occupants, injuries we mark, what they state to us, where they claim those injuries are, whether or not air bags are deployed. And asphalt conditions, you know, what's – what's the lane markings. All those have places to be put on here. Whether or not the roadway is straight, if there's a grade to it. These are all part of the basic accident investigation. Lighting conditions, if it took place during -- during nighttime. If there's any contributing factors, whether that be alcohol, fatigue, those are all things that we're looking for. So it's actually very in-depth.

Fortunately the program that we use is mostly a series of drop-down boxes. So it goes directly to lighting conditions, is it daylight, dawn, dusk, you know, one street light. And we're able to use those as we go through. So you have to go through each step in the accident scene. If there's any errors or you forgot anything, when we go to approve it at the end, it will signal that something has been left out. We then have to go back and get that information and fill it back in. So that's why we complete it on scene.

Q. And correct me if I'm wrong, but probably one of the only sections that's not just a drop-down box is the Description of Accident and Narrative section?

A. Correct.

Q. What kind of training did you receive on what – on the type of information that you should include in that section?

A. Basically the Narrative section of an accident report is ours and ours alone. It's to give us information to recollect during a later event. You can really include it any way that you want. A supervisor just will normally look it over to see if there is enough information in his general opinion. And so sometimes officers are writing Narratives just to seek their supervisor's approval. I never had any

supervisors that were like that. I had some that were very specific in, Okay, remember to write down the color of the vehicle, the type of the vehicle, who was driving that vehicle, their directions of travel, the roadways that they were on. Those are all important factors. Whether or not they had their seatbelts on, air bags, injuries, those are all relatively important factors to have in – in recalling it. Because 95 percent of all accidents we're not going to take photographs of, we're not going to diagram the scene because they're minor in nature. So we just want basic information to be able to recall at a later date.

Q. But primarily for the officer – purposes of the officer being able to recollect the accident?

A. Correct.

Q. Okay. Is your intent in including information in that section also to be objective in – in the information, observations that you make on scene?

MR. SMITH: Object as to form.

THE WITNESS: The information that I include in the scene is what I believe to be – be important, okay? So anything that I put in there is what I thought was going to be important to be able to be recalled at a later date. In my opinion it is objectible (sic). It's – it's, you know, my perception of the events that

took place. And so I'm trying to be as fair as I can, but I want to make sure that I have the facts and circumstances that I've heard.

Q. (BY MS. BRASIER) All right. You also told us that you took an advanced accident investigation course; is that correct?

A. Correct.

Q. How long is that course?

A. I can't recall the exact amount of time. I believe it was two weeks, but I'm not a hundred percent certain on that.

Q. When did you take that course?

A. Approximately a year and a half ago.

Q. Do you remember if that was before or after this accident which was in March?

A. It was after this accident.

Q. And then you indicate that there's an additional course called Vehicle Dynamics that you didn't take; is that right?

A. Correct.

Q. Okay. Is there a reason why you didn't take that course?

A. It's -- you only take that if you want to become a fatal detective. It is a very, very complicated course, and I had no intention of becoming a

fatal detective, so therefore I was not going to subject myself to that rigorous testing there.

Q. Have you ever taken any courses in biomechanics?

A. No.

Q. Have you ever been qualified as an accident reconstruction expert?

A. No.

Q. What about a biomechanical expert?

A. No.

Q. All right. I just want to take a look at page five of your report. There's a section that documents Injury Severity and Injury Location.

A. Correct.

Q. And it has some codes next to those. Can you explain to me what the codes mean?

A. Injury Severity is claimed; that's what C stands for. Injury Location, I believe that's a 5. It's hard to see on this one. But – so I can't be certain. And I also don't have my drop-down bar to tell you what a 5 is. You have to see it actually in the drop-down. It doesn't state it here.

Q. And based on your description, your recollection of this accident, would it be fair to assume that that code either stood for neck or back?

A. Neck, back, and possibly spine is another option. So I may have just generalized between being neck and back to be the entirety of the spine.

Q. And what does claimed injury mean?

A. Claimed means that there is no visible injuries. There's no other indicators for me to believe that there's any other injuries occurred other than just what they're claiming. So I also go based upon when medical looks at an individual, they'll say, Listen, she's got no feeling in her toes, her fingers, we got tingling sensations. Anything like that, there's a possibility for a serious injury. I ask people if they have those symptoms, and none of those were present.

Q. Okay. If those signs were present, would you have selected something other than "claimed"?

A. Correct. Well, actually I'd wait until I went down to the hospital to have a final conclusion. But that's one of those situations where I sit there and go, okay, this might be a little bit more serious in nature, let me lock down my scene, let me preserve it, let me document it. We get a little bit more entailed. Then I would go down to the hospital and I would wait until we could get final results from the doctor on scene of the severity of the injury.

Q. Prior to joining Metro, generally what kind of

employment did you have?
A. I worked in the hospitality industry. I was a bellman, a baggage handler, a limo driver, a front desk auditor, a front desk clerk, front desk manager, night auditor, hotel administrator. I also did numerous back-of-the-house positions such as busboy, doing stuff like that.
Q. Okay. So fair to say it was all in the hospitality industry?
A. Yes.
Q. Okay. No medical training?
A. No.
Q. When you were answering questions earlier about this accident, it appeared you weren't referring to your – as far as I could tell, you weren't referring to the report. You were going off memory; is that accurate?
A. Correct.
Q. Okay. Prior to reviewing that accident report last night, did you have an independent memory of this accident scene?
A. I had small recollections of the – of the accident. It was a very new time period for me being in training with Bob Holland. Some of those few that you do remember because of, you know, circumstances that

exist and helps you recall them.
Q. What was it – other than the fact that you were training with Officer Holland, anything else about this accident that stood out to you?
A. It was just being that it was new it kind of stuck with me. And one of the things is this is probably the first time ever where somebody had told me that they had previous injuries or injuries that could have been a contributing factor to what occurred at the time and place. And so therefore that's – this is where I learned to ensure that people that had claimed injuries or injuries that happened prior, to list those in there. So if I ever came across somebody who had a cast on already, that would also be something that I'd document and make sure it's in there.
Q. And speaking of the prior claimed injuries, did Mrs. Seastrand offer you that information when you went to talk to her, or did you – or was there – did you ask her questions to elicit that information?
A. I didn't ask her if she had any prior injuries. It was information that she just gave to me when I was asking her about her injury. I was asking her, you know, Where do you hurt, things like that. Well, my neck, my back. And then she basically made an utterance that she had already been in a prior vehicle

collision and had hurt her neck and back before.
Q. And did she indicate to you when that prior accident was?
A. No, she did not.
Q. Okay.
A. She just said – I knew it was more than a year. She said years.
Q. Okay. Did she describe to you what kind of injuries she had in that prior accident?
A. She just claimed neck and back.
Q. And did she go into any detail with you about the last time that she had any treatment for those injuries?
A. No, she did not.
Q. All right. I want to look at the last two sentences of your Narrative.
A. Okay.
Q. Actually let's look at the last sentence, "The injuries claimed by Seastrand are not consistent with being caused during this collision." When you refer to "the injuries claimed", what types of injuries was she claiming?
A. She was claiming severe neck and back pain and not being able to move. We actually had medical take her out of the vehicle. That's pretty severe in nature

if somebody claims that they're not going to be able to move themselves versus saying, Ah, I got, you know, a sore neck, I can be able to step out of the vehicle. And those people normally complain about having C-spines put on them when they're being put into the ambulance and stuff like that and making sure they're nonambulatory so they don't hurt themselves further.
I tend to see her types of injuries on much more substantial collisions, not in small – this is what we would technically call a fender-bender. This is as minor as could be. If it wasn't for the fact that a hole was punched in her bumper, this would be less than $750 in damage to repair a bumper of the paint scratch. But since she did have a hole, it's greater than 750 bucks to repair a bumper. So this is still a minor classification of accident for us.
Q. And, I'm sorry, I was trying to write as you were talking. You said you tend to see her types of injuries in more – did you say "substantial"?
A. Substantial collisions, correct.
Q. Collisions.
And when you say "substantial", are you referring to property damage?
A. No, I'd say higher speeds and the amount of intrusion on vehicles and damage.

Q. So would it be fair to say that you were surprised at the injuries she was claiming based on the accident scene that you arrived to?
A. Correct.
Q. Did Mrs. Seastrand indicate to you any surprise that her injuries were as significant as she was claiming?
A. No.
Q. Would you agree with me that Mrs. Seastrand's injuries and her claims of injuries need to be evaluated on her specific – her specific injuries, this specific accident rather than what may happen in the general population?
MR. SMITH: Object as to form.
THE WITNESS: I – no. Because unfortunately in my line of work and in my profession I run into lots of people that do not provide me with the truth. I have to determine my own opinion based upon the facts and circumstances that occur and I have to make those. So the last statement in this Narrative is – is my opinion, okay? And it's based upon the totality of the circumstances that I included it within my Narrative. And the reason being is because I will take people's statements, I will compare them with the facts and circumstances that I have, and I will form my own

opinion, because a lot of people do like to lie to me.
Q. (BY MS. BRASIER) Did you have any indication that Mrs. Seastrand was not being truthful with you?
A. I did not believe that her injuries were as severe as she had stated.
Q. And what led you to believe that her injuries weren't as severe as what she was stating?
A. Due to the fact that it was a minor collision, very little intrusion into the bumper, very little damage to either vehicle, no roadway markings. There was no contributing factors to show that she should have had the claimed injuries in which she had.
Q. And when you categorized her claimed injuries as severe, what do you mean by "severe"?
A. She was stating that she couldn't move, she wasn't going to be able to get up and get out of the vehicle on her own. That's – that's pretty severe if you're no longer mobile, in my opinion.
Q. And you believe that she could have gotten out of the vehicle?
A. Yes, I do.
Q. Did you perform any examination on her at the scene?
A. No, I did not.
Q. Did you get a detailed medical history from

her at the scene?
A. No, I did not.
Q. Or any type --
A. No.
Q. Did you review any of her medical records, either prior medical records or records created as a result of this accident?
A. No.
Q. Did you perform an inspection of the vehicles involved?
A. No, we did not do any certified inspections.
Q. When you say "certified", what -- what is that qualifying –
A. I mean I look over vehicles and I inspect it with my eyes, but I don't sit down and I don't open up hoods, I don't check brakes. Those – there's no indicators that any of these were a contributing factor to the accident. So nothing other than their statements was obtained.
Q. Did you take any measurements of the bumper heights or any other portions of the vehicles?
A. No, I did not.
Q. This may fall under what you were talking about as a certified inspection, but did you look underneath or behind either of the bumpers to see if

there was any structural -- structural damage to the frames?
A. Not to frames, no.
Q. I think you testified to this earlier, but you didn't do any speed analysis for either of the vehicles; is that correct?
A. It was unable to be determined.
Q. Did you determine the length of time the vehicles were in contact during the impact?
A. No.
Q. Did you do any calculations of the Delta V or the forces at issue in this impact?
A. No. There's no evidence to be able to determine.
Q. Did you diagram the scene at all?
A. No.
Q. And, again, I think you testified to this earlier but just want to get it clear. Did you make any determination whether either of the vehicles were moved in any direction as a result of the impact?
A. They couldn't recall if they had let off the brakes, slightly moved over. They couldn't tell me what they had done.
Q. Have you ever participated in any crash testing?

A. No, I have not.
Q. Your opinions regarding the fact that this minor impact could not have caused the -- the claimed injuries, tell me your -- your basis for that. I know we've kind of gone through it again but so I can have it in a concise statement.
A. On showing up to multiple vehicle collisions, you get a tendency to see what kind of damage -- I can look at a vehicle and sit there and go, Wow, that's a lot of speed that took place before this collision occurred. You just go to so many that your personal experiences on viewing them and seeing them, having been involved in collisions myself, you just have a general understanding for what's a minor fender-bender and what is a very substantial accident.
Q. Those accidents that you consider to be minor, do you ever follow up with the people involved to see if they eventually sustain some kind of injury?
A. No.
Q. And was your -- was your intent in including that statement about -- that her claimed injuries aren't consistent with being caused during the collision, was that -- earlier you indicated what you include in the Narrative is more for your recollection. Is that --
A. Correct.

Q. -- your purpose in including that statement?
A. Correct.
Q. I'll represent to you that -- that there are multiple medical doctors, medical experts involved in this case, and also biomechanical experts, who have inspected the vehicles and done analysis on the forces at issue in this accident. Would you defer to the biomechanical and medical experts to form any opinions whether Mrs. Seastrand could have sustained injuries in this accident?
MR. SMITH: Object as to form.
THE WITNESS: A doctor is obviously going to have much more insight using x-rays and other technologies which I don't have on site, so he is definitely going to be able to determine whether or not she has injuries. And, again, if you had somebody that was capable of performing a vehicle dynamic work-up on this, even though we had no roadway evidence, if they could determine it, then absolutely. But they would have to do a crush factor. The vehicles would have had to have been secured, not tampered with. There's a lot of variables that go into that one. But a doctor absolutely.
Q. (BY MS. BRASIER) Based on your investigation of the accident, who did you determine to be the

at-fault driver?
A. At fault was Mr. Khoury. He admitted it.
Q. And what was Mr. Khoury's duty as he approached the intersection at the time of the impact?
A. He followed too closely.
Q. So his duty would have been to keep a safe distance?
A. Correct, between him and Mrs. Seastrand's car.
Q. Okay. Based on your investigation, you concluded that he breached that duty?
A. Correct.
Q. Explain to me the process of how you input the information into, you know, your -- your computer, your device at the scene and how that information turns into what we've labeled as Exhibit A.
A. We have what we call the Form 5 on our iPAQ. Our iPAQ is the handheld computer device which we use. We open it and it has fields to have information provided. So obviously the first one is our event number. We provide the last four. It automatically creates the date for which it occurs. We put in our times, our sector beats. It automatically comes up with the day of the year that it is. It totals -- it does all the calculations when we do it. So if I put in two vehicles, it will say two vehicles; I didn't put that

there. It's automatically going to tabulate and form -- form those up for me.
I will put in the roadways. The roadways are actually already inputted in there. I just have to find them in drop-down menus on Craig and Rancho. It automatically shows what roads are connected to Craig in order for me to come up with it.
I'll provide the -- the sector beat, all the times, roadway widths, roadway conditions. That's all stuff that I'll check out. I put in my Narrative last. After form -- I go through each page, I hit save and sync. And the sync app goes through, tells me if I missed any boxes, any areas that needed to be filled out. Once I do determine I filled everything out, I hit save.
I'll then go back -- after everything is completed, I've given people their copies of the accident reports, I'll go to someplace nice and quiet, a little bit of shade, and write out my Narrative. So that's away from people and -- and I'm able to sit there and not be disturbed while I'm typing up my Narrative. I then save it again and then we sync it. And syncing means that it's sent from my iPAQ to a central database for the Form 5 at the Metropolitan Police Department. So any computer that has that I can pull it up, I can go

through the approval process again in which I review it, go back over it, and make sure that all the boxes are again checked. I then hit click for approval. That report is then given over to my supervisor. My supervisor then reviews it.

Normally what they're looking for, again, is make sure all boxes are checked, that all the roadway markings are there. He gives a general once-over and goes, Okay, yeah, both cars appear to be traveling in the same direction and it matches that Narrative of what he said occurred, I don't see any mistakes. And so then he approves it so that eventually insurance companies, victims, and involved parties can obtain their copies.

Q. Now, on the bottom of Exhibit A, it indicates Reviewed By. It has John Hines listed. Was that your supervisor at the time?

A. That was my supervisor at the time, correct.

Q. Okay. Did you ever have any conversations with him about this accident report that you can recall?

A. No, I did not.

Q. Oh, did Officer Holland have any – any input or any participation in creating the report?

A. No.

MS. BRASIER: I don't think I have any more questions for you.

MR. SMITH: Just to briefly follow up on one thing.

REDIRECT EXAMINATION

BY MR. SMITH:

Q. Now, you mentioned that the Narrative section is inserted last in the police report, correct?

A. Correct.

Q. Are there – do you take notes throughout the report that you rely on to create the Narrative?

A. Yes, I do. When I flip open my note pad, I immediately write down – because the first thing I do, control, I've arrived, I ask for my last four times and sector beats. And when I say that, I want the last four of my event number, my three times, which are the time of call, my time of en route, my time of arrival. The sector beat, which would be the area command in which it took place at, even refine the location a little bit more. And then whether it occurred within the city or county. And so I immediately write those down.

And then go up to a vehicle, whatever vehicle I come up to first, I write down the person's last name, I write down their phone number, I ask them for injuries. I write those down real quick.

Then I go over to the next vehicle, I do the same thing; last name, phone number, injuries. The

quick, immediate details that I know that I may need if they get up and out. If I have a phone number, I can complete the report if they go unconscious. Because a phone number is hard to get if they are ever induced at a hospital. It's hard for me to get that information, and it's a requirement of the form.

And then I have that notebook with me. So the times, the names are all right there on one piece of paper. Anything that I determine – when I take my roadway measurements, for instance, I write down – I'll put LW, lane width, write it down. AIC, I'll do, you know, so many feet east of east and west of west. I'll mark it down. I'll put V-1, so many feet traveled after, V-2. And I'm writing down those specific numbers so that when I have to put it in there later, I just set down my notebook on top of my motorcycle, write down – when I need to list those specific numbers, I have them in front of me.

Q. So safe to say that when you're crafting this Narrative at the end, it's not like you're trying to go back and remember everything; you have a series of notes of impressions that you've taken down throughout your investigation?

A. Correct. The – the pertinent information has been written down in my notebook so that I will have it

specific upon putting it into the Narrative.

MR. SMITH: Fair enough. That's all I've got.

MS. BRASIER: I don't have any more questions.

THE VIDEOGRAPHER: This concludes today's deposition of Todd Conn. We're going off record. The time is 10:41 a.m.

(Off the video record.)

THE REPORTER: Do you want to read and review?

THE WITNESS: No.

(Deposition concluded at 10:41 a.m.)

* * * * *

CERTIFICATE OF REPORTER

STATE OF NEVADA)
SS:
COUNTY OF CLARK)

I, Ann Salisbury, Certified Court Reporter for the State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, Todd Conn, commencing on Monday, July 30, 2012, at 9:10 o'clock a.m.

That prior to being examined the witness was by me duly sworn to testify to the truth.

That the foregoing transcription is a true, complete, and accurate transcription of the stenographic notes of the testimony taken by me in the matter entitled herein to the best of my knowledge, skill, and ability.

That prior to the completion of the proceedings, the reading and signing of the transcript was not requested by the witness or a party.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of an attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this _____ day of _____, 2012.

_____
Ann Salisbury, RPR, CCR 185

EXHIBIT 10

Event Number: 090313-1357

Code Revision:

STATE OF NEVADA
TRAFFIC ACCIDENT REPORT
SCENE INFORMATION SHEET
Revised 5/21/03

Accident Number: LVMPD-090313-1357

☐ Property ☒ Injury ☐ Fatal

☒ 1) Urban ☐ 2) Rural ☐ 1) Emergency Use ☐ 2) Office Report ☐ 1) Preliminary Report ☐ 3) Resubmission ☒ 2) Initial Report ☐ 4) Supplement Report ☐ 1) Hit and Run ☐ 2) Private Property

Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Collision Date	Time	Day	Beat / Sector	☐ County ☒ City
3/13/2009	10:27	FRIDAY	X2	LAS VEGAS

Mile Marker	# Vehicles	# Non Motorists	# Occupants	# Fatalities	# Injured	# Restrained
	2	0	2	0	1	2

Surface: ☒ 1) Asphalt ☐ 2) Concrete ☐ 3) Gravel ☐ 4) Dirt ☐ 5) Other

Intersection: ☒ 1) Four Way ☐ 2) > Four Way ☐ 3) T ☐ 4) Y ☐ 5) Roundabout ☐ 6) Other

Paddle Markers: ☒ 1) None ☐ 2) Left Side ☐ 3) Right Side ☐ 4) Both Side ☐ 5) Unknown

Access Control: ☒ 1) None ☐ 2) Full ☐ 3) Partial

Occurred On: *(Highway # or Street Name)*
☐ 1) Parking Lot CRAIG RD

☐ 1) At Intersection With: West Of *(Cross Street)* RANCHO DR
☒ 2) Or 23 ☒ 3) Feet ☐ 4) Miles ☒ 5) Approximate

Roadway Character: ☐ 1) Curve & Grade ☐ 2) Curve & Hillcrest ☐ 3) Curve & Level ☐ 4) Straight & Grade ☐ 5) Straight & Hillcrest ☒ 6) Straight & Level ☐ 7) Unknown ☐ 8) Other

Roadway Conditions: ☒ 1) Dry ☐ 2) Icy ☐ 3) Wet ☐ 4) Snow ☐ 5) Sand / Mud / Oil / Dirt / Gravel ☐ 6) Other ☐ 7) Slush ☐ 8) Standing Water ☐ 9) Moving Water ☐ 10) Unknown

Total Thru Lanes: Main Road ☐ 1) One ☐ 2) Two ☒ 3) Three ☐ 4) Four ☐ 5) Five ☐ 6) > 5 — Total All Lanes: 5

Average Roadway Widths: Travel Lane 12 Ft; Storage / Turn Lane 12 Ft; Median 0 Ft

Paved Shoulder: Inside 0; Outside 0

Roadway Grade: ☐ 1) Not Determined ☒ 2) Relatively Level Roadway ☐ 3) Up Slope (+) ☐ 4) Down Slope (-) — Relative To — Grade %

Pavement Markings and Type: 4 4) Lane Line, Broken White; 5) Lane Line, Solid White; ☐ 12) None; ☒ 13) Unknown

Highway Description: ☐ 1) Two-Way, Not Divided ☒ 2) Two-Way, Div., Unpro. Median ☐ 3) Two-Way, Div., Median Barrier ☐ 4) One-Way, Not Div. ☐ 5) Unknown ☐ 6) Off Road

Weather Conditions: ☒ 1) Clear ☐ 2) Cloudy ☐ 3) Snow ☐ 4) Rain ☐ 5) Blowing Sand, Dirt, Soil, Snow ☐ 6) Other ☐ 7) Fog, Smog, Smoke, Ash ☐ 8) Severe Crosswinds ☐ 9) Sleet / Hail ☐ 10) Unknown

Light Conditions: ☐ 1) Dusk ☐ 2) Dawn ☒ 3) Daylight ☐ 4) Unknown ☐ 5) Other ☐ 6) Dark - No Roadway Lighting ☐ 7) Dark - Spot Roadway Lighting ☐ 8) Dark - Continuous Roadway Lighting ☐ 9) Dark - Unknown Roadway Lighting

Vehicle Collision Type: ☐ 1) Head On ☒ 2) Rear End ☐ 3) Backing ☐ 4) Angle ☐ 5) Rear to Rear ☐ 6) Sideswipe - Meeting ☐ 7) Sideswipe - Overtaking ☐ 8) Non - Collision ☐ 9) Unknown

Location of First Event: ☒ 1) Travel Lane 3 ☐ 2) Turn Lane ☐ 3) Lane ☐ 4) Median ☐ 5) Inside Shoulders ☐ 6) Outside Shoulder ☐ 7) Intersection ☐ 8) Gore ☐ 9) Roadside ☐ 10) Other ☐ 11) Ramp ☐ 12) Unknown

Highway / Environment Factors: ☒ 1) None ☐ 2) Weather ☐ 3) Debris ☐ 4) Glare ☐ 5) Other Highway ☐ 6) Other Environmental ☐ 7) Shoulders ☐ 8) Road Obstruction ☐ 9) Worn Traffic Surface ☐ 10) Wet Icy, Snow/Slush ☐ 11) Ruts, Holes, Bumps ☐ 12) Active Work Zone ☐ 13) Inactive Work Zone ☐ 14) Animal In Roadway ☐ 15) Unknown

Property Damage To Other Than Vehicle

Describe Property Damage: Insurance/Attorney/Time

Owner's Name: By [illegible] Date 3/14/09 Las Vegas Metro Police Dept. ☐ Owner Notified

Owner's Address: (Street Address City, State Zip)

First Harmful Event

Code #: 214 Description: 214 MOTOR VEHICLE IN TRANSPORT

Description of Accident / Narrative

SEASTRAND WHO WAS THE SOLE OCCUPANT OF MAROON 2002 VAN WAS STOPPED IN THE FAR RIGHT EASTBOUND LANE AT CRAIG ROAD APPROACHING RANCHO DRIVE. SEASTRAND STATES THE SHE THEN FELT HER VEHICLE BEING IMPACTED. SEASTRAND CLAIMED INJURY TO HER NECK, AND BACK. LAS VEGAS FIRE DEPARTMENT RESCUE UNIT 9 RESPONDED, AND TRANSPORTED TO MOUNTAIN VIEW HOSPITAL. I THEN MADE CONTACT WITH KHOURY WHO IS THE SOLE OCCUPANT OF A WHITE 2007 INFINITY SUV. KHOURY STATES THAT HE WAS TRAVELING IN THE FAR RIGHT EASTBOUND

☐ 1) Continued On Back of Scene Information Sheet

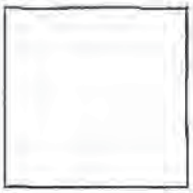
Investigation Complete	Photos Taken	Scene Diagram	Statements	Date Notified	Time Notified	Arrival Date	Arrival Time
☒ 1) Yes ☐ 2) No	☐ 1) Yes ☒ 2) No	☐ 1) Yes ☒ 2) No	☐ 1) Yes ☒ 2) No #	3/13/2009	10:29	3/13/2009	10:38

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
8101 T. CONN	8101	3/13/2009	4350 JOHN HINES	3/14/2009	1 of 6

Event Number: 090313-1357	STATE OF NEVADA TRAFFIC ACCIDENT REPORT SCENE INFORMATION SHEET Revised 5/21/03	Accident Number: LVMPD-090313-1357 Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Description of Accident / Narrative Continuation

LANE OF CRAIG ROAD APPROACHING RANCHO DRIVE. KHOURY STATES THAT HE OBSERVED THE HONDA IN FRONT OF HIM AND ANTICIPATED THAT IT WAS GOING TO MAKE A SOUTHBOUND RIGHT TURN AT THE INTERSECTION. THE INFINITY THEM MOVED FORWARD AND STRUCK THE FRONT OF ITS BUMPER AGAINST THE REAR BUMPER OF THE HONDA. BOTH OCCUPANTS WERE PROPERLY SECURED AND NO AIRBAGS WERE DEPLOYED ON EITHER VEHICLE. BOTH VEHICLES HAD MINOR DAMAGE. THE REAR OF THE HONDA HAD A SMALL HOLE IN THE REAR BUMPER WHICH WAS CAUSED BY A FORWARD TOW HOOK ON THE INFINITY'S FRONT BUMPER. THE INFINITY HAD APPROXIMATELY A 4 INCH CRACK ON THE BUMPER NEXT TO THE TOW HOOK. SEASTRAND TOLD OFFICERS THAT SHE HAD PRIOR NECK AND BACK INJURIES CAUSED BY A PREVIOUS VEHICLE ACCIDENT YEARS BEFORE. THE INJURIES CLAIMED BY SEASTRAND ARE NOT CONSISTENT WITH BEING CAUSED DURING THIS COLLISION.



Indicate North

A.I.C.:

Event Number: 090313-1357	STATE OF NEVADA TRAFFIC ACCIDENT REPORT VEHICLE INFORMATION SHEET Revised 5/2/03	Accident Number: LVMPD-090313-1357
Vehicle #: 1 / # Occupants: 1 / ☒ 1) At Fault ☐ 2) Non Contact Vehicle		Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Direction of Travel: ☐ 1) North ☒ 3) East ☐ 5) Unknown ☐ 2) South ☐ 4) West

Highway / Street Name: CRAIG RD

Travel Lane #: 3

Vehicle Action: ☒ 1) Straight ☐ 3) Left Turn ☐ 5) U-Turn ☐ 7) Wrong Way ☐ 9) Passing ☐ 11) Leaving Parked ☐ 13) Leaving Lane ☐ 15) Enter Parked (#) ☐ 17) Lane Change ☐ 19) Unknown ☐ 2) Backing ☐ 4) Right Turn ☐ 6) Parked ☐ 8) Stopped (^) ☐ 10) Racing ☐ 12) Entering Lane ☐ 14) Other Turning ☐ 16) Driverless Vehicle ☐ 18) Other

Driver: (Last Name, First Name, Middle Name Suffix) KHOURY RAYMOND RIAD

Transported By: ☒ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other

Street Address: 9190 W ANN RD

Transported To:

City: LAS VEGAS **State / Country:** ☒ 1) NV NV **Zip Code:** 89149

Person Type: 1 **Seating Position:** 1 **Occupant Restraints:** 7

☒ 1) Male ☐ 3) Unknown ☐ 2) Female **DOB:** 12/30/1957 **Phone Number:** 7026498931

Injury Severity: N **Injury Location:** 0

OLN: 2600515145 **State:** ☒ 1) NV NV ☐ 1) CDL ☒ 2) DL **License Status:** 0

Airbags: 2 **Airbag Switch:** 4 **Ejected:** 0 **Trapped** 0

Compliance: ☒ 1) Restrict ☐ 2) Endorse

Endorsements			Restrictions		
			1		

Alcohol/Drug Involvement: ☒ 1) Not Involved ☐ 2) Suspected Impairment ☐ 3) Alcohol ☐ 4) Drugs ☐ 5) Unknown

Method of Determination (check up to 2): ☐ 1) Field Sobriety Test ☐ 2) Evidentiary Breath ☐ 3) Driver Admission ☐ 4) Urine Test ☐ 5) Blood Test ☐ 6) Preliminary Breath Test

Test Results:

Driver Factors

☒ 1) Apparently Normal ☐ 2) Had Been Drinking ☐ 3) Drug Involvement ☐ 4) Apparently Fatigued / Asleep ☐ 5) Contacted Blew ☐ 6) Driver Ill / Injured ☐ 7) Other Improper Driving ☐ 8) Driver Inattention / Distracted ☐ 9) Physical Impairment ☐ 10) Unknown

Vehicle Year: 2007	Vehicle Make: INFINITI	Vehicle Model: QX56	Vehicle Type: LL - SUV
Plate / Permit No.: 546UJC	**State:** ☒ 1) NV NV	**Expiration Date:** 5/8/2009	**Vehicle Color:** WHITE

Vehicle Identification Number: 5NJAA08C27N800289

Registered Owner Name: ☒ 1) Same As Driver KHOURY RAYMOND RIAD

Registered Owner Address: 9190 W ANN RD

Vehicle Factors

☐ 1) Failed To Yield Right Of Way ☐ 3) Failed To Maintain Lane ☐ 16) Driverless Vehicle ☐ 2) Disregard Control Device ☒ 10) Following Too Close ☐ 17) Unsafe Backing ☐ 3) Too Fast For Conditions ☐ 11) Unsafe Lane Change ☐ 18) Ran Off Road ☐ 4) Exceeding Speed Limit ☐ 12) Made Improper Turn ☐ 19) Hit and Run ☐ 5) Wrong Way / Direction ☐ 13) Over Correct/Steering ☐ 20) Road Defect (^) ☐ 6) Mechanical Defects ☐ 14) Other Improper Driving ☐ 21) Object Avoidance ☐ 7) Drove Left Of Center ☐ 15) Aggressive / Reckless / Careless ☐ 8) Other ☐ 22) Unknown (#)

Insurance Company Name: ☒ 1) Insured STATE FARM INSURANCE

Policy Number: 295 7095-A27-28E **Effective:** 1/27/2009 **To:** 7/27/2009

Insurance Company Address or Phone Number: 702-645-3300

☐ 1) Vehicle Towed **Towed By:** RETAINED BY DRIVER

Removed To: RETAINED BY DRIVER

1st Contact

☐2 ☐3 ☐4 ☒1 — ☐5 ☐8 ☐7 ☐6

☐ 1) Override ☒ 2) Under Ride

Damaged Areas

☒ 1) Front ☐ 2) Right Side ☐ 3) Left Side ☐ 4) Rear ☐ 5) Right Front ☐ 6) Right Rear ☐ 7) Top ☐ 8) Under Carriage ☐ 9) Left Front ☐ 10) Left Rear ☐ 11) Unknown ☐ 12) Other

Traffic Control

F	1) Speed Zone		11) Stop Sign
F	2) Signal Light		12) Yield Sign
	3) Flashing Light		13) R. R. Sign
	4) School Zone		14) R. R. Gates
	5) Ped. Signal		15) R. R. Signal (#)
	6) No Passing	F	16) Marked Lanes
	7) No Control		17) Tire Chains/Snow Req.
	8) Warning Sign		18) Permissive Green
	9) Turn Signal	☐	19) Unknown
	10) Other		

Distance Traveled After Impact: 0

Speed Estimate

From	To	Limit
		45

Extent Of Damage

☒ 1) Minor ☐ 2) Moderate ☐ 3) Major ☐ 4) Total ☐ 5) None ☐ 6) Unknown

Sequence Of Events

	Code #	Description	Collision With Fixed Object	Most Harmful Event
1st	21d	21d MOTOR VEHICLE IN TRANSPORT	☐	☒
2nd			☐	☐
3rd			☐	☐
4th			☐	☐
5th			☐	☐

	Violation	NOC	Citation Number
☐ 1) NRS ☐ 2) CFR ☒ 3) CC / MC ☐ 4) Pending (1)	LVO FOLLOWING TOO CLOSE	0808	E09072112208101
☐ 1) NRS ☐ 2) CFR ☐ 3) CC / MC ☐ 4) Pending (2)	Violation	NOC	Citation Number

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
8101 T. CONN	8101	3/13/2009	4350 John Hines	3/14/2009	3 of 8

Event Number: 090313-1357	STATE OF NEVADA TRAFFIC ACCIDENT REPORT VEHICLE INFORMATION SHEET Revised 5.21.03	Accident Number: LVMPD-090313-1357 Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Name: Last Name, First Name, Middle Name Suffix

Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other

Street Address:

Transported To:

City: | State / Country ☐ 1) NV | Zip Code:

Person Type: | Seating Position: | Occupant Restraints:

☐ 1) Male ☐ 3) Unknown ☐ 2) Female | DOB: | Phone Number:

Injury Severity: | Injury Location:

Airbags: | Airbag Switch: | Ejected: | Trapped:

Name: Last Name, First Name, Middle Name Suffix

Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other

Street Address:

Transported To:

City: | State / Country ☐ 1) NV | Zip Code:

Person Type: | Seating Position: | Occupant Restraints:

☐ 1) Male ☐ 3) Unknown ☐ 2) Female | DOB: | Phone Number:

Injury Severity: | Injury Location:

Airbags: | Airbag Switch: | Ejected: | Trapped:

Name: Last Name, First Name, Middle Name Suffix

Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other

Street Address:

Transported To:

City: | State / Country ☐ 1) NV | Zip Code:

Person Type: | Seating Position: | Occupant Restraints:

☐ 1) Male ☐ 3) Unknown ☐ 2) Female | DOB: | Phone Number:

Injury Severity: | Injury Location:

Airbags: | Airbag Switch: | Ejected: | Trapped:

☐ 1) Trailing Unit 1 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 2 VIN:	Plate:	State: ☐ 1) NV	Type:
☐ 1) Trailing Unit 3 VIN:	Plate:	State: ☐ 1) NV	Type:

Commercial Vehicle Configuration

☐ 1) Commercial Vehicle ☐ 2) School Bus

☐ 1) Bus, 9 – 15 Occupants
☐ 2) Bus, > 15 Occupants
☐ 3) Single 2 Axle and 6 Tire
☐ 4) Single > 3 Axle
☐ 5) Any 4 Tire Vehicle
☐ 6) Tractor Only
☐ 7) Tractor / Trailer
☐ 8) Tractor / Doubles
☐ 9) Tractor / Triples
☐ 10) Truck with Trailer
☐ 11) Tractor / Semi Trailer
☐ 12) Passenger Vehicle, (Haz-Mat)
☐ 13) Light Truck, (Haz-Mat)
☐ 14) Other Heavy Vehicle

Source

☐ 1) Driver
☐ 2) Log Book
☐ 3) Shipping Papers / Trip Manifest
☐ 4) State Reg.
☐ 5) Side Of Vehicle
☐ 6) Other

Carrier Name:

Power Unit GVWR

☐ 1) ≤ 10,000 Lbs ☐ 2) 10,000 – 26,000 Lbs ☐ 3) ≥ 26,000 Lbs

☐ 1) Haz-Mat ☐ 2) Released

Carrier Street Address: | City: | State: ☐ 1) NV | Zip:

Cargo Body Type

☐ 1) Pole
☐ 2) Tank
☐ 3) Flatbed
☐ 4) Dump
☐ 5) Unknown
☐ 6) Van / Box
☐ 7) Concrete Mixer
☐ 8) Auto Carrier
☐ 9) Garbage/Refuse
☐ 10) Not Applicable
☐ 11) Grain, Gravel Chips
☐ 12) Bus, 9 – 15 Occupants
☐ 13) Bus, > 15 Occupants
☐ 14) Other

Haz-Mat ID #:

Hazard Classification #:

Type of Carrier

☐ 1) Single State
☐ 2) USDOT
☐ 3) Canada
☐ 4) Mexico
☐ 5) None

NAS Safety Report #:

Carrier Number:

Page 4 of 8

Event Number: 090313-1357

STATE OF NEVADA
TRAFFIC ACCIDENT REPORT
VEHICLE INFORMATION SHEET
Revised 5/2/03

Accident Number: LVMPD-090313-1357

Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Vehicle #: 2 | # Occupants: 1 | ☐ 1) At Fault ☐ 2) Non Contact Vehicle

Direction of Travel: ☐ 1) North ☒ 3) East ☐ 5) Unknown ☐ 2) South ☐ 4) West

Highway / Street Name: CRAIG RD

Travel Lane #: 3

Vehicle Action: ☐ 1) Straight ☐ 3) Left Turn ☐ 5) U-Turn ☐ 7) Wrong Way ☐ 9) Passing ☐ 11) Leaving Parked ☐ 13) Lagging Lane ☐ 15) Enter Parked (#) ☐ 17) Lane Change ☐ 19) Unknown ☐ 2) Backing ☐ 4) Right Turn ☐ 6) Parked ☒ 8) Stopped (^) ☐ 10) Racing ☐ 12) Entering Lane ☐ 14) Other Turning ☐ 16) Driverless Vehicle ☐ 18) Other

Driver: (Last Name, First Name, Middle Name Suffix) SEASTRAND MARGARET G

Transported By: ☐ 1) Not Transported ☒ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other LV FIRE/RESCUE

Street Address: 6440 SPANISH GARDEN CT

Transported To: MT. VIEW

City: LAS VEGAS | State / Country: ☒ 1) NV NV | Zip Code: 89110

Person Type: 1 | Seating Position: 1 | Occupant Restraints: 7

☐ 1) Male ☐ 3) Unknown ☒ 2) Female | DOB: 12/27/1981 | Phone Number: 7022831082

Injury Severity: C | Injury Location: 6

O.L.N.: 2101970247 | State: ☒ 1) NV NV | ☐ 1) CDL ☒ 2) DL | License Status: 0

Airbags: 1 | Airbag Switch: 1 | Ejected: 0 | Trapped 0

Compliance: ☐ 1) Restrict ☐ 2) Endorse

Endorsements | Restrictions

Alcohol/Drug Involvement: ☒ 1) Not Involved ☐ 2) Suspected Impairment ☐ 3) Alcohol ☐ 4) Drugs ☐ 5) Unknown

Method of Determination (check up to 2): ☐ 1) Field Sobriety Test ☐ 4) Urine Test ☐ 2) Evidentiary Breath ☐ 5) Blood Test ☐ 3) Driver Admission ☐ 6) Preliminary Breath Test

Test Results:

Driver Factors
☒ 1) Apparently Normal ☐ 6) Driver Ill / Injured
☐ 2) Had Been Drinking ☐ 7) Other Improper Driving
☐ 3) Drug Involvement ☐ 8) Driver Inattention / Distracted
☐ 4) Apparently Fatigued / Asleep ☐ 9) Physical Impairment
☐ 5) Obstructed View ☐ 10) Unknown

Vehicle Year: 2002 | Vehicle Make: HONDA | Vehicle Model: ODYSSEY | Vehicle Type: VN - VAN

Plate / Permit No.: 782TRY | State: ☒ 1) NV NV | Expiration Date: 6/29/2009 | Vehicle Color: MAROON

Vehicle Identification Number: 2HKRL18062H584449

Registered Owner Name: ☐ 1) Same As Driver TRUST LEGACY

Registered Owner Address: 6440 SPANISH GARDEN CT LAS VEGAS NV 89110

Vehicle Factors
☐ 1) Failed To Yield Right Of Way ☐ 5) Failed To Maintain Lane ☐ 16) Driverless Vehicle
☐ 2) Disregard Control Device ☐ 10) Following Too Close ☐ 17) Unsafe Backing
☐ 3) Too Fast For Conditions ☐ 11) Unsafe Lane Change ☐ 18) Ran Off Road
☐ 4) Exceeding Speed Limit ☐ 12) Made Improper Turn ☐ 19) Hit and Run
☐ 5) Wrong Way / Direction ☐ 13) Over Correct / Steering ☐ 20) Road Defect (^)
☐ 6) Mechanical Defects ☐ 14) Other Improper Driving ☐ 21) Object Avoidance
☐ 7) Drove Left Of Center ☐ 15) Aggressive / Reckless / Careless
☐ 8) Other ☐ 22) Unknown (#)

Insurance Company Name: ☒ 1) Insured USAA

Policy Number: 003316207C71614 | Effective: 7/11/2008 | To: 7/11/2009

Insurance Company Address or Phone Number: 18005318222

☒ 1) Vehicle Towed | Towed By: EWING BROTHERS TOWING

Removed To: TOW YARD

1st Contact
☐ 2 ☐ 3 ☐ 4
☐ 1 — ☒ 5
☐ 8 ☐ 7 ☐ 6

☒ 1) Override ☐ 2) Under Ride

Damaged Areas
☐ 1) Front
☐ 2) Right Side
☐ 3) Left Side
☒ 4) Rear
☐ 5) Right Front
☐ 6) Right Rear
☐ 7) Top
☐ 8) Under Carriage
☐ 9) Left Front
☐ 10) Left Rear
☐ 11) Unknown
☐ 12) Other

Traffic Control
F 1) Speed Zone
F 2) Signal Light
3) Flashing Light
4) School Zone
5) Ped. Signal
6) No Passing
7) No Control
8) Warning Sign
9) Turn Signal
10) Other
11) Stop Sign
12) Yield Sign
13) R. R. Sign
14) R. R. Gates
15) R. R. Signal (#)
F 16) Marked Lanes
17) Tire Chains/Snow Req.
18) Permissive Green
☐ 19) Unknown

Distance Traveled After Impact: ()

Speed Estimate: From | To | Limit: 45

Extent Of Damage: ☒ 1) Minor ☐ 2) Moderate ☐ 3) Major ☐ 4) Total ☐ 5) None ☐ 6) Unknown

Sequence Of Events

	Code #	Description	Collision With Fixed Object	Most Harmful Event
1st	217	217 SLOW / STOPPED VEHICLE	☐	☒
2nd			☐	☐
3rd			☐	☐
4th			☐	☐
5th			☐	☐

	Violation	NOC	Citation Number
☐ 1) NRS ☐ 2) CFR ☐ 3) CCC / MC ☐ 4) Pending (1)			
☐ 1) NRS ☐ 2) CFR ☐ 3) CCC / MC ☐ 4) Pending (2)			

Investigator(s)	ID Number	Date	Reviewed By	Date Reviewed	Page
8101 T. CONN	8101	3/13/2009	4350 John Hines	3/14/2009	5 of 6

Event Number: 090313-1357	STATE OF NEVADA TRAFFIC ACCIDENT REPORT VEHICLE INFORMATION SHEET Revised 5/21/03	Accident Number: LVMPD-090313-1357 / Agency Name: 2 - LAS VEGAS METROPOLITAN POLICE DEPARTMENT

Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:
Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:
Name: (Last Name, First Name, Middle Name Suffix)	Transported By: ☐ 1) Not Transported ☐ 2) EMS ☐ 3) Police ☐ 4) Unknown ☐ 5) Other
Street Address:	Transported To:
City: / State / Country ☐ 1) NV / Zip Code:	Person Type: / Seating Position: / Occupant Restraints:
☐ 1) Male ☐ 3) Unknown ☐ 2) Female / DOB: / Phone Number:	Injury Severity: / Injury Location:
	Airbags: / Airbag Switch: / Ejected: / Trapped:
☐ 1) Trailing Unit 1 VIN:	Plate: / State: ☐ 1) NV / Type:
☐ 1) Trailing Unit 2 VIN:	Plate: / State: ☐ 1) NV / Type:
☐ 1) Trailing Unit 3 VIN:	Plate: / State: ☐ 1) NV / Type:

Commercial Vehicle Configuration

☐ 1) Commercial Vehicle ☐ 2) School Bus

☐ 1) Bus, 9 - 15 Occupants ☐ 2) Bus, > 15 Occupants ☐ 3) Single 2 Axle and 6 Tire ☐ 4) Single > 3 Axle ☐ 5) Any 4 Tire Vehicle ☐ 6) Tractor Only ☐ 7) Tractor / Trailer ☐ 8) Tractor / Doubles ☐ 9) Tractor / Triples ☐ 10) Truck with Trailer ☐ 11) Tractor / Semi Trailer ☐ 12) Passenger Vehicle, (Haz-Mat) ☐ 13) Light Truck, (Haz-Mat) ☐ 14) Other Heavy Vehicle

Source: ☐ 1) Driver ☐ 2) Log Book ☐ 3) Shipping Papers / Trip Manifest ☐ 4) State Reg. ☐ 5) Side Of Vehicle ☐ 6) Other

Carrier Name:

Power Unit GVWR: ☐ 1) ≤ 10,000 Lbs ☐ 2) 10,000 - 26,000 Lbs ☐ 3) ≥ 26,000 Lbs ☐ 1) Haz-Mat ☐ 2) Released

Carrier Street Address: City: State: ☐ 1) NV Zip:

Cargo Body Type: ☐ 1) Pole ☐ 2) Tank ☐ 3) Flatbed ☐ 4) Dump ☐ 5) Unknown ☐ 6) Van / Box ☐ 7) Concrete Mixer ☐ 8) Auto Carrier ☐ 9) Garbage/Refuse ☐ 10) Not Applicable ☐ 11) Grain, Gravel Chips ☐ 12) Bus, 9 - 15 Occupants ☐ 13) Bus, > 15 Occupants ☐ 14) Other

Haz-Mat ID #:

Hazard Classification #:

Type of Carrier: ☐ 1) Single State ☐ 2) USDOT ☐ 3) Canada ☐ 4) Mexico ☐ 5) None

NAS Safety Report #:

Carrier Number:

Page 6 of 6

EXHIBIT 11

DISTRICT COURT
CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND,

Plaintiff,

vs.

RAYMOND RIAD KHOURY; DOES 1 through 10; and ROE ENTITIES 11 through 20, inclusive,

Defendants.

Case No. A-11-636515-C

DEPOSITION OF JERRY BUSBY
Taken on Monday, November 5, 2012
At 1:55 o'clock p.m.
At 7425 Peak Drive
Las Vegas, Nevada 89128

Reported by: Ann Salisbury, RPR, CCR 185

APPEARANCES:

For the Plaintiff: ALISON BRASIER, ESQ.
Richard Harris Law Firm
801 South Fourth Street
Las Vegas, Nevada 89101
(702)444-4444

For Defendant Raymond Riad Khoury: JACOB S. SMITH, ESQ.
Hall Jaffe & Clayton, LLP
7425 Peak Drive
Las Vegas, Nevada 89128
(702)316-4111

INDEX

EXHIBITS

(Prior to the commencement of the deposition, NRCP Rule 30(b)(4) was waived by the parties.)

Thereupon—

JERRY BUSBY

was called as a witness by Defendant Raymond Riad Khoury, and having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SMITH:

Q. Please state your name for the record.

A. Jerry Busby.

Q. Will you spell your last name?

A. B-u-s-b-y.

Q. All right. Jerry, have you had your deposition taken before?

A. Once.

Q. One time?

A. Yeah.

Q. How long ago was that?

A. Last year.

Q. Okay. Do you consider yourself fairly familiar with the rules of depositions --

A. I do.

Q. – that I can skip over all those rules?

A. Please do.

Q. All right. We'll cut to the chase, then.

How long have you known – well, first of all, what's your current address?

A. 6445 Spanish Garden Court, Las Vegas, Nevada.

Q. And that's the same address that was reflected on the subpoena that you were served with?

A. I think so. I didn't check it.

Q. How long have you known Margaret Seastrand?

A. I don't recall exactly when I met her, but since sometime in the early nineties, as I recall.

Q. And how did you meet her?

A. She moved in across the street.

Q. You've been across-the-street neighbors ever since?

A. Yes.

Q. Now, you have represented Hollywood Kids Academy previously in litigation; is that correct?

A. Yes.

Q. And approximately when was that?

A. I don't recall. I think we filed it two years ago, approximately. And it went on for maybe a little less than a year, or a year.

Q. And that was related to an insurance claim by Hollywood Kids?

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A. Yes.
Q. And you never represented Hollywood Kids Academy or Ms. Seastrand in any other matter?
A. No.
Q. Are you aware that Ms. Seastrand was involved in an automobile accident?
A. I've heard that.
Q. All right. And how have you heard that? Is that something you learned through her, through conversations with others?
A. I think through her. I know I have talked with her about it so I assume that's how I found out about it.
Q. Do you have any recollection as to what you discussed with her about that accident?
A. Well, we've talked about it a few times over the years. I think so. I don't recall what she told me about the accident itself, if that's what you're asking.
Q. What about – that's fair enough. Thank you for that.
What about injuries or physical ailments or anything that she suffers as a result of the accident? Have you ever had discussions with her about that?
A. Yes.
Q. On how many occasions, approximately?

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A. I don't remember for sure, you know, because we see her fairly often. She talks about her back hurting her quite often, so I would assume there's – I'd just be guessing if I assume it's been multiple, you know, dozens of times.
Q. Let's follow up on just the extent of your relationship with Ms. Seastrand. Now, you're across-the-street neighbors. You represented Hollywood Kids Academy one time in a lawsuit. In what other capacities or involvement do you have with her on a social level?
A. Well, our daughter went to Hollywood Kids for a year or two. We attend the same church, so we see her, you know, almost weekly for that. Occasionally I think we've probably had some neighborhood functions going on. So a number of times we see her.
Q. Are you and the Seastrands friends on a social level where you would go out to dinner together?
A. I recall one time doing that, but that was a birthday party, not just for the two us but for other people, too, her husband. And, yeah, I recall going out to dinner with them.
Q. Is it fair to say then that most of your interaction with them comes from being neighbors and being members of the same church?

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A. Yes.
Q. Have you ever taken any joint family vacations with the Seastrands?
A. No.
Q. What about church excursions or activities that involve, well, trekking, handcart pulling, anything of that nature? Have you ever been involved with the Seastrands in anything like that?
A. With her husband I have several times. I do recall one time that I went to – as kind of a supervisor for a girls camp, and Margie was there, too.
Q. Do you recall approximately when that was?
A. I think it was a couple years ago, but that's – it could be two or it could be three.
Q. Do you recall any specific interactions with Ms. Seastrand at that Girl Scout camp or girls camp?
A. Yes.
Q. What kind of interactions did you have?
A. Well, I saw her just about every day and, you know, talked to her, and most of the other people there, too.
Q. Do you recall her complaining of any physical ailments or physical limitations at the time?
A. Yes.
Q. And what do you recall about that?

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A. I recall that there was some apprehension of her going because of her physical limitations, and I recall talking with her about her condition while we were there.
Q. And what specifically did you discuss about her condition?
A. She was talking about the problems she was having with her back and potentially having surgery.
Q. Did you have any discussions as to which areas of her back she was having pain in, whether it was upper back, middle back, lower back?
A. I seem to recall it was lower back, but I'm not real certain.
Q. Currently – well, let's do it this way. So you've known Ms. Seastrand since the early nineties, seeing her on a, you know, weekly, if not monthly, at the very least, basis, being involved as her neighbor and at church. Can you explain to me any physical differences you see in her now as opposed to before the accident happened?
A. She seems to be a lot more guarded in her back, has difficulty sitting periods of time. I've had some back problems myself, and so I can kind of recognize the way she moves that you can tell that her back's bothering her. At least to me it appears that

way.
Q. And in what way is that? Describe that for me.
A. Well, yesterday I recall she was sitting in front of me in church and – and oftentimes I see her sitting there and I just kind of see her moving about like she's trying to get comfortable with her back (demonstrating). And a couple times – I don't recall this happening in the last couple weeks, but several times I recall her getting up and going and standing rather than being able to sit and – you know, so changing her position to try and get comfortable.
Q. Have you ever had any discussions with her about any surgery or medical procedures that she's undergone?
A. Yes.
Q. What have you discussed with her about that?
A. Well, I think at the girls camp we talked about – I think that was before she had the surgery, if I'm not mistaken, and I -- since I'm a defense attorney, I think at that time she was treating with Dr. Grover, and I said, Be very careful with him; I think he's over aggressive with his recommendations for surgery. And I think she subsequently went to UCLA. And I thought she went to UCLA and got a second opinion, and I think they

did surgery. And I vaguely recall that she had a disc replacement, but I could be off on that. Since I deal with back cases quite often, I could be confusing with some other case, but I think it was her.
Q. But you do specifically remember that she was treating with Dr. Grover?
A. I thought that's who she told me, but, again, I could be – it could have been somebody else.
Q. Now, you're a defense attorney?
A. Yes.
Q. And you do insurance defense?
A. Yes, although it's mainly self-insureds.
Q. And how long have you been licensed in Nevada?
A. I think I was licensed in '84. Too long.
Q. I don't know if I have another 20 years in me.
A. Yeah. I don't, that's for sure.
Q. Other than how guarded Ms. Seastrand is with her back, difficulty sitting, moving around her position or standing to get comfortable, do you have any other current observations as to how she is impacted by back pain?
A. I'm kind of struggling with that. I haven't personally observed it, but I think at Hollywood Kids she does less because of that. But I think that's just

what I've heard some other people saying. I can't recall who said it. Maybe something I heard during the litigation I handled.
Q. Okay. So you don't have any personal knowledge of the limitations that are on her at least from observing her, but you have heard through some source that she is limited in her work?
A. Yes, and just seeing her around the neighborhood or, you know, like functions we go to. I would be surprised if she's doing many things that are physical in nature.
Q. Did you consume any drugs, alcohol, or other substances that would impair your ability to reason or think clearly today?
A. No.
Q. Have you ever been convicted of a felony?
A. I don't think so. No, I have not.
MR. SMITH: I think that's about all I got.
MS. BRASIER: I have no questions.
MR. SMITH: Do you want to read and sign or waive?
THE WITNESS: I'm fine either way. I'm happy to waive it unless one of you wants me to read it.
MR. SMITH: It's up to you.
THE WITNESS: I will waive, then.

(Deposition concluded at 2:08 p.m.)
* * * * *

CERTIFICATE OF REPORTER

STATE OF NEVADA)
SS:
COUNTY OF CLARK)

I, Ann Salisbury, Certified Court Reporter for the State of Nevada, do hereby certify:

That I reported the taking of the deposition of the witness, Jerry Busby, commencing on Monday, November 5, 2012, at 1:55 o'clock p.m.

That prior to being examined the witness was by me duly sworn to testify to the truth.

That the foregoing transcription is a true, complete, and accurate transcription of the stenographic notes of the testimony taken by me in the matter entitled herein to the best of my knowledge, skill, and ability.

That prior to the completion of the proceedings, the reading and signing of the transcript was not requested by the witness or a party.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of an attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Clark, State of Nevada, this _____ day of _____, 2012.

_____
Ann Salisbury, RPR, CCR 185

EXHIBIT 12

DOEW
STEVEN T. JAFFE
sjaffe@lawhjc.com
Nevada Bar No. 007035
JACOB S. SMITH
jsmith@lawhjc.com
Nevada Bar No. 010231

HALL JAFFE & CLAYTON, LLP
7455 WEST WASHINGTON AVENUE, SUITE 460
LAS VEGAS, NEVADA 89128
(702) 316-4111
FAX (702) 316-4114

Attorneys for Defendant
Raymond R. Khoury

DISTRICT COURT

CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND, Plaintiff, vs. RAYMOND RIAD KHOURY; DOES I through 10; and ROE ENTITIES 11 through 20, inclusive, Defendants.	CASE NO. A-11-636515-C DEPT NO. XXX DEFENDANT RAYMOND RIAD KHOURY'S DESIGNATION OF EXPERT WITNESSES

Defendant, RAYMOND RIAD KHOURY., by and through his counsel of record, STEVEN T. JAFFE, ESQ. and JACOB S. SMITH, ESQ. of HALL JAFFE & CLAYTON, LLP, pursuant to Rule 26(b)(5)(D) of the Nevada Rules of Civil Procedure, designate the following expert witnesses:

I.

WITNESSES

1. Craig L. Greene, CPA
McGovern & Greene, LLP
2831 St. Rose Parkway, Suite 285
Henderson, NV 89052
(702) 818-1168

Mr. Greene is a founding partner of McGovern & Greene, LLP, a firm of Certified Public Accountants practicing in assurance, forensic accounting, and fraud examination. He will offer testimony regarding his review of Plaintiffs' financial information and business documents, the matters

further discussed in his August 10, 2012 report, and his background and credentials. Mr. Greene reserves the right to amend and/or supplement his expert report and opinions pending review of additional records, items and testimony in this matter.

2. Joseph Schifini, M.D.
600 S. Tonopah Drive, #240
Las Vegas, NV 89106
(702) 870-0011

Dr. Schifini is a certified pain management physician and will offer testimony regarding his review of Plaintiff's medical records, including the medical and billing records specific to Integrated Spine Specialists, the matters further discussed in his August 25, 2012 report, and his background and credentials. Dr. Schifini reserves the right to amend and/or supplement his expert report and opinions pending review of additional records, items and testimony in this matter.

3. Staci L. Schonbrun, Ph.D.
Labor Market Consulting Services
7477 E. Broadway
Tucson, AZ 85710
(520) 881-6160

Dr. Schonbrun is a Certified Life Care Planner, a Certified Rehabilitation Counselor, a Certified Disability Management Specialists, and a Certified Case Manager. She will offer testimony regarding her review of Plaintiff's medical and income records, the telephonic interview of the Plaintiff on July 9, 2012, the matters further discussed in her August 30, 2012 report, and her background and credentials. Dr. Schonbrun reserves the right to amend and/or supplement her expert report and opinions pending review of additional records, items and testimony in this matter.

4. John B. Siegler, M.D.
Spine and Pain Management
2510 Wigwam parkway, Suite 201
Henderson, NV 89074
(702) 457-7463

Dr. Siegler is a physical medicine and rehabilitation expert and will offer testimony with regard to his review of Plaintiff's medical records, the items referenced within his July 12, 2012 report, and his background and credentials. Dr. Siegler reserves the right to amend and/or supplement his expert report and opinions pending review of additional records, items and testimony in this matter.

\\\

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

Board Certified American Board of Physical Medicine and Rehabilitation
Board Certified American Board of Electrodiagnostic Medicine
Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
Fax: (702) 878-7463

09-16-2009	I reviewed records. Plasma disc decompression L4 through S1 performed by Dr. Muir.
09-22-2009	I reviewed a dictation from Dr. Belsky. Prescription written for Ms. Seastrand.
09-29-2009	I reviewed a note from Dr. Muir recommending Medrol Dose Pack and CBC.
10-06-2009	I reviewed a visit with Dr. Muir. Increase in leg pain noted. A new MRI ordered.
10-06-2009	I reviewed a dictation from Dr. Belsky. Medications prescribed.
10-13-2009	I reviewed a dictation from Dr. Belsky. Medications prescribed.
10-21-2009	I reviewed records. Caudal epidural steroid injection by Dr. Belsky.
11-02-2009	I reviewed a note from Dr. Belsky. No relief following the injection. Medications adjusted.
11-02-2009	I reviewed a dictation from Dr. Muir recommending Toradol, TENS unit and medications.
11-17-2009	I reviewed a dictation from Dr. Muir recommending continue medications and electrodiagnostic studies.
11-20-2009	I reviewed a dictation from Dr. Belsky. Medications prescribed.
12-09-2009	I reviewed a procedure note from Dr. Belsky. A caudal epidural steroid injection was done.
12-10-2009	I reviewed a dictation from Dr. Shah who notes electrodiagnostic studies showing minimal active denervation potentials.
12-15-2009	I reviewed a dictation from Dr. Belsky recommending continue meds.

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

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Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
Fax: (702) 878-7463

12-15-2009	I reviewed a dictation from Dr. Muir recommending a fusion of the neck.
01-07-2010	I reviewed a dictation from Dr. Shah recommending electrodiagnostic studies in the lower extremities which was positive for subacute L5 radiculopathy.
01-20-2010	I reviewed a dictation from Dr. Muir recommending proceeding with a fusion.
02-02-2010	I reviewed a progress note from Dr. Muir. Status post fusion. Reports improvement of cervical pain.
02-16-2010	I reviewed a dictation from Dr. Muir. Continue to monitor. Avoid activity.
03-05-2010	I reviewed a dictation from Dr. Muir recommending a lumbar fusion.
04-02-2010	I reviewed an evaluation from Dr. Langolis.
04-14-2010	I reviewed electrodiagnostic studies in the lower extremities performed and were negative.
04-29-2010	I reviewed a dictation from Dr. Khavkin recommending consideration of surgery at the L4 through S1 level.
05-2010	I reviewed nursing notes, progress notes, physician orders, medication administration records for May 2010 hospitalization for the lumbar fusion.
05-12-2010	I reviewed records. L4-5 and L5-S1 interbody fusion performed by Dr. Grover.
06-08-2010	I reviewed a progress note from Dr. Khavkin. Follow-up status post lumbar fusion, improvement of low back pain.

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

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Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
Fax: (702) 878-7463

01-05-2011	I reviewed physical therapy progress note from Matt Smith Physical Therapy. Initial evaluation.
01-05-2011	I reviewed a plan of care from Matt Smith Physical Therapy.
01-07-2011	I reviewed a daily note from Matt Smith Physical Therapy. Recommended continue with current treatment plan.
01-10-2011	I reviewed a physical therapy progress note from Matt Smith Physical Therapy recommending continued rehab plan.
01-11-2011	I reviewed a physical therapy progress note from Matt Smith Physical Therapy. Continue with recommended continue therapy.
01-13-2011	I reviewed a physical therapy progress note from Matt Smith Physical Therapy recommending continue with rehab.
01-20-2011	I reviewed a physical therapy progress note from Matt Smith recommending continue with rehab.
01-20-2011	I reviewed a note from Dr. Langolis who recommended therapy and adjusted medications.
01-24-2011	I reviewed a physical therapy progress note from Matt Smith recommending continue with rehab.
01-27-2011	I reviewed a Matt Smith Physical Therapy progress note recommending continue with rehab.
01-31-2011	I reviewed a Matt Smith Physical Therapy progress note recommending advancement to home exercise program.
	I reviewed defendant's initial disclosure as well as answer to complaint.

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

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Board Certified American Board of Electrodiagnostic Medicine
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Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
Fax: (702) 878-7463

Margaret Seastrand **Date of Loss: March 13, 2009**

Imaging Studies Reviewed:

03-13-2009	I reviewed x-ray reports read by Dr. Gorczyca. Negative.
	I reviewed a CT report of the brain read by Dr. Blake. Negative.
04-03-2009	I reviewed an MRI report of the cervical spine. Degenerative changes at C5-6 with a disc protrusion. Also evidence of a bone contusion at the C5-6 level.
04-03-2009	I reviewed an MRI report of the lumbar spine. Annular tear at L4-5 and L5-S1 read by Dr. Lewis.
10-13-2009	I reviewed a lumbar MRI report. Protrusions at L4-5 and L5-S1.

Charges Reviewed:

	I reviewed a ledger from the Neck and Back Clinic.
	I reviewed charges from City of Las Vegas EMS.
	I reviewed charges from Mountain View Hospital.
	I reviewed charges from Radiology Specialist, Ltd.
	I reviewed charges from CHW Nevada Imaging.
	I reviewed vehicle estimates totals repair, $1672.33 for car belonging to Ms. Seastrand.
	I reviewed charges from Fremont Emergency Services.
03-20-2009	I reviewed charges from Primary Care Consultants.
03-20-2009 through 07-22-2009	I reviewed charges from Dr. Olmstead for 23 visits.

JOHN B. SIEGLER, M.D.

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Margaret Seastrand **Date of Loss: March 13, 2009**

I reviewed a ledger from Dr. Belsky.

I reviewed charges from Surgery Center of Southern Nevada.

I reviewed charges from Summerlin Medical Center.

I reviewed charges from Dr. Russell Shah.

Clinical Summary:

Ms. Seastrand was injured 03-13-09 in a rear-end accident and developed headache and neck pain. She followed up with The Neck and Back Clinic and underwent chiropractic treatment. She was noted to have low back pain and pain radiating to both legs at that time. The symptoms continued and she was referred to Dr. Belsky who performed a lumbar discogram on 09-16-09 followed immediately by a plasma disc decompression procedure by Dr. Muir.

Ms. Seastrand's developed an increase in leg pain and continued to see Dr. Belsky. She underwent epidural injections in the lumbar spine as well as the cervical spine and continued to see Dr. Muir. She was recommended for consideration of surgery and underwent a fusion at L4-5 and L5-S1 by Dr. Grover.

Diagnoses Secondary to Motor Vehicle Accident of March 13, 2009

1. Exacerbation of cervical pain.
2. Exacerbation of lumbar pain.
3. Cervicogenic headache.

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Margaret Seastrand **Date of Loss: March 13, 2009**

Discussion:

Ms. Seastrand has had two previous motor vehicle accidents and a documented history of cervical and lumbar pain. Back pain with flare ups is documented in 2007 and in 2008 she was seen for numbness and tingling radiating to both arms and shooting pain into the left arm.

Imaging studies documented disc pathology was in the cervical as well as the lumbar spine, however, there is nothing to indicate that the pathology is acute. Given Ms. Seastrand's history of pain and previous trauma, there is significant likelihood that the disc findings may be pre-existing.

Appropriateness of Treatment:

Given the increased pain after the subject motor vehicle accident, chiropractic treatment was reasonable, appropriate and performed as a result of the 03-13-09 motor vehicle accident.

The injection therapy administered by Dr. Belsky was problematic. On 05-20-09, both epidurals injections and facet injections were done at the same time. This is inappropriate. The purpose of a facet injection is to test the hypothesis as to whether or not a specific facet joint is a pain generators. By combining this diagnostic injection with an epidural injection at the same time, the clinical utility of the facet injected is negated.

On 09-16-09, provocative discography was done and was followed immediately by a plasma disc decompression. It appears that the total time documented in which both procedures were performed was from 7:38 to 8:02.

Prior to the discogram, the clinic notes document that Ms. Seastrand received a significant amount of both propofol and fentanyl. This renders interpretation of the results of the discogram problematic, as problematic as sedation will confound the patient's ability to express pain and describe the pain when the discs are stimulated.

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Margaret Seastrand **Date of Loss: March 13, 2009**

Plasma disc decompression is a procedure indicated primarily for radicular pain that is occurring at one level. As a discogram is done to diagnose discogenic pain, not radicular pain, it is unclear why the decompression is being done in conjunction with the discogram. The discogram results are irrelevant as to clinical decision making as to whether or not a plasma disc decompression is indicated.

Provocative discography is a presurgical test, and plasma disc decompression is utilized once conservative treatment has been exhausted. Given that only one set of injections were done prior to the discogram and plasma disc decompression, it would appear that implementation of these procedures was not indicated at that time.

The subsequent fusion done to address discogenic pain was based upon the problematic data from the discography thus the discography, plasma disc decompression and the subsequent lumbar fusion were not medically necessary.

The opinions above are expressed to a reasonable degree of medical probability. If additional information becomes available I would be willing to review it including if Ms. Seastrand would be available to conduct a history or physical examination. Please note the opinions expressed above may be subject to change depending on information that is obtained.

Respectfully,

John B. Siegler, M.D.

JBS/lfpd

EXHIBIT 4

JOHN B. SIEGLER, M.D.
SPINE AND PAIN MANAGEMENT
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Henderson NV 89074

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October 9, 2012

ADDENDUM TO A MEDICAL RECORD REVIEW

Re: **Khoury adv. Seastrand**

Record Reviews:

Life-Care Plan by Dr. Gross

Neurosurgical supplemental report by Dr. Gross.

Discussion:

In the Life-Care Plan rendered by Dr. Gross, recommendations included physical therapy on a yearly basis. There is no need for yearly physical therapy. Typically, a therapy course encompasses treatment for symptoms until a particular patient has reached a functional plateau and is then taught a home exercise program. Certainly therapy may be ordered in the future should Ms. Seastrand have an additional injury in the future but the need for this would be speculative and unrelated to the subject accident.

Future x-rays for Ms. Seastrand is a reasonable future medical expense.

The potential medical need of Ms. Seastrand for sacroiliac joint injections and facet rhizotomies is, at best, speculative. No diagnosis of facet mediated pain or sacroiliac pain has been established. There is no justification for including this as a probable future medical expense for Ms. Seastrand.

Dr. Gross includes the costs of a cervical fusion as a future medical expense. Although Ms. Seastrand may be at an increased risk for needing subsequent surgery in the spine, the likelihood of future surgery being necessary certainly does not cross the threshold of being probable. The medical costs of additional fusion surgeries, postoperative physical therapy, and preoperative laboratory testing cannot be justified as a probable future medical expense.

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The need for an Internal Medicine evaluation cannot be related to any injury stemming from the subject motor vehicle accident. Inclusion of a Pain Management Specialist and a Spine Specialist is redundant as most Pain Management specialists are, in fact, Spine Specialists. The future need for Pain Management is recommended presumably to prescribe pain medications. Currently, Ms. Seastrand is not utilizing any medications. Thus, the inclusion of costs for future medications and future pain management visits is not accurate.

In his supplemental report, Dr. Gross reviewed and commented on other expert reports. In commenting on my report, Dr. Gross is critical of the fact that I had mentioned the patient had a clearly documented history of cervical and lumbar complaints. Dr. Gross inaccurately states these past complaints are only mentioned on one occasion in the medical record, when in fact there are multiple references present. It is baffling that Dr. Gross would be critical of the mere mention of a past history of complaints in the involved spinal regions, as this history is clearly potentially relevant.

A bit further on, Dr. Gross contradicts his early statement of there being only one reference in the medical record of spine pain. He arbitrarily attributes the plane "flare-ups" to "stress," an ambiguous and clinically useless term which Dr. Gross does not even bother to explain.

Dr. Gross's comments are meant to confuse and obscure the issues, but the facts remain simple. Ms. Seastrand does have a significant pre-existing history of cervical and lumbar complaints which she had reported to medical providers in the past.

Dr. Gross is also deceptive in his complete misstatement of my interpretation regarding Ms. Seastrand's imaging studies. I used the word "likelihood" and not the word "likely" which would have completely changed the meaning of my statement. Unable to attack my true statement, he was forced to change what I had actually said in order to serve his agenda. With respect to my original statement that nothing was present on the imaging studies to support that the pathologic findings were acute, Dr. Gross does not provide any facts to contradict this statement.

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Dr. Gross notes that he uses sedation with discography but awakens the patient prior to provocative testing. This is a reasonable approach, but then the medical record needs to reflect that this was done. It would have been helpful for Dr. Gross to have mentioned what he usually uses for sedation as well, but Dr. Gross neglects to indicate how much sedation he typically uses as well as neglects to mention that Dr. Belsky's discography procedure note makes no mention of the patient being brought out of sedation, nor does the medication record reflect any medication was administered that would have brought the patient out of sedation.

In discussing the appropriateness of Ms. Seastrand for surgery, apparently, Dr. Gross feels that four months of chiropractic treatment and a set of inappropriately administered injections is ample enough conservative treatment to proceed with a life altering permanent surgery. I obviously disagree. Additional treatments such as physical therapy, as well as a series of well thought out and documented injections to try and pinpoint the pain generator should have been attempted before surgery was even considered.

It is noteworthy that Dr. Gross makes no mention with respect to Dr. Belsky's discography results and its impact on the subsequent plasma disc decompression that was performed.

Dr. Gross is inaccurate in his attack on Dr. Schifini's opinions regarding Dr. Shaw's electrodiagnostic studies. Electrodiagnostic testing nine months would not show subacute findings. This is counter to the very definition of subacute. At nine months, only ongoing denervation and/or chronic changes would be expected.

The opinions above are expressed to a reasonable degree of medical probability. If additional information becomes available, I would be willing to review it.

Sincerely,

John B. Siegler, M.D.

JBS/lfpd

EXHIBIT 5

www.controlpain.com
JOSEPH J. SCHIFINI, M.D., LTD
Diplomate of the American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

August 25, 2012

Steven T. Jaffe, Esq.
Hall, Jaffe & Clayton, LLP
7455 W. Washington Avenue, Suite 460
Las Vegas, NV 89128

Claimant: Margaret Seastrand
RE: Khoury adv. Seastrand
DOL: March 13, 2009

Dear Mr. Jaffe:

This letter will serve to summarize my opinions/conclusions following my review of approximately 700 pages of medical records regarding Ms. Seastrand. You have asked me to me review these records as a medical expert and provide opinions following my review. Attached to the end of this document will be more formal records review. Below, you will find a listing of the categories of records reviewed in preparation of this document.

1. Complaint
2. Answer to Complaint
3. Plaintiff's Response to Request for Admissions
4. Plaintiff's Response to Interrogatories
5. Plaintiff's Response to Second Set of Interrogatories
6. Traffic Accident Report - Bates No. CF-00196 - CF-00201
7. Five color photos of vehicle damage taken at scene of accident by Mr. Khoury - Bates No. Khoury-00001 - Khoury-00005
8. 32 color photos of vehicle damage from State Farm Insurance Claim File - Bates No. CF-00220 - CF00251
9. 10/27/08 x-ray report of cervical spine, Michael A. Baron, M.D., LTD (we were not able to obtain these films) - Bates No. CF-00998
10. Medical and billing records from Integrated Pain Specialists, Marjorie Belsky, M.D. - Bates No. IPS-00001 - IPS-00029

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11. Medical and billing records from Las Vegas Radiology – Bates No. LVR-00001 – LVR-00009
12. Medical and billing records from William Muir, M.D. – Bates No. WMMD-00001 WMMD-00199
13. Medical and billing records from Nevada Imaging Centers – Bates No. NICS-00001 – NICS-00018
14. Medical records from Summerlin Hospital:
    A. Discharge Summary, Enad Soumi, M.D. – Bates No. SHMC-00093
    B. History & physicals, Enad Soumi, M.D. – Bates No. SHMC-00094 – SHMC-00095
    C. Pre-Op history & physical, William Muir, M.D. – Bates No. SHMC-00096 – SHMC-00097
    D. Operative report, William Muir, M.D. – Bates No. SHMC-00098 – SHMC-00099
15. Medical records from Surgery Center Of Southern Nevada – Bates No. SCSN-00001 – SCSN-00110
16. Deposition of Margaret Seastrand, 5/31/12

Although there was only one record which was provided which predates the events of March 13, 2009, there are mentions and descriptions of multiple previous accidents involving Ms. Seastrand. In 1981, she was involved in a single vehicle rollover accident which occurred on the freeway in Idaho. She was traveling as a passenger without a seat belt. A result of this accident, she was taken by ambulance to a hospital in Idaho complaining of neck and knee pain. She states that she received holistic care for this 1981 motor vehicle accident. In 1985, Ms. Seastrand was involved in another motor vehicle accident while stopped at a light. Apparently, the front of her vehicle was struck by a trailer which became unhitched. She describes treatment to her spine including neck, low back and shoulders as a result of this accident. In September of 2004, Ms. Seastrand suffered a concussion when she bumped her head on the hatchback of her vehicle requiring treatment with a neurologist. Approximately two months later, she struck her head on a towel dispenser at her church and also feels she suffered a concussion as a result of this second head trauma as well. There are no other accidents to report which predate the

events of March 13, 2009. On October 27, 2008, Ms. Seastrand underwent x-ray studies of her cervical spine and chest as ordered by her primary care physician. The chest x-ray was normal, and the x-ray of the cervical spine showed mild rightward flexion of the spine compatible with muscle spasm as well as spondylolytic changes of a mild degree at C5-6. There are no other records to review which predate the 03/13/09 date of injury.

On March 13, 2009, Ms. Seastrand was the restrained driver of her vehicle stopped at light when she was rear-ended by another vehicle causing a "jolt" to her vehicle. She was reportedly taken by ambulance to MountainView Hospital. A police report was filed. I appear to be missing records from MountainView Hospital, as well as subsequent treatment from Dr. Benjamin Lurie, Dr. Olmstead and Dr. Koka. I am also missing records which occur later in Ms. Seastrand's treatment from Dr. Leo Langlois, Dr. Jorg Rosler, Dr. Yevgenly Khavkin, and Dr. Jaswinder Grover. Ms. Seastrand appeared to have a gap in care from March 13, 2009 through April 3, 2009, which likely represents a gap in produced medical records rather than a true gap in care. On April 3, 2009, Ms. Seastrand underwent an MRI of the cervical spine which shows evidence of chronic C5-6 degenerative disc disease, disc osteophyte complex and neuroforaminal narrowing as well as straightening of the cervical lordosis. On the same day, an MRI of the lumbar spine was ordered and demonstrated L4-5 and L5-S1 annular tearing, L4-5 disc bulging and neuroforaminal narrowing, L5-S1 disc protrusion and multi-level lumbar facet joint arthropathy extending from L3-4 through L5-S1. While undergoing these MRI studies at Nevada Imaging, Ms. Seastrand was asked "how long have you had back pain"? Ms. Seastrand's answer was "26 years".

After obtaining MRIs, Ms. Seastrand was referred to Dr. Marjorie Belsky, a pain management physician, for her complaints of neck and right upper extremity pain as well as her complaints of low back pain. As a result of this initial evaluation on May 5, 2009, Ms. Seastrand was diagnosed with cervical pain strain and radiculopathy, discogenic cervical

pain, lumbar pain/sprain and radiculopathy as well as lumbar disc displacement. It was recommended by Dr. Belsky that Ms. Seastrand undergo bilateral L4 and L5 transforaminal epidural steroid injections under fluoroscopic guidance and bilateral L4-5 facet joint injections as well as right C5-6 transforaminal epidural steroid injection to be performed on a different day. On May 20, 2009, Ms. Seastrand underwent bilateral L4-5 and L5-S1 transforaminal selective epidural steroid injections under fluoroscopic guidance along with bilateral L4-5 facet joint injections. Although the Visual Analog Pain Scale scores before and after the procedure were not documented in Dr. Belsky's notes, it was noted in the nursing notes that Ms. Seastrand claimed a reduction in her Visual Analog Pain Scale scores from an eight out of ten to a seven out of ten. Upon return to Dr. Belsky after an apparent 2.5 month gap in care, she continued to recommended a right C5-6 transforaminal epidural injection as well as a surgical consultation.

A surgical consultation was obtained with obtained with Dr. William Muir on August 24, 2009. On this date, Mr. Muir recommended lumbar discography as well as plasma disc decompression at L4-5 and L5-S1. Upon return to Dr. Belsky's office on August 26, 2009, a right C5-6 transforaminal epidural steroid injection was performed under Propofol, Fentanyl and Versed sedation, similar to the prior lumbar injections. There were no Visual Analog Pain Scale scores noted in Dr. Belsky's notes, but my review of the nursing notes note a reduction in Ms. Seastrand's Visual Analog Pain Scale scores from a six out of ten to a zero out of ten. Ms. Seastrand followed up with Dr. Muir following this cervical injection by Dr. Belsky where once again plasma disc decompression was recommended at L4-5 and L5-S1.

On September 16, 2009, Ms. Seastrand underwent L3-4, L4-5 and L5-S1 provocation discography followed by plasma disc decompression. The L3-4 disc was felt to be negative with pressurization from 30 PSI to 81 PSI. The L4-5 and L5-S1 discs had 17 guage ArthroCare cannulas placed. These discs exhibited concordant pain patterns at anywhere from 10 to 50

PSI above the opening pressure. The L4-5 disc exhibited a concordant pain pattern at 15 PSI above the opening pressure, but continued to be pressurized to 50 PSI above the opening pressure. The L5-S1 disc exhibited a concordant pain pattern at 10 PSI above the opening pressure, but was continued to be pressurized up to 25 PSI over the opening pressure. The ArthroCare cannulas were left in place. Dr. Belsky performed analgesic discography and Dr. Muir completed the plasma disc decompression at L4-5 and L5-S1. Upon a follow up visit with Dr. Belsky on September 22, 2009, medications were dispensed. On this same day, Ms. Seastrand was reevaluated through Dr. Muir's office and noted an increase in her pain, which was now rated as a nine out of ten. By September 29, 2009, Dr. Muir's office stated that Ms. Seastrand had a poor result with plasma disc decompression. Continued medication management, a lumbar MRI and a right L5 selective nerve root block were recommended. Ms. Seastrand followed up with Dr. Belsky's office who continued medication management. Medication management was also prescribed through Dr. Muir's office. Dr. Belsky recommended Ms. Seastrand undergo a caudal epidural steroid injection due to her continued symptoms. An update MRI of the lumbar spine was also ordered and reviewed on October 13, 2009, which showed evidence of L4-5 disc bulging, facet joint hypertrophy and mild spinal stenosis. The L5-S1 disc exhibited a disc protrusion, facet joint hypertrophy and left neuroforaminal narrowing.

Ms. Seastrand returned to the care of Dr. William Muir on October 16, 2009, who recommended lumbar epidural injections. On October 21, 2009, Ms. Seastrand underwent her first caudal epidural steroid injection under fluoroscopic guidance, which reduced her Visual Analog Pain Scale score from an eight out of ten to a five out of ten. Following the initial caudal epidural steroid injection, Ms. Seastrand followed up with Dr. Belsky who continued to provide medication management. Ms. Seastrand also received medications and a TENS unit from Dr. Muir's office. On November 17, 2009, Dr. Muir's office recommended continued medication management as well as neurodiagnostic studies of the right upper extremity.

Upon return to Dr. Belsky's office, she recommended continued medication management and a repeat caudal epidural steroid injection under fluoroscopic guidance. This second caudal injection was performed on December 9, 2009, which resulted in a reduction in Ms. Seastrand's Visual Analog Pain Scale scores from a five out of ten to a zero out of ten. These reductions in Visual Analog Pain Scale scores were not reported on Dr. Belsky's procedure notes, but were available in the nursing notes. This injection was performed similarly to the previous injections under Propofol, Fentanyl and Versed sedation. On December 10, 2009, Dr. Russell Shah performed neurodiagnostic studies on Ms. Seastrand and demonstrated a subacute right C6 radiculopathy. Ms. Seastrand continued to treat through Dr. Belsky's office as well as through the office of Dr. Muir. On December 15, 2009, Dr. Muir's office recommended a neurodiagnostic study of the right lower extremity as well as an anterior cervical discectomy and fusion at C5-6. On January 7, 2010, Dr. Russell Shah performed neurodiagnostic studies of the bilateral lower extremities which showed evidence of mild subacute bilateral L5 radiculopathy. Dr. Muir's office continued to recommend cervical fusion which was completed on January 25, 2010, in the form of a C5-6 anterior cervical discectomy and fusion. It was noted that Ms. Seastrand was doing well following her surgery. Unfortunately, on February 16, 2010, Ms. Seastrand's pain returned. She was continued on medication management. By March 15, 2010, Dr. Muir was recommending L4-5 and L5-S1 anterior fusion. I appear to be missing records from March 5, 2010 through September 23, 2010.

During the gap in medical records from March 5, 2010 through September 23, 2010, Ms. Seastrand has clearly undergone lumbar fusion from L4 through S1. There was a disc bulge at L2-3 measuring 2 mm. There appears to be persistent disc bulges at L4-5 and L5-S1. There are no medical records to review beyond September 23, 2010.

After having the opportunity to review all provided medical records, it is clear that I am missing records from multiple providers including billing records. In either case, based on what I have had the opportunity to review, I have formulated several opinions regarding the care, appropriateness of care, neccessity of care and relatedness of care provided to Ms. Seastrand following the 03/13/09 date of loss. It is clear that Ms. Seastrand has been involved in multiple prior motor vehicle accidents in 1981 and 1985. She also has had two episodes of head injury causing concussion. All of these accidents and/or injuries required treatment for complaints of headache, neck pain, shoulder pain and low back pain. An x-ray of the cervical spine performed on October 27, 2008, demonstrated C5-6 degenerative changes and evidence of spasm within six months of the 03/13/09 accident, which was known to have caused only minor damage to both involved vehicles. On an intake form from Nevada Imaging from April 3, 2009, Ms. Seastrand admitted to a 26 years history of "back pain". Based on the described mechanism of injury, review of all produced medical records, and the preexisting nature of Ms. Seastrand's complaints, if injury is assumed, more likely than not, these injuries would have been limited to a temporary exacerbation of preexisting conditions or development of soft tissue injuries. These injuries would have resolved within four to eight weeks of the minor 03/13/09 motor vehicle accident. The reporting police officer on March 13, 2009, documented that "Seastrand told officers that she had prior neck and back injuries caused by a previous vehicle accident years before. These injuries claimed by Seastrand are not consistent with being caused during this collision". Treatment beyond May 13, 2009, should be considered unrelated to the events of March 13, 2009.

In reference to secondary gain, I have found a few issues of concern. Ms. Seastrand's subjective complaints often outweigh the objective findings. Throughout the medical records there are omissions or minimization of Ms. Seastrand's prior conditions. The medicolegal context of these complaints are also suspicious for secondary gain behavior.

Certain individuals may minimize, withhold, exaggerate or embellish facts for personal gain. Secondary gain is defined in the DSM IV as "external benefits [are] obtained or noxious duties or responsibilities [are] evaded." (DSM IV, Page 453). However, the concept of "secondary gain" is endowed with different meaning depending on the context. For example if a patient's disease/symptoms allow him or her to miss work, gains him or her sympathy, allows for potential financial gain or avoids a jail sentence.

At this point, based on the records I have had the opportunity to review, there appears to be early ordering of the cervical and lumbar MRIs from April 3, 2009. Dr. Marjorie Belsky performed multi-level and multi-site lumbar injections on May 20, 2009, the combination of which reduced the diagnostic usefulness of these injections. Diagnostic usefulness was further reduced by the lack of consistent inclusions of pre-procedure and post-procedure Visual Analog Pain Scale scores. The lumbar discography performed on Ms. Seastrand had a truly negative disc at L3-4, a likely indeterminate disc at L4-5, and either a concordant or indeterminate disc at L5-S1, depending on which pressure one believes. There is no reason to continue pressurizing lumbar discs once a reliable pain reproduction is achieved. During the discography, a #22 gauge 5 inch spinal needle was easily placed into the center of the L3-4 disc, but #17 gauge ArthroCare cannulas were placed at L4-5 and L5-S1, the suspected positive levels. Plasma disc decompression was performed in ten minutes or less through these indwelling cannulas immediately following the discography. Plasma disc decompression is considered experimental by most insurers and is considered non-standard in the Southern Nevada medical community. Neurodiagnostic testing performed by Dr. Shah was likely unnecessary and demonstrated "subacute" findings, which Dr. Shah previously has previously defined as an age of occurrence between three to nine months prior to the performance of the test, which would indicate that on a more likely than not basis the upper extremity and lower extremity findings are unrelated to the events of March 13, 2009. I am unclear as to the logic used in making the decisions to operate

on Ms. Seastrand's cervical and lumbar spines. I did not have the opportunity to review these records regarding the pending lumbar surgery. All injections performed by Dr. Belsky were performed under deep sedation using Versed, Fentanyl and Propofol. It was not uncommon for the recovery room nurses to have documented an altered state of consciousness following the injections performed by Dr. Belsky which raises questions about the diagnostic usefulness of these injections. Versed, a benzodiazepine, is commonly used for conscious sedation and is safe and reversible. Versed also provides no pain relief during the performance of these injections. Its main purpose is to provide anxiolysis. Fentanyl, a potent opiate medication, has no role in the performance of diagnostic spinal injections, as this medicine is capable, independent of the performed procedure, to cause reduction in pain, decreasing the diagnostic usefulness of these injections. Propofol, a sedative hypnotic, general anesthetic agent, increased the cost of these procedures as well as increased the risk to the patient. The increased cost of the procedure is secondary to the required presence of a second anesthesia provider to administer this medication known to case unconsciousness when conscious sedation is the goal. The increased risk associated with the use of Propofol is due to positioning concerns and decreased ability or inability to respond to noxious stimuli. I am unaware of any reputable medical organization which supports or promotes the use of Propofol for the purposes or conscious sedation for the performance of these complex spinal procedures.

As a member of ISIS (International Spine Intervention Society), Dr. Belsky should be familiar with the ISIS Practice Guidelines of Spinal Diagnostic & Treatment Procedures, which contains the following opinions on the use of General anesthetic agents during the performance of delicate spinal procedures: "Sedation is not indicated for any of the procedures described in these Guidelines. Notwithstanding practices and instructions to which practitioners in the USA may have been accustomed, elsewhere

in the world these procedures have been conducted, and continue to be conducted, without sedation. There are no features of any of the procedures covered by these Guidelines that warrant preemptive or routine sedation." Whenever sedation is used, however, the patient must always be sufficiently alert so as to be able to recognize and warn of any impending misadventure by reporting any unexpected, unfamiliar, or undesired sensations. Under no circumstances should any of the procedures be performed under general anesthesia. For diagnostic procedures, using general anesthesia defeats the very purpose of the investigation. For procedures that rely on provocation, the patient must be awake in order to report the production of pain and be able to describe its intensity, quality and distribution. For diagnostic blocks, the patient must be awake and mobile immediately after the procedure in order to assess the response. For ablative procedures, the patient must be awake in order to report any impending misadventure. Although not reported in the literature, cases have arisen in the Medicolegal arena of neurological injuries that should not have occurred during lumbar and cervical radiofrequency neurotomies, and which would have been avoided had general anesthesia not been used. (ISIS Guidelines Page XX)

There are some comments regarding the reviewed billing in this matter which are necessary. My comments on the billing are not meant in any way to justify the billed charges as being related to the events of March 13, 2009. There are multiple missing records including billing records from providers discussed above. I am also missing records from Surgery Center of Southern Nevada. The reviewed billing from Nevada Imaging fits well within the usual and customary ranges seen in the Southern Nevada medical community. The billing through Dr. Muir's office in general fits within the usual and customary ranges seen in the Southern Nevada medical community. Dr. Muir's bill for plasma disc decompression using CPT Code 62287 of $11,000 is quite steep considering this procedure took ten minutes or less to perform. This fee should be significantly less, as this

procedure is considered experimental by most insurers, requiring practitioners to bill an unlisted CPT Code rather than 62287. My review of Dr. Belsky's billing in this matter exhibited abnormalities as well. Dr. Belsky, as an anesthesiologist, bills utilizing the guidelines of the American Society of Anesthesiologists (ASA). Anesthesiologists bill utilizing ASA units. The most common billed charges per ASA unit in the Southern Nevada medical community is $75 to $100 per ASA unit. Dr. Belsky's office prefers to bill at $146.25 per ASA unit. Dr. Belsky, as an anesthesiologist, should understand that billing for closed fluoroscopy and epidurography is considered unbundling. One or the other should be billed, but not both. Most commonly, fluoroscopy is billed as epidurography requires a separate, lengthy report, describing, in detail, the epidural anatomy. I found no such report, and therefore, epidurography was inappropriate to have billed. Dr. Belsky's office does not appropriately utilize the bilateral modifier (-50). The appropriate use of the bilateral modifier would have reduced the billed charges of a second side of a bilateral procedure by (50%). During the performance of lumbar provocation discography, Dr. Belsky chose to infuse local anesthetic into the discs she considered to have exhibited concordant pain patterns. Since no separate needle was utilized to perform this procedure, these billed charges should be eliminated as a separate procedure was not performed. As discussed above the inclusion of a second anesthesiologist during these injections was unnecessary, and these charges should be eliminated. As additional medical billing becomes available, I would be happy to review these billed charges. If these criticisms of the reviewed billing are taken into account, the billed charges will fit better within the Southern Nevada medical community.

In reference to Ms. Seastrand's future, at this point, her future is guarded. I would need to review the latest records for a more complete discussion on Ms. Seastrand's future needs. I do not anticipate any decreased work life capacity

or permanent impairment for Ms. Seastrand based on what I have reviewed thus far. No future care related to the events of March 13, 2009, is anticipated.

I, Joseph J. Schifini, M.D., do hereby affirm that I am a physician licensed to practice the full scope of medicine and surgery in Nevada and California; that I have an unrestricted license to prescribe every class of medication issued by the FDA; that I am Board Certified by the American Board of Anesthesiology and the American Board of Pain Medicine, and that I am a Diplomate of the American Academy of Pain Management.

I do further affirm that my opinions are derived from a review of the records provided and based on multiple factors including my experience in addition to my knowledge and familiarity with current evidence based medicine. The opinions/conclusions presented above are based on the records reviewed and/or performance of a history and physical examination, and may or may not be supplemented or changed upon presentation of additional materials not presently available for review. The opinions above were derived only after reviewing the entirety of the records submitted and/or examining the patient. No assumptions of validity or invalidity were made prior to an actual review of the materials provided. Unless noted otherwise, all presented opinions are rendered to a reasonable degree of medical probability on a more likely than not basis. The derived opinions expressed herein are the author's alone and have not been modified or skewed on the basis of any prejudice, financial consideration, or secondary influence other than an analysis of the available data, including provided medical records, photographs, radiographs, video surveillance, history and physical examination, etc. The opinions stated above would remain the same based upon the evidence provided regardless of the parties involved or the agent or agency requesting this review and/or examination.

If further clarification of these opinions is necessary, please do not hesitate to contact me.

Sincerely,

Joseph J. Schifini, M.D.

JJS/dt

RECORD REVIEW

CLAIMANT: Margaret Seastrand

REVIEW OF RECORDS

Records Prior to DOL of 03/13/09

2008

10/27/08 **S. Robert Hurtwitz, M.D. – Michael A. Baron, M.D. – X-ray: Chest – Impression:** 1) Normal examination. **X-ray: Cervical Spine – Impression:** 1) Mild rightward flexion of spine compatible with muscle spasm. 2) Spondylolytic changes of mild degree at C5-6.

Records Following DOL of 03/13/09

2009

03/13/09 **Motor Vehicle Accident** – Ms. Seastrand was the restrained driver of her van. She was stopped at a light when she was unexpectedly struck from the rear. She was taken by ambulance to Mountain View Hospital.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Cervical Spine Without – Findings:** There is straightening of the cervical lordosis. Vertebral body heights are well preserved. Marrow signal intensity throughout the cervical region is normal, except for subtle findings related to chronic degenerative disc disease at C5-6 in the endplates. The foramen magnum and craniovertebral junction are normal. The C1-2 joint is normal. The C2-3, C3-4, and C4-5 discs are normal. The C5-6 disc space narrowing and endplate signal intensity changes are seen, consistent with chronic degenerative disc disease. There is also posterior protruding disc and osteophyte in the midline with indentation on the ventral thecal sac. This is a broad-based indentation and there is some mild bilateral foraminal encroachment. The C6-7, C7-T1 and T1-2 discs are normal. The cervical cord is normal in caliber and signal intensity. **Impression:** 1) Moderate chronic disc degenerative changes at C5-6 with posterior protruding disc osteophyte complex and broad indentation on the ventral thecal sac. Associated mild bilateral neural foraminal narrowing. 2) Straightening of the cervical lordosis.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Lumbar Spine Without – Impression:** 1) Evidence for lumbar strain. 2) Posterior annular tears at L4-5 and L5-S1 intervertebral discs. 3) Bilateral posterolateral disc bulges at L4-5. 4) Central disc protrusion at L5-S1. 5) Posterior facet joint arthropathy L3-4 through L5-S1 bilaterally, with left

posterior facet joint synovitis at L4-5. 6) Moderate bilateral neural foraminal narrowing at L4-5. 7) No significant central spinal canal stenosis in the lumbar spine.

05/05/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Recommend set of lumbar epidural steroid injections at the levels where the MRI shows pathology to alleviate some of the presenting complaints and findings L4 and L5 TFESI bilaterally and consider lumbar facets L4-5 B/L. After this C5-6 on the right TFESI. Ultram and Flexeril.

05/20/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Transforaminal epidural at L4-5 and L5-S1 bilaterally with L4-5 bilateral facet injections and epidurogram with fluoroscopic guidance. **Preoperative Dx:** 1) Lumbar disc bulge. 2) Lumbar radiculopathy. 3) Lumbar facet pain. **Postoperative Dx:** Same. ***The same procedure was repeated on the left.*** **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 7/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Versed 1mg; Fentanyl 50mcg; and Propofol 100mg. Arouses to name, responsive to verbal stimuli in PACU.

08/04/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with

disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Recommend C5-6 on the right TFESI. 2) Tylenol #4. 3) Send for surgical consult.

08/24/09 **William Muir, M.D. – Initial Visit – Chief Complaints:** Neck and back pain. **History of Injury:** Patient was involved in an MVA on 03/13/09. She was rear-ended by another vehicle. She had a similar injury 23 years ago. **Pain Score:** 7/10 cervical, 10/10 lumbar. **ROM:** Lumbar spine ROM 10% of normal and painful. Extension 5% of normal and painful, lateral flexion 10% of normal and painful. **Impression:** 1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal of normal lordotic curve. 3) Probable in internal disc disruption syndrome. 4) Mild degenerative disc changes L4-5 and L5-S1. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Lumbar IDD/IDDS. 3) Lumbar radiculitis. **Plan:** 1) Naprosyn. 2) Continue Tylenol #4. 3) Pending cervical injection. 4) Discogram/plasma disc decompression L4-5, and L5-S1. 5) Return for evaluation of the cervical spine.

08/26/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure;** 1) Transforaminal epidural injection at C5-6 on the right with epidurogram and fluoroscopic guidance. **Preoperative Dx:** 1) Cervical disc bulge. 2) Cervical radiculopathy. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 6/10. **Post Procedure Pain Score:** 0/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Versed 1mg; Fentanyl 50mcg. Propofol 100mg. No response to verbal or tactile stimuli.

08/28/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that resulted in significant improvement regarding her cervical spine. **Pain Score:** 5/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:**

1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 3) Probable in internal disc disruption syndrome L4-5. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Naprosyn. 2) Continue Tylenol #4 for pain. 3) Pending L4-5, L5-S1 plasma disc decompression. 4) Obtain medical records from recent injection in the cervical spine. 5) Return in one month.

09/16/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Discogram at L3-4, L4-5, and L5-S1 with fluoroscopic guidance and discographic interpretation. The L3-4 disc was negative OP 30psi → 81psi. The L4-5 disc was positive OP 25psi →40psi →75psi. 17g ArthroCare cannula inserted. The L5-S1 disc was positive OP 15psi →25psi →40psi 17g ArthroCare cannula inserted. Analgesic discography performed at L4-5 and L5-S1 prior to Plasma Disc Decompression.

09/16/09 **William Muir, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** Lumbar plasma disc decompression surgery, L4-S1. **Pre Procedure Dx:** Discogenic pain L4-5. **Post Procedure Dx:** Same. **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 6/10. **Anesthesia:** Versed 1mg; Fentanyl 50mcg and Propofol 200mg.

09/22/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Neurontin. 2) Valium. 3) Flector patches. 4) Follow up in one week.

09/22/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. **Pain Score:** 9/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 3) Probable in internal disc disruption syndrome L4-5. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Follow up with Dr. Belsky. 2) Continue present medication therapy. 3) Follow up in one week.

09/29/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 9-10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Prescriptions for pain from Dr. Tarquino. Start Medrol Dosepak after results from lab work. 2) CBC and Sed rate to rule out infection

associated with injection. 3) May need new MRI and possible right L5 selective nerve root block. 4) Follow up in one week.

10/06/09 **Mario Tarquino, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Neurontin. 2) Valium. 3) Ultram. 4) Follow up in one week.

10/06/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1)

Continue present meds. 2) Pending MRI scan. 3) Medrol Dosepak. 4) Return after MRI.

10/13/09 **Mario Tarquino, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Increase Neurontin. 2) Schedule her for caudal to relieve some of her pain. 3) Add Lortab. 4) Follow up in one week.

10/13/09 **Sonny A. Patidar, M.D. – Las Vegas Radiology – MRI of the Lumbar Spine Without Contrast – Findings:** There is straightening of the lumbar lordosis. Mild disc desiccation is noted at L4-5 and L5-S1. The vertebral body heights are maintained. The conus medullaris ends at L1-2. T12-L1: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L1-2: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L2-3: No significant disc bulge or protrusion. The neural foramin are patent, and the exiting nerve roots are normal. L3-4: There is a minimal 1 to 2 mm disc protrusion that abuts the thecal sac. The neural foramina are patent, and the exiting nerve roots are normal. L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing. **Impression:** 1) L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. 2) L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing.

10/16/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Pending right sided selective nerve root block by Dr. Belsky. 3) Return in two weeks.

10/21/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Lumbar caudal epidural with epidurogram and fluoroscopic guidance. **Preoperative Dx:** Lumbar disc bulge. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 8/10. **Post Procedure Pain Score:** 5/10. **Anesthesia:** Versed 1mg; Fentanyl 100mcg; Propofol 100mg.

11/02/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion

and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Ultram. 2) Neurontin. 3) Add Lortab. 4) Follow up in four weeks.

11/02/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 10/10. **ROM:** Lumbar flexion 10% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 80% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Toradol. 3) TENS unit for home use. 4) Return in two weeks.

11/17/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient returns and underwent a cervical injection by Dr. Belsky that has resulted in significant improvement regarding her cervical spine. The right leg neuritis is so severe it overwhelms her neck pain. She underwent plasma disc decompression of L4-5 and L5-S1 on September 16, 2009. She has had increased symptoms since that time episodes of severe vomiting after the procedure and pain she finds intolerable. She was placed on short-term morphine but could not tolerate the medication. She vomited approximately 15 times violently in response to the morphine. **Pain Score:** 8-10/10, low back and buttocks, 4/10 right leg pain. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion

50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Prescription for Tramadol and Ibuprofen. 3) Return in one month. 4) EMG of the right upper extremity.

11/20/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **Pain Score:** 4/10. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Utram. 2) Neurontin. 3) Repeat caudal. 4) Follow up in four weeks.

12/09/09 **Marjorie Belsky, M.D. – Surgery Center of Southern Nevada – Operative Report – Procedure:** 1) Lumbar caudal epidural with dye study and fluoroscopic guidance. **Preoperative Dx:** 1) Lumbar disc bulge. 2) Lumbar radiculopathy. **Postoperative Dx:** Same. **Pre Procedure Pain Score:** 5/10. **Post Procedure Pain Score:** 0/10. (Note, these Pain scores were not contained within the dictated procedure notes. They were only available after review of the nursing notes). **Anesthesia:** Propofol 100mg, Fentanyl 50mcg, and Versed 1mg. Drowsy but arousable.

12/10/09 **Russell J. Shah, M.D. – Upper Extremity EMG/NCV Study – Impression:** Subacute C6 radiculopathy with minimal active denervating potentials. Please note the patient did have a steroid treatment in the neck area and active axonal denervating potentials may not be as reflective given the indicated therapeutic intervention.

12/15/09 **Marjorie Belsky, M.D. – Marjorie Belsky, M.D., Inc. – Chief Complaint:** Lumbar and cervical pain. **History of Present Illness:** Patient is a 47-year-old female who was the restrained driver involved in a motor vehicle accident on 03/13/09. The collision occurred when the patient was stopped at a light waiting for it to change when unexpectedly the car was impacted at the rear. Soon after the accident, the patient was taken to the ER at MountainView where she was evaluated and discharged home the same day. Patient now reports associated symptoms including cervical pain and numbness down the right upper extremity and C5-6 with disc osteophyte 2-3 mm. Lumbar L4-5 distribution pain 2 mm bulges and facet arthropathy and tear, also at L5-S1 level. She is having a lot of hot flashes since steroid injections. **Pain Score:** Lumbar pain 5/10. **ROM:** Cervical ROM limited on flexion, extension and lateral rotation. Thoracic ROM normal to extension, flexion and lateral rotations. Lumbar ROM limited on flexion, extension and lateral extension. **Assessment:** 1) Cervical neck pain/strain. 2) Cervical radiculopathy. 3) Discogenic pain cervical. 4) Lumbar pain/sprain. 5) Lumbar disc displacement. 6) Lumbar radiculopathy. **Plan:** 1) Ultram ER. 2) Neurontin. 3) Follow up in four weeks.

12/15/09 **Jose Ramon Troche, PA-C – William Muir, M.D. – Follow Up – Description of Injury:** Rear-ended by another vehicle. **Chief Complaint:** Neck and back pain. **General Update:** Patient is here for follow up with Dr. Muir. Patient is status post plasma disc decompression at the L4-5 and S1 done on September 16, 2009. Subsequently, she developed a severe right L5 radiculitis which was intolerable. She had 2 epidural steroids by Dr. Belsky and was provided temporary relief. Due to the severity of the right leg pain, the neck problems were somewhat ignored. Nevertheless, the neck pain and arm pain have worsened. Initially after her epidural injection, she had some relief but that has worn off. She describes neck pain and arm pain as quite severe. **Pain Score:** 8/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the

foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) ACDF at C5-6 in January. 3) EMG right lower extremity from Dr. Shah. 4) Return in one month.

2010

01/07/10 **Russell J. Shah, M.D. – Lower Extremity EMG/NCV Study – Impression:** Mild subacute bilateral L5 radiculopathies.

01/20/10 **Jose Ramon Troche, PA-C - William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here for preoperative follow up. The patient is scheduled for cervical fusion at the C5 to C6 with spinal cord monitoring on January 25, 2010. She continues to have significant cervical spine pain with increased symptomatology. She is also complaining of significant lumbar spine pain as well. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) ACDF at C5-6. 3) Preoperative history and physical completed today. 4) Avoid high impact activities. 5) Keflex. 6) Follow up one week after surgery. 7) Go to Summerlin Hospital to preregister. 8) No PT for six weeks.

01/22/10 **Rajashree Vyas, M.D. – Summerlin Hospital Medical Center – X-ray: Chest Two Views – Impression:** Normal chest.

01/25/10 **William Muir, M.D. – Summerlin Hospital Medical Center – Pre-Op History and Physical – Chief Complaint/History of Present Illness:** Neck pain and lumbar spine pain as well. She is here for neck pain which is severe pain, constant radiating to both upper extremities. **Clinical Impression:** Cervical spine C5-6 with a herniated nucleus pulposus and a C6 radiculopathy. **Plan:** Proposed surgery by Dr. Muir is anterior cervical interbody fusion with spinal cord monitoring at C5-6 with instrumentation.

01/25/10 **William Muir, M.D. – Summerlin Hospital Medical Center – Operative Report – Procedure:** 1) Anterior approach to the cervical spine. 2) Decompression diskectomy C5-6. 3) Anterior cage placement, C5-6. 4) Anterior fusion C5-6. 5) Anterior plating C5-6. 6) Spinal cord monitoring. 7) Closure. **Preoperative Dx:** Herniated nucleus pulposus, C5-6. **Postoperative Dx:** Same.

01/26/10 **Enad S. Soumi, M.D. – Summerlin Hospital Medical Center – History and Physical** – Patient presents with neck pain. She is a 48-year-old female who was admitted for surgical intervention 01/25/10. **Assessment:** 1) Right upper extremity numbness and pain status post C5-6 diskectomy. The pain is resolved. The patient is doing very well, hemodynamically stable, with no neurological deficit. 2) Lower back pain. 3) Mild leukocytosis. No sings of infection. Hold IV antibiotics for now.

01/27/10 **Enad S. Soumi, M.D. – Summerlin Hospital Medical Center – Discharge Summary – Admitting Dx:** 1) Neck pain. 2) Lower back pain. **Discharge Dx:** 1) Neck pain, resolved, status post decompression, diskectomy on C5-6 with anterior cage placement, anterior fusion of C5 and C6. 2) Lower back pain. Patient did well, kept overnight for postop monitoring.

02/02/10 **Jose Ramon Troche, PA-C - William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here for postoperative follow up appointment. The patient is status post anterior cervical interbody fusion at the C5 to C6 that was done on January 25, 2010. She is approximately 90% overall improved since her surgical intervention. She has mild difficulties in sleeping secondary to some incisional pain. The patient states that her lumbar sine pain continues to be quite significant at this time. She would like to proceed with lumbar spine surgery within the next six weeks. **Pain Score:** 5/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Avoid high impact activities. 3) Keflex. 4) Follow up in two weeks. 5) No PT for six weeks. 6) Valium.

02/16/10 **William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here today for postoperative appointment. The patient is status post anterior cervical interbody fusion at C5 to C6 that was done on January 25, 2010. Approximately two weeks out from surgery the patient stated she was 90% improved since her surgical intervention. Unfortunately, in the past three days she was experiencing some posterior cervical and shoulder region stabbing pain and discomfort which Lortab and Valium is helping. **Pain Score:** 7-10/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Severe right sided L5 radiculitis. 5) C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal to normal lordotic curve. 6) Right to C6 and possibly C7 radiculopathy. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc without myelopathy. 4) Lumbar radiculitis. **Plan:** 1) Continue present meds. 2) Avoid high impact activities. 3) Follow up in two weeks. 4) No PT for six weeks. 5) Continue Valium.

03/05/10 **William Muir, M.D. – Follow Up – Chief Complaint:** Neck and back pain. **General Update:** Patient is here today for postoperative appointment. The patient is status post anterior cervical interbody fusion at C5 to C6 that was done on January 25, 2010. She does have some discomfort at night in the shoulder region stabbing pain which Lortab and Valium help at night time. **Pain Score:** 5-7/10. **ROM:** Lumbar flexion 40% of normal and painful; extension 5% of normal and painful; lateral flexion 10% of normal and painful. Cervical spine flexion 50% of normal and painful; extension 60% of normal and painful; lateral flexion 50% to the right, 70% to the left of normal and painful; rotation 60% of the right and 80% of the left of normal and painful. **Impression:** 1) MVA 03/13/09. 2) Status post PDD 09/16/09 with poor results to date. 3) Internal disc disruption syndrome L4-5 and L5-S1 per a discogram. 4) Bilateral L5 radiculitis. 5) Status post C5-6 disc protrusion, mild deformation of the spinal cord, disc protrusion is in the foramina bilaterally, apex of reversal of normal lordotic curve. 6) Status post right to C6 and possibly C7 radiculopathy/radiculitis. 7) ACDF C5-6, 01/25/10 with good outcome to date. **Dx:** 1) Cervical disc displacement. 2) Cervical radiculitis. 3) Displacement disc site without myelopathy. 8) Lumbar radiculitis. **Plan:** 1) Anterior posterior lumbar fusion L4-S1. 2) Avoid high impact activities. 3) Follow up in one month. 4) No PT for the neck until April. 5) Continue Valium and Neurontin.

09/23/10 **Lawrence Bogle, M.D. – Las Vegas Radiology – CT Lumbar Spine Unenhanced With CT Reconstructions – Findings:** Spinal alignment: Normal lordosis, no significant listhesis. Paraspinal soft tissue: Normal. T12 to L5: Normal height without compression fracture. Anterior fixation at L4, L5 and S1 vertebral bodies are noted. T12/L1: AP dimension of central canal measures 15 mm. L1/L2: AP dimension of central canal measures 15 mm. L2/L3: AP dimension of central canal measures 15.2 mm. L3/L4: Disc: 2 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 13.7 mm. Right neural foramen: Mild stenosis due to disc bulge. Left neural foramen: Mild stenosis due to disc bulge. L4/L5: Disc: Postoperative changes are noted in anterior portion of disc. Central canal: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. Right neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: Postoperative changes are noted in anterior portion of disc. 3 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) Interval anterior fixation of L4, L5 and S1 vertebral bodies, postoperative changes at L4-5 and L5-S1 intervertebral discs. 2) L3/L4: 2 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis. 3. L4/L5: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There is moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis.

09/23/10 **Laurie Seltzer, D.O. – Las Vegas Radiology – Bilateral Screening Mammography – Impression:** Bilateral mammography reveals no evidence of malignant change. Recommend annual screening. Bi-Rads 2, benign.

Diagnostic Imaging Records Prior to DOL of 03/13/09

2008

10/27/08 **S. Robert Hurtwitz, M.D. – Michael A. Baron, M.D. – X-ray: Chest – Impression:** 1) Normal examination. **X-ray: Cervical Spine – Impression:** 1) Mild rightward flexion of spine compatible with muscle spasm. 2) Spondylolytic changes of mild degree at C5-6.

Diagnostic Imaging Records Following DOL of 03/13/09

2009

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Cervical Spine Without – Findings:** There is straightening of the cervical lordosis. Vertebral body heights are well preserved. Marrow signal intensity throughout the cervical region is normal, except for subtle findings related to chronic degenerative disc disease at C5-6 in the endplates. The foramen magnum and craniovertebral junction are normal. The C1-2 joint is normal. The C2-3, C3-4, and C4-5 discs are normal. The C5-6 disc space narrowing and endplate signal intensity changes are seen, consistent with chronic degenerative disc disease. There is also posterior protruding disc and osteophyte in the midline with indentation on the ventral thecal sac. This is a broad-based indentation and there is some mild bilateral foraminal encroachment. The C6-7, C7-T1 and T1-2 discs are normal. The cervical cord is normal in caliber and signal intensity. **Impression:** 1) Moderate chronic disc degenerative changes at C5-6 with posterior protruding disc osteophyte complex and broad indentation on the ventral thecal sac. Associated mild bilateral neural foraminal narrowing. 2) Straightening of the cervical lordosis.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Lumbar Spine Without – Impression:** 1) Evidence for lumbar strain. 2) Posterior annular tears at L4-5 and L5-S1 intervertebral discs. 3) Bilateral posterolateral disc bulges at L4-5. 4) Central disc protrusion at L5-S1. 5) Posterior facet joint arthropathy L3-4 through L5-S1 bilaterally, with left posterior facet joint synovitis at L4-5. 6) Moderate bilateral neural foraminal narrowing at L4-5. 7) No significant central spinal canal stenosis in the lumbar spine.

10/13/09 **Sonny A. Patidar, M.D. – Las Vegas Radiology – MRI of the Lumbar Spine Without Contrast – Findings:** There is straightening of the lumbar lordosis. Mild disc desiccation is noted at L4-5 and L5-S1. The vertebral body heights are maintained. The conus medullaris ends at L1-2. T12-L1: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L1-2: No significant disc bulge or protrusion. The neural foramina are patent, and the exiting nerve roots are normal. L2-3: No significant disc bulge or protrusion. The neural foramin are patent, and the exiting nerve roots are normal. L3-4: There is a minimal 1 to 2 mm disc protrusion that abuts the thecal sac. The neural foramina are patent, and the exiting nerve roots are normal. L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing. **Impression:**

1) L4-5: 4.3 mm disc bulge and facet and ligamentum flavum hypertrophy produces mild spinal canal narrowing and mild to moderate left and mild right neural foraminal narrowing. 2) L5-S1: 3.1 mm disc protrusion and facet hypertrophy produces mild left neural foraminal narrowing.

12/10/09 **Russell J. Shah, M.D. – Upper Extremity EMG/NCV Study – Impression:** Subacute C6 radiculopathy with minimal active denervating potentials. Please note the patient did have a steroid treatment in the neck area and active axonal denervating potentials may not be as reflective given the indicated therapeutic intervention.

2010

01/07/10 **Russell J. Shah, M.D. – Lower Extremity EMG/NCV Study – Impression:** Mild subacute bilateral L5 radiculopathies.

01/22/10 **Rajashree Vyas, M.D. – Summerlin Hospital Medical Center – X-ray: Chest Two Views – Impression:** Normal chest.

09/23/10 **Lawrence Bogle, M.D. – Las Vegas Radiology – CT Lumbar Spine Unenhanced With CT Reconstructions – Findings:** Spinal alignment: Normal lordosis, no significant listhesis. Paraspinal soft tissue: Normal. T12 to L5: Normal height without compression fracture. Anterior fixation at L4, L5 and S1 vertebral bodies are noted. T12/L1: AP dimension of central canal measures 15 mm. L1/L2: AP dimension of central canal measures 15 mm. L2/L3: AP dimension of central canal measures 15.2 mm. L3/L4: Disc: 2 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 13.7 mm. Right neural foramen: Mild stenosis due to disc bulge. Left neural foramen: Mild stenosis due to disc bulge. L4/L5: Disc: Postoperative changes are noted in anterior portion of disc. Central canal: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. Right neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Moderate stenosis due to disc bulge and facet joint arthrosis. L5/S1: Disc: Postoperative changes are noted in anterior portion of disc. 3 mm diffuse disc bulge. Central canal: AP dimension of central canal measures 12.2 mm. Right neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. Left neural foramen: Mild stenosis due to disc bulge and facet joint arthrosis. **Impression:** 1) Interval anterior fixation of L4, L5 and S1 vertebral bodies, postoperative changes at L4-5 and L5-S1 intervertebral discs. 2) L3/L4: 2 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis. 3. L4/L5: 10.5 mm central canal stenosis due to 4.5 mm diffuse disc bulge. There is moderate bilateral neural foraminal stenosis. 4) L5/S1: 3 mm diffuse disc bulge causing mild bilateral neural foraminal stenosis.

09/23/10 **Laurie Seltzer, D.O. – Las Vegas Radiology – Bilateral Screening Mammography – Impression:** Bilateral mammography reveals no evidence of malignant change. Recommend annual screening. Bi-Rads 2, benign.

EXHIBIT 6

www.controlpain.com
JOSEPH J. SCHIFINI, M.D., LTD
Diplomate of the American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

October 15, 2012

Steven T. Jaffe, Esq.
Hall, Jaffe & Clayton, LLP
7455 W. Washington Avenue, Suite 460
Las Vegas, NV 89128

Claimant: Margaret Seastrand
RE: Khoury adv. Seastrand
DOL: March 13, 2009

Dear Mr. Jaffe:

This letter will serve to summarize my opinions/conclusions following my review of additional documentation in this matter. You have asked me to review these records as a medical expert and provide opinions following my review. You have provided me with records and accompanying letters dated October 1, 2012 and October 8, 2012, which contain a rebuttal expert report of Marjorie Belsky, M.D., dated September 21, 2012, and a neurosurgical supplemental report from Jeffrey D. Gross, M.D., dated September 29, 2012. You have asked me to review these records in addition to my previously authored document of August 25, 2012, and provide supplemental opinions following my review. I felt no need to supplement my formal record review after reviewing these documents.

Dr. Gross' report of September 29, 2012, consisted of 21 pages in which Dr. Gross attempts to discredit all of the medical experts hired by the Defense. I will comment specifically on the comments made regarding my report. I will attempt to comment on them in the order in which Dr. Gross utilized in his report. Dr. Gross recognized the multiple motor vehicle accidents in which Ms. Seastrand was involved in the past. Dr. Gross also noted the "minor" nature of Ms. Seastrand's 03/13/09 motor vehicle accident. In comparison, Ms. Seastrand was involved in much more severe accidents in the past including a rollover accident in 1991 for which she received only holistic care as well as other

690 S. Tonopah Drive, Suite #240, Las Vegas, NV 89106 ▫ (702) 870-0011 ▫ Fax (702) 870-1144

accidents which caused head injury, neck injury, low back injury and shoulder injury. Dr. Gross appears to disagree with the concept that a "minor" motor vehicle accidents are usually associated with minor injuries. He states that this is not a concept instructed in medical school. Although Dr. Gross may be correct in his assertion that this concept is not instructed in medical school, it is a concept which is dealt with on a daily basis in any medical practice which deals with injured patients. Although "minor" accidents can cause injury, this remains possible, but in this instance, I do not feel it was probable. Although Dr. Gross reviewed my report noting a Nevada Imaging Intake form reflecting a "26 year history of back pain", Dr. Gross does not discuss this as a significant medical fact. Instead, he uses this fact out of context to attempt to discredit me and my opinions regarding a possible temporary exacerbation of Ms. Seastrand's preexisting conditions. Dr. Gross attempts to refute the commonly held belief that "minor injuries are often limited to short courses of treatment". He states that Ms. Seastrand's ongoing need for treatment "supports the fact that injury was greater than that as described by" myself. My use of the term soft tissue in this matter specifically referred to musculoligamentous injuries, not injuries to discs, nerves or spinal cord. Although it is believed that patients who have preexisting injuries are more susceptible to further injury, it is unclear as to whether or not Dr. Gross has even opined or agreed that Ms. Seastrand has had previous injuries for which she would be more susceptible. My discussions of medical facts and statistics in this case specifically refer to scenarios which were likely to have occurred following such a "minor" impact motor vehicle accident. Dr. Gross criticizes my opinions as "incomplete and over simplified" due to the logical approach I have taken to report my opinions. It is only Ms. Seastrand's opinion that her quality of life has not returned to baseline. Neither I nor Dr. Gross knew Ms. Seastrand prior to this injury, and therefore, he is being a patient advocate, believing that everything Ms. Seastrand discusses is accurate, despite inconsistencies with known facts and concern for secondary gain behavior. Ms. Seastrand's subjective complaints often outweigh the objective data. Ms.

Seastrand also has omissions and minimization of her prior conditions which were not discussed with her previous providers. Dr. Gross did not find any evidence of psychological elements during his evaluation, but that does not prove that these were not present. Dr. Gross attempted to defend Dr. Belsky's use of multi-level and multi-site lumbar injections. It is my opinion that these injections had no diagnostic value. Furthermore, the lumbar discography performed by Dr. Belsky did not fit with the usual standards as recommended by the International Spine Intervention Society (ISIS). My comments regarding plasma disc decompression (PDD) are not economically motivated, but are based on known facts and evidence based medicine. Typically insurance companies will reimburse for procedures which have proven clinical utility, not experimental procedures such as PDD. The neurodiagnostic testing performed by Dr. Shah showed evidence of "subacute" findings which fall outside the typical date range which would make these findings relevant and possibly related to the subject accident. The medical logic used to determine Ms. Seastrand was a surgical candidate is still in question. I did not refer to the treating physicians as "illogical" as Dr. Gross would have one believe, but I felt the decision making by these physicians did not follow a logical pattern, likely due to the omissions and minimization of Ms. Seastrand's preexisting conditions. Dr. Gross attempts to further defend Dr. Belsky's use of deep sedation during these procedures with the use of Fentanyl, Versed and Propofol, which raised questions regarding the validity of these diagnostic/therapeutic tools. Although Dr. Gross may "prefer" his patients to have pain injections under such sedation, it is not the standard way these injections are performed based on ISIS Guidelines. Dr. Gross, as a practicing neurosurgeon, may not be familiar with the ISIS Guidelines, but hopefully, he does not base his surgical decisions on testing that was performed in such a fashion to leave doubt about the diagnostic utility of these injections. I stand by my criticism of the billing in this matter and still do not relate any of the billing to any specific event. My designation of a "guarded" future for Ms. Seastrand was related to the potential for additional surgical intervention and has nothing to do with the motor vehicle accident of March 13, 2009.

There are comments which are necessary regarding Dr. Marjorie Belsky's report of September 21, 2012. Although this report was written to "To Whom It May Concern", clearly, this report was intended for Ms. Seastrand's attorney. Dr. Belsky's letter served as rebuttal to my 08/25/12 report. As I have done with Dr. Gross, I will attempt to address Dr. Belsky's relevant rebuttal issues in the same order in which she brought them up in her reporting. Dr. Belsky appears to be able to differentiate a head injury from a potential neck injury. Dr. Belsky states that "striking your head on a towel dispense would be considered a head injury, not injury to the neck or low back, for which she (Ms. Seastrand) is being treated for her 03/13/09 accident". Although it is possible to have a head injury without a neck injury, these injuries usually go hand in hand. A low back injury is usually not related to "head injury". Dr. Belsky must have not been aware, as she was only a treating physician of Ms. Seastrand's long standing history of back pain, which was admittedly present for 26 years prior to the 03/13/09 motor vehicle accident as was demonstrated in an intake form from Nevada Imaging on April 3, 2009. Although this form does not elucidate what part of the back this reference entails, it is clear that Ms. Seastrand has a long standing history of pain which she did not discuss with her treating physicians. The EMG studies Dr. Belsky refers to are unrelated to the accident as they are outside the range of "subacute" episodes as were defined by Dr. Russell Shah. Dr. Belsky attempted to defend her use of lumbar provocation discography and plasma disc decompression. It remains my opinion that Dr. Belsky's lumbar discography did not follow the recommended protocol as recommended by ISIS. The ISIS Guidelines, although they were adopted in 2004, are still the "gold standard" regarding discography. The discography at L4-5 should have been labeled as indeterminate, and the discography at L5-S1 should have been labeled indeterminate as well based the pressures in which they occurred, based on ISIS Guidelines. The plasma disc decompression which immediately followed the lumbar provocation discography is considered experimental. Although Dr. Belsky has performed over 300 discographies involving

plasma disc decompression, it is still my opinion and the opinion of most insurers that this procedure is considered "experimental". I am aware of no other physicians performing plasma disc decompression in the Southern Nevada medical community other than Dr. William Muir. These procedures are typically performed in a medicolegal context and therefore do not require authorization. Although Dr. Belsky did a poster presentation at an ISIS conference in 2010, this does not necessarily represent the standard of care. Occasionally, ISIS will allow presenters to present controversial issues to stimulate discussion. Dr. Belsky discussed a recent ISIS conference which occurred on July 18, 2012. If Dr. Belsky actually attended this conference, in which opinions were provided Dr. Paul Dreyfuss, she would be aware of the questions and answer session in which I specifically asked a question to all of the panel members who are considered experts in their fields regarding conscious sedation for interventional pain procedures. Dr. Belsky, although she references "conscious sedation", what she is using is unconscious sedation. Dr. Belsky failed to include the conscious sedation panel questions and answer discussion in which unanimously the panel stated that under no circumstances Propofol should be used, at any dose, due to its propensity to cause unconsciousness. Although Dr. Belsky may have presented evidence where two-thirds of patients "felt better" following plasma disc decompression, it is odd that I have not yet reviewed any records in which even one patient has received any long term benefit from this procedure. It appears to be a procedure which is a prelude to additional surgical intervention rather than a stand alone successful procedure. Although Dr. Belsky attempts to defend her use of an epidurogram billed simultaneously with fluoroscopy, the American Society of Anesthesiologists (ASA), has issued guidelines stating that this is inappropriate. Therefore, Dr. Belsky's outside billing company is incorrect. As an anesthesiologist, Dr. Belsky bills utilizing ASA units. Most of the standard procedures performed by pain interventionalists are covered in the ASA Relative Value Guide. An ASA unit monetary value is assigned to these cases, and multiplied by the number of units allotted for

each procedure. Whether Dr. Belsky sets one price for these procedures or uses ASA units, the average cost per ASA unit can typically be calculated, and her bills are higher than the usual and customary ranges seen in the Southern Nevada medical community.

After reviewing these two reports, I have had no changes to my previously expressed opinions in this matter.

I, Joseph J. Schifini, M.D., do hereby affirm that I am a physician licensed to practice the full scope of medicine and surgery in Nevada and California; that I have an unrestricted license to prescribe every class of medication issued by the FDA; that I am Board Certified by the American Board of Anesthesiology and the American Board of Pain Medicine, and that I am a Diplomate of the American Academy of Pain Management.

I do further affirm that my opinions are derived from a review of the records provided and based on multiple factors including my experience in addition to my knowledge and familiarity with current evidence based medicine. The opinions/conclusions presented above are based on the records reviewed and/or performance of a history and physical examination, and may or may not be supplemented or changed upon presentation of additional materials not presently available for review. The opinions above were derived only after reviewing the entirety of the records submitted and/or examining the patient. No assumptions of validity or invalidity were made prior to an actual review of the materials provided. Unless noted otherwise, all presented opinions are rendered to a reasonable degree of medical probability on a more likely than not basis. The derived opinions expressed herein are the author's alone and have not been modified or skewed on the basis of any prejudice, financial consideration, or secondary influence other than an analysis of the available data, including provided medical records, photographs, radiographs, video surveillance, history and physical examination, etc. The opinions stated above would remain the same based upon the evidence provided regardless of the parties involved or the agent or agency requesting this review and/or examination.

If further clarification of these opinions is necessary, please do not hesitate to contact me.

Sincerely,

Joseph J. Schifini, M.D.

JJS/dt

EXHIBIT 7

www.comedpain.com
JOSEPH J. SCHIFINI, M.D., LTD
Diplomate of the American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

February 25, 2013

Steven T. Jaffe, Esq.
Hall Jaffe & Clayton, LLP
7455 West Washington Avenue, Suite 460
Las Vegas, Nevada 89128

RE: Khoury adv. Seastrand
Claimant: Margaret Seastrand
DOL: March 13, 2009

Dear Mr. Jaffe:

This letter will serve to summarize my opinions/conclusions following my review of supplemental documentation in reference to Ms. Seastrand. You have provided me with records totaling approximately 400 pages with accompanying letters dated January 4, 2013 and January 17, 2013. You have asked me to review these records in addition to my previously authored reports in this matter dated August 25, 2012 and October 15, 2012 as a medical expert and provide updated opinions/conclusions following my review. I will attach an updated more formal record review to the end of this document. Below, you will find a listing of the categories of records reviewed in preparation of this document.

1. Deposition of William Muir, M.D., taken November 27, 2012
2. Deposition of Margaret Belsky, M.D., taken November 27, 2012
3. Deposition of Yevgeniy Khavkin, M.D., taken November 29, 2012
4. Medical and billing records from Kern Island Pain Medicine, Leo Langlois, M.D. KIPM-00001 - KIPM-00011
5. Medical and billing records from Matt Smith Physical Therapy MSPT-00001 - MSPT-00037
6. Medical records from Mountain View Hospital on date of subject accident, 3/13/2009 MVHM-00001 - MVHM-0016

600 S. Tonopah Drive, Suite #240, Las Vegas, NV 89106 • (702) 870-0011 • Fax (702) 870-1144

7. Medical and billing records from Neck & Back Clinics/Primary Care Consultants, Matthew Olmstead, D.C., Benjamin Lurie D.C., Govind Koka, D.O., and T. Knauff, P.A.-C. NBCL-00001 - NBCL00083
8. Medical and billing records from Nevada Spine Clinic, Yevgeniy Khavkin, M.D., Jaswinder Grover, M.D., and Jorg Rosler, M.D. NSC-00001 - NSC-00093, NSC-B-00001 - NSC-B-00015
9. Nevada Spine Clinic NSC-SDT-00007 - NSC-SDT-00008, NSC-SDT-00036 - NSC-SDT-00044, NSC-SDT-00093

In addition to my previously authored reports in this matter, I have had the opportunity to review supplemental records which provided further insight regarding the care provided to Ms. Seastrand on the day of her motor vehicle accident, March 13, 2009, and the early care provided through Dr. Benjamin Lurie's office, as well as the medical comanagement provided through Primary Care Consultants. The remainder of the newly produced and reviewed records reflected treatment from April of 2010 to the present, including records surrounding Ms. Seastrand's anterior L4 through S1 fusion surgery performed by Dr. Yevgeniy Khavkin. Due to the migration of the anterior lumbar plates, Dr. Khavkin has discussed posterior lumbar instrumentation with Ms. Seastrand. Accompanying these medical records were three deposition testimonies from some of Ms. Seastrand's treating physicians, Dr. Marjorie Belsky, Dr. William Muir, and Dr. Yevgeniy Khavkin. After reviewing all produced medical records and deposition testimony in addition to re-reviewing my previously authored reports on this matter, I have had no significant changes to my previously expressed opinions in this matter. Instead, I have formulated some new opinions and solidified some of my previously held opinions.

Based on the reviewed medical records, I do not have any significant changes to my opinions as discussed above, but it remains my opinion, based on my review of Dr. Khavkin's records surrounding Ms. Seastrand's lumbar surgery as well as Dr. Khavkin's deposition testimony regarding Ms. Seastrand's surgery, that the surgery performed on Ms. Seastrand in the form of a two level anterior lumbar fusion surgery was not medically indicated based on the diagnostic testing available. Dr. Khavkin, in his deposition testimony, on page 22 listed objective findings warranting recommendations for surgery to include "blackening of the disc and the presence of wear and tear changes within the disc spaces".

These objective findings described by Dr. Khavkin represent pre-existing, degenerative, expected age related findings in discs and do not represent any traumatic conditions which can be attributed to the March 13, 2009 motor vehicle accident. Additionally, Dr. Khavkin opined that discography was a "significant" element that he relied upon in recommending surgery. In my previous reports, I have detailed multiple reasons that the discography results should be considered indeterminate, at best. The results of the discography performed just prior to plasma disc decompression were not useful as a diagnostic tool for either Dr. Muir performing the plasma disc decompression, which in and of itself is considered by most insurance companies as an experimental or investigational procedure, nor should it have been useful to Dr. Khavkin in formulating a surgical plan. Instead, Dr. Muir pursued plasma disc decompression based on these equivocal results, and Dr. Khavkin felt that these equivocal results represented "significant" factors in determining his preparation for multilevel lumbar fusion surgery. The discography results after plasma disc decompression has been performed are more likely than not invalidated based on the presumed altered anatomy of the disc following any plasma disc decompression surgery. Therefore, even if the discography was felt to have been performed utilizing the guidelines of the International Spine Intervention Society (ISIS), these test results would be invalidated due to the subsequent performance of lumbar plasma disc decompression. Therefore, the surgery performed by Dr. Khavkin was not medically indicated.

I have also had the opportunity to review some additional diagnostic testing ordered by Dr. Khavkin in the form of neurodiagnostic studies of the upper and lower extremities. On August 23, 2012, Ms. Seastrand presented with complete resolution of back pain and leg pain, but she had numbness and tingling in her right arm, primarily along the medial aspect of her right arm. Dr. Khavkin ordered an MRI and neurodiagnostic studies to better define this area, although Ms. Seastrand had previously had neurodiagnostic studies performed by Dr. Shah which demonstrated a "subacute right C6 radiculopathy". The MRI performed on January 10, 2013 showed evidence of a C6 fusion with small diffuse disc bulges at C4-5 and C6-7 measuring 1.5 to 2 millimeters. The neurodiagnostic study performed by Dr. Christopher Milford on October 30, 2012 showed evidence of a right C8-T1 radiculopathy as well as a right carpal tunnel syndrome.

These results are different than the results previously demonstrated by Dr. Shah. This discrepancy was not explained. Additionally, on December 27, 2012, Dr. Khavkin noted Ms. Seastrand's upper extremity neurodiagnostic study results and stated that he wanted to obtain neurodiagnostic studies of her lower extremities. This additional testing was also performed by Dr. Christopher Milford on January 15, 2013 and demonstrated bilateral L5-S1 radiculopathy, similar to the "subacute bilateral L5 radiculopathy" previously noted by Dr. Russell Shah. It does not appear Dr. Khavkin has had an opportunity to review these studies. In my opinion, which is similar to my opinion stated previously, Ms. Seastrand's neurodiagnostic studies originally being described as "subacute" by Dr. Shah indicate that these results are not associated with the motor vehicle accident of March 13, 2009 as the results were obtained outside the period which is defined as subacute by Dr. Shah, which Dr. Shah indicates the presence of findings within four to nine months of the accident. The new findings on the upper extremity neurodiagnostic studies need further explanation as these results were not present on previous studies and clearly are unrelated to the motor vehicle accident of March 13, 2009.

Based on my review of the other deposition testimony and the remainder of the medical records, I have had no other significant changes or additions to my previously expressed opinions in this matter.

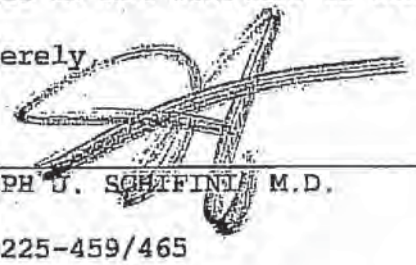
I, Joseph J. Schifini, M.D., do hereby affirm that I am a physician licensed to practice the full scope of medicine and surgery in Nevada and California; that I have an unrestricted license to prescribe every class of medication issued by the FDA; that I am Board Certified by the American Board of Anesthesiology and the American Board of Pain Medicine, and that I am a Diplomate of the American Academy of Pain Management.

I do further affirm that my opinions are derived from a review of the records provided and based on multiple factors including my experience in addition to my knowledge and familiarity with current evidence based medicine.

The opinions/conclusions presented above are based on the records reviewed and/or performance of a history and physical examination, and may or may not be supplemented or changed upon presentation of additional materials not presently available for review. The opinions above were derived only after reviewing the entirety of the records submitted and/or examining the patient. No assumptions of validity or invalidity were made prior to an actual review of the materials provided. Unless noted otherwise, all presented opinions are rendered to a reasonable degree of medical probability on a more likely than not basis. The derived opinions expressed herein are the author's alone and have not been modified or skewed on the basis of any prejudice, financial consideration, or secondary influence other than an analysis of the available data, including provided medical records, photographs, radiographs, video surveillance, history and physical examination, etc. The opinions stated above would remain the same based upon the evidence provided regardless of the parties involved or the agent or agency requesting this review and/or examination.

If further clarification of these opinions is necessary, please do not hesitate to contact me.

Sincerely,



JOSEPH J. SCHIFFINI, M.D. JJS/bjs

c: 0225-459/465

RECORD REVIEW

CLAIMANT: Margaret Seastrand

REVIEW OF RECORDS

Records Prior to DOL of 03/13/09

2008

10/27/08 **S. Robert Hurtwitz, M.D. – Michael A. Baron, M.D. – X-ray: Chest – Impression:** 1) Normal examination. **X-ray: Cervical Spine – Impression:** 1) Mild rightward flexion of spine compatible with muscle spasm. 2) Spondylolytic changes of mild degree at C5-6.

Records Following DOL of 03/13/09

2009

03/13/09 **Motor Vehicle Accident** – Ms. Seastrand was the restrained driver of her van. She was stopped at a light when she was unexpectedly struck from the rear. She was taken by ambulance to Mountain View Hospital.

03/13/09 **Mark Ferdowsian, D.O. – MountainView Hospital – History of Present Illness:** Patient was wearing a lap belt and shoulder harness. The impact was on the left rear area of the vehicle, rear of the vehicle and right rear area of the vehicle. The accident involved two vehicles and a low impact velocity and resulted in mild damage to the patient's vehicle. Estimated speed of the collision (other vehicle) 10 mph. **Clinical Impression:** 1) Acute pain in the head and neck. 2) Cervical strain. **Plan:** Lortab, Soma. Follow up with Dr. Edward Ashman.

03/13/09 **David P. Groczyca, M.D. – MountainView Hospital – X-ray: Cervical Spine Five Views – Impression:** Negative study.

03/13/09 **Lindsey C. Blake, M.D. – MountainView Hospital – CT Brain Without IV Contrast – Impression:** 1) Negative brain. 2) No significant change.

03/20/09 **Benjamin S. Lurie, D.C. – Initial Consultation and Examination – Medical History:** Patient is currently receiving treatment for syncope, heart condition and hormone therapy. She stated she had a hysterectomy approximately in 2003, bilateral foot surgery approximately in 2008, 2 DNC's in 1990 and 1991, and ovarian cyst surgery in the past with no evidence of residual difficulties. She was seen in the hospital for 2 concussions in approximately 2004. She couldn't recall the name of the

treating physician at this time. She was seen in the hospital for syncope episodes in approximately 2005 and 2006. She stated she couldn't recall the name of her treating physician. She had a positive stress test in 2008 by her cardiologist. Ms. Seastrand denied any other surgeries, fractures or serious illness in the past year that she can recall. She was involved in a motor vehicle collision (rollover) in approximately 1981 and was treated and released with no evidence of residual difficulties. She recalls injuries to the neck, mid back and lower back. She also stated she was involved in a motor vehicle collision in 1985 which described as a head on collision. She recalled injuring her neck, mid back, lower back as well. **Mechanism of Injury:** She was involved in a motor vehicle collision on 03/13/09. She was the driver of a mid sized vehicle and stated she was wearing both her shoulder harness and lap belt at the time of the motor vehicle collision. Ms. Seastrand stated before the motor vehicle collision occurred she was traveling on Craig and rancho. She stated she stopped at a red light and was suddenly rear-ended pushed forward more than a little. She was unaware she was about to be impacted by the other vehicle and therefore did not try to brace herself. She was moderately jolted and dazed by the impact. She stated her head struck the headrest. She stated the police, fire department, and paramedics were on scene and a police report was issued. She did not lose consciousness during or after the crash and was taken to MountainView Hospital via ambulance on a PCS board with a cervical collar. **Present Symptomatology: Original Complaints:** Immediately after the MVA she complained of headaches, neck pain, mid back pain, low back pain and right shoulder pain. **Present Complaints in Our Office:** 1) Headache pain, 8/10. 2) Neck pain, 9/10. 3) Mid back pain, 9/10. 4) Lower back pain, 9/10. Bilateral shoulder pain, 7/10. **ROM:** Cervical flexion 38, extension 46, left lateral flexion 36, right lateral flexion 38, left rotation 72, right rotation 70 degrees. Lumbosacral flexion 54, extension 10, left and right lateral flexion 15 degrees. Shoulder, wrist, elbow, hip, knee and ankle ROM full. **Assessment/Working Dx:** 1) Cervical articular sprain with associated cervical posterior facet syndrome, facet capsulitis, secondary to motor vehicle collision. 2) Sprain/strain injuries of the cervical paravertebral soft tissue structures with associated neuritis/radiculitis, paresthesia, myofascial pain syndrome and segmental dysfunction of the cervical/thoracic spinal articulations attendant cervicalgia. 3) Sprain/strain injuries of the thoracic paravertebral soft tissue structures with associated myofascial pain syndrome and segmental dysfunction of the thoracic/lumbar spinal articulations attendant dorsalgia. 4) Sprain/strain injuries of the lumbosacral paravertebral soft tissue structures with associated neuritis/radiculitis paresthesia myofascial pain syndrome and segmental dysfunction of the lumbar spinal articulations attendant lumbalgia. 5) Traumatic onset of post traumatic headaches secondary to motor vehicle collision. 6) Sprain/strain injury of the right/left shoulder rotator cuff secondary to motor vehicle collision with associated tendonitis/bursitis. **Current Type of Treatment:** Diversified

technique chiropractic manipulative therapy, trigger point therapy, and soft tissue mobilization, EMS, therapeutic ultrasound, interferential current therapy, hot packs, cold packs, neuromuscular re-education. Patient treated: 03/20/09, 03/25/09, 03/27/09, 03/30/09, 03/31/09, 04/03/09, 04/08/09, 04/15/09, 04/17/09, 04/21/09, 04/24/09, 04/28/09, 05/01/09, 05/06/09, 05/11/09, 05/13/09, 05/15/09, 05/18/09, 05/26/09, 06/01/09, 06/03/09, 07/21/09, and 07/22/09. **(23 visits).**

03/20/09 **Timothy Knauff, PA-C – Primary Care Consultants – History and Physical – History of Present Illness:** Patient is a 47-year-old female who on 03/13/09 was the driver of a vehicle that was involved in a rear-end collision. Her initial chief complaints are of headache, cervical pain, and stiffness as well as bilateral trapezius pain and stiffness. The patient did not anticipate the collision. Air bags were not deployed. The patient was taken to MountainView Hospital on 03/13/09 and evaluated. **ROM:** Cervical stiffness with flexion, extension, left and right rotation left and right lateral flexion. **Assessment:** 1) Cervical sprain/strain. 2) Cervical pain. 3) Headaches. 4) Bilateral trapezius sprain/strain. 5) All of the above secondary to the MVA. **Plan:** 1) Conservative rehabilitation. 2) Candidate for trigger point injections. 3) May need ortho evaluation. 4) May need pain management evaluation. Fioricet, Valium. Potential side effects. Obtain records from MountainView ER.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Cervical Spine Without – Findings:** There is straightening of the cervical lordosis. Vertebral body heights are well preserved. Marrow signal intensity throughout the cervical region is normal, except for subtle findings related to chronic degenerative disc disease at C5-6 in the endplates. The foramen magnum and craniovertebral junction are normal. The C1-2 joint is normal. The C2-3, C3-4, and C4-5 discs are normal. The C5-6 disc space narrowing and endplate signal intensity changes are seen, consistent with chronic degenerative disc disease. There is also posterior protruding disc and osteophyte in the midline with indentation on the ventral thecal sac. This is a broad-based indentation and there is some mild bilateral foraminal encroachment. The C6-7, C7-T1 and T1-2 discs are normal. The cervical cord is normal in caliber and signal intensity. **Impression:** 1) Moderate chronic disc degenerative changes at C5-6 with posterior protruding disc osteophyte complex and broad indentation on the ventral thecal sac. Associated mild bilateral neural foraminal narrowing. 2) Straightening of the cervical lordosis.

04/03/09 **William W. Orrison, M.D. – Nevada Imaging Centers – MRI of the Lumbar Spine Without – Impression:** 1) Evidence for lumbar strain. 2) Posterior annular tears at L4-5 and L5-S1 intervertebral discs. 3) Bilateral posterolateral disc bulges at L4-5. 4) Central disc protrusion at L5-S1. 5) Posterior facet joint arthropathy L3-4 through L5-S1 bilaterally, with left

0071
RICHARD A. HARRIS, ESQ.
Nevada Bar No. 505
JOSHUA R. HARRIS, ESQ.
Nevada Bar No. 9580
ALISON M. BRASIER, ESQ.
Nevada Bar No. 10522
RICHARD HARRIS LAW FIRM
801 South Fourth Street
Las Vegas, Nevada 89101
Phone (702) 444-4444
Fax (702) 444-4455
Attorneys for Plaintiff

DISTRICT COURT

CLARK COUNTY, NEVADA

MARGARET G. SEASTRAND, Plaintiff, vs. RAYMOND RIAD KHOURY; DOES I-X, and ROE CORPORATIONS I-X, inclusive, Defendants.	CASE NO.: A-11-636515-C DEPT. NO.: XXX **PLAINTIFF'S OMNIBUS MOTIONS IN LIMINE**

Plaintiff Margaret Seastrand ("Margie"), by and through her attorneys of record, the RICHARD HARRIS LAW FIRM, hereby submits her Omnibus Motions in Limine. These Motions are based on the following Memorandum of Points and Authorities, the papers

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pleadings on file, and any oral argument entertained by this Court.

DATED this 29th day of April 2013.

RICHARD HARRIS LAW FIRM

By: _____

Richard A. Harris, Esq.
Nevada Bar No. 505
Joshua R. Harris, Esq.
Nevada Bar No. 9580
Alison Brasier, Esq.
Nevada Bar No. 10522
801 South Fourth Street
Las Vegas, Nevada 89101
Attorneys for Plaintiff

DECLARATION IN SUPPORT OF PLAINTIFF'S OMNIBUS MOTIONS IN LIMINE

The undersigned hereby declares the following under penalty of perjury of the laws of the State of Nevada:

1. I am an attorney at RICHARD HARRIS LAW FIRM, counsel of record for Plaintiff in the above-captioned case.

2. On April 23, 2013, I spoke with Steve Jaffe, Esq. and Jacob Smith, Esq., counsel of record for Defendant, pursuant to EDCR 2.47.

3. Defense counsel and I were able to agree to several pre-trial, evidentiary issues and a stipulation and order regarding those issues will be submitted to the Court.

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4. Defense counsel and I were unable to agree to the pre-trial, evidentiary issues addressed in the following motions in limine, therefore, it was necessary to seek the Court's intervention to resolve these issues.

DATED this 4th day of April 2013.

ALISON BRASIER, ESQ.

NOTICE OF MOTION

TO: ALL PARTIES AND THEIR COUNSEL OF RECORD

PLEASE TAKE NOTICE that the undersigned will bring this motion on for hearing on the 4 day of June 2013, at 9:00 a.m. before the above-captioned court.

DATED this 4th day of April 2013.

RICHARD HARRIS LAW FIRM

By:

Richard A. Harris, Esq.
Nevada Bar No. 505
Joshua R. Harris, Esq.
Nevada Bar No. 9580
Alison Brasier, Esq.
Nevada Bar No. 10522
801 South Fourth Street
Las Vegas, Nevada 89101
Attorneys for Plaintiff

RICHARD HARRIS LAW FIRM

I. STATEMENT OF FACTS

On March 13, 2009, Margie was injured when Defendant Khoury negligently rear-ended her vehicle while she was stopped at a red light. As a result of Defendant's negligence, Margie was forced to undergo years of medical treatment, including cervical and lumbar fusion surgeries. Margie's past medical specials total over $433,000.

This matter is set on the Court's July 1, 2013 trial stack.

II. REQUESTED RELIEF

Plaintiff requests that the Court enter an Order before selection of the jury, instructing Defendant, his attorneys and any witnesses, not to directly or indirectly mention, refer to, interrogate concerning, or attempt to convey to the jury in any manner any of items precluded by these motions in limine without obtaining Court permission to do so. Defendant, his attorneys, and any witnesses should be instructed that Court permission may only be obtained outside the presence and hearing of the jury. Further, Defendant, his attorneys, and any witnesses should be instructed to strictly follow any Order entered by the Court in connection with this matter.

III. LEGAL ARGUMENT

A. Standard for Motion in Limine.

The primary purpose of a motion in limine is to prevent prejudice at trial.[1] The Court has authority to issue a preliminary ruling on the admissibility of evidence.[2] The decision to do

[1] See Brodit v. Cambra, 350 F.3d 985, 1005 (9th Cir. 2003).

[2] See NRS § 47.080.

so is vested in the sound discretion of the Court.[3] The Court's discretion will not be overturned absent a showing of clear abuse of discretion.[4]

Importantly, NRS § 48.035(2) states that "[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of issues, or misleading the jury." When the proffered testimony or evidence is not relevant for the aforementioned reasons, that evidence must be considered prejudicial — and therefore excludable — in the upcoming trial.[5]

By these motions in limine, Plaintiff seeks to exclude the following at trial:

1. Hypothetical Medical Questions Designed to Confuse Jury.

Hypothetical medical questions are permitted with medical experts. It is expected that Plaintiff and Defendant will ask these types of questions during trial.

By this motion, Plaintiff seeks to preclude specific types of hypothetical medical questions that will ultimately confuse the jury. Plaintiff submits to the Court that hypothetical medical questions must be based on evidence related to our case. A common defense tactic is to create confusion by asking treating physicians about **non-existent** medical conditions, symptoms, or injuries.

What would be a non-existent injury? Suppose that this is a neck injury accident that happened in 2010. And suppose that Plaintiff has no neck injuries prior to our crash. An impermissible hypothetical question would be to ask a doctor: "Tell us how Plaintiff's neck

[3] See United States v. Kennedy, 714 F.2d 968, 975 (9th Cir. 1983).

[4] See Longenecker v. General Motors Corp., 594 F.2d 1283, 1286 (9th Cir. 1979).

[5] See Uniroyal Goodrich Tire Co. v. Mercer, 111 Nev. 318, 890 P.2d 785 (1995).

injury in 2003 affects her alleged neck injury from this case?" Or, "Doctor, were you aware of Plaintiff's neck injury from 2003?"

Invariably, the doctor will testify that he was not aware that Plaintiff had a prior neck injury in 2003, or any other time prior to our crash in 2007. The defense question is specifically designed to lead jurors to believe there was a prior neck injury that is being hidden from the jury. The defense then hopes that even though there is no testimony regarding a prior neck injury, the jury will consider "the prior injury" during deliberation and reduce the damage award. Such questions are impermissible and the Court must not allow them.[6]

2. Suggesting to Jury that There Might Be Related Medical Records Prior to the Subject Crash When There Are None.

Margie was treated for injuries directly related to our crash. Every treating physician has said so. By this motion, Plaintiff seeks to preclude Defendant from suggesting to the jury that there were ***possible*** records of related injuries prior to our crash that Plaintiff is withholding. How is this done? Defense counsel will suggest in closing argument that Defendant must trust Plaintiff to provide all related medical records. If Plaintiff is dishonest in the disclosure of medical information, or fails to disclose all prior medical information, then Defendant has no way of procuring that information. Thus, the defense will argue that they would have been able to show a pre-existing injury but for the absence of medical records.

[6] See Motion in Limine No. 6 regarding arguing outside the evidence; see also Marshall v. Bally's Pacwest, Inc, 972 P.2d 475, 479 (Wash. 1999) (verdict cannot be founded on jury speculation); FRE 403 (evidence not admissible if it misleads or confuses the jury); Duthie v. Worker's Comp. Appeals Bd., 150 Cal. Rptr. 530 (1978) (medical examiner's educated guess or speculation is not competent evidence); Hyatt v. Sierra Boat Co., 145 Cal. Rptr. 47, 55 (Ct. App. 1978) (it is error in a hypothetical question to an expert witness to assume facts not within the evidence).

Such an argument is impermissible. It is arguing outside the evidence of the case.[7] The argument is designed to confuse or mislead the jury.[8] And it also requires Plaintiff to prove a negative. The absence of medical records cannot prove or disprove the existence of any medical condition, injury, or disease. If the Court allowed Defendant to make such an argument, it would force Plaintiff to counter Defendant's suggestions of a prior injury — even though the contention is not supported by fact or evidence — by proving that Margie **did not** suffer from such a condition. This is an impossible task.

3. Precluding Defendant From Referring to Case as "Attorney-Driven Litigation" or a "Medical Buildup" Case, and Precluding any Statements Insinuating that Plaintiff Sought Treatment at the Direction of Attorneys, or Because of this Litigation.

By this motion, Plaintiff seeks to preclude any evidence or statement implying that medical treatment was sought as a result of litigation — or at the suggestion of Plaintiff's attorneys. This includes, but is not limited to referencing Margie's treatment as: "litigation driven," "attorney driven," or suggesting that in the now commonplace defense bar vernacular that this is a "medical buildup" case. Evidence of or reference to these types of allegations is not relevant and is wholly prejudicial.[9]

Despite the lack of evidence supporting these allegations, it is anticipated that Defendant will argue at trial that Plaintiff's attorneys directed the medical care and that Margie's physicians performed unnecessary, unwarranted, and non-indicated medical procedures. This is simply a fabricated argument, however, intended to poison the jury. There is no evidence to

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[7] See Nevada Rule of Professional Conduct 3.4 (trial counsel "shall not allude to any matter that the lawyer does not reasonably believe is relevant or that will not be supported by admissible evidence").

[8] See Marshall, 972 P.2d at 479; NRS § 48.035.

[9] See NRS § 48.025.

suggest otherwise. All of the doctors in this case agree that Margie's treatment was based on medical necessity and not because of any attorney or litigation driven practice. And none of the doctors indicate that there was any medical billing fraud by the treating physicians.

In light of the fact that there is no supporting evidence for any allegations of attorney-directed care or "medical buildup," such references must be precluded at trial.

4. Precluding Reference to Plaintiff's Retention of Counsel.

Evidence of or reference to when or why Plaintiff retained counsel for this matter should be excluded at trial on relevancy grounds.[10] Plaintiff believes that Defendant will attempt to poison the jury at trial by suggesting that the retention of an attorney shortly after the collision suggests a secondary gain motive. Such an argument, however, is highly prejudicial.

All parties have a right to legal counsel following an injury accident. Plaintiffs seek legal counsel to recover property damage to their vehicles and for damages related to medical bills and pain and suffering. Insurance carriers have agreements with defendant drivers to defend and indemnify and immediately provide counsel subsequent to a lawsuit. The defendants' rights are contractual under the terms of the insurance policy. The plaintiffs' right to remuneration stems from statute.

To allow Defendant to attack Margie's credibility or motives simply because counsel was sought pursuant to a legal right should not be condoned by the Court. This would be no different than allowing Plaintiff to question Defendant as to why the insurance company did not settle the case prior to the commencement of the lawsuit, or to inquire as to when the insurance

[10] See id.

carrier actually agreed to indemnify and defend — a topic that is clearly prohibited by law. Thus, the when and why of counsel's retention is inadmissible.

5. Precluding Reference as to Plaintiff's Counsel Working with Margie's Treating Physicians on other Unrelated Cases.

By this motion, Plaintiff seeks to preclude Defendant from insinuating to the jury that Plaintiff's counsel has any connection to the treating physicians — or in other words — that Plaintiff's counsel regularly works with these same treating physicians on other unrelated personal injury cases. Such an insinuation is done to imply conspiracy or wrongful conduct by the doctors and/or attorneys. Such an insinuation is not only prejudicial, but is designed to poison the jury against Plaintiff's counsel and the treating physicians. It must not be permitted.[11]

6. Closing Arguments Must Be Limited to Evidence Presented at Trial.

Attorneys enjoy wide latitude in arguing facts and drawing inferences from the evidence during closing argument.[12] However, there are critical limitations with respect to arguments during closing. There is no rule of trial practice more universally accepted and applied than the rule that counsel is precluded from arguing matters outside the record — those which are not in evidence.[13] In fact, the ABA Code of Professional Responsibility — a Code that was adopted by Nevada —states that it is a professional abuse to argue outside the evidence:

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[11] See NRS § 48.015; NRS § 48.025; NRS § 48.035; see also Cancio v. White, 697 N.E.2d. 749 (Ill. Ct. App. 1998) (defendant's insinuation of "a connection" between plaintiff's counsel and physicians "was improper, unsupported by the evidence, highly prejudicial and deprived plaintiffs of a fair trial").

[12] See Silver v. McFarland, 109 Nev. 465, 476, 851 P.2d 450, 457 (1993).

[13] See Wickliffe v. Sunrise Hosp., Inc., 104 Nev. 777, 781, 766 P.2d 1322, 1325 (1988) ("courts will ban closing arguments which go beyond the inferences the evidence in the case will bear"); State of Nevada v. Kassabian, 69 Nev. 146, 149 (1952) (citing 53 Am. Jur. 386 (Trial § 480)).

> Trial counsel "**shall not allude to any matter that the lawyer does not reasonably believe is relevant or that will not be supported by admissible evidence.**"[14]

Likewise, it is a professional abuse to interject personal opinion into the closing argument:

> "[C]ounsel shall not assert his personal knowledge of facts in issue, except when he is testifying as a witness."[15]

It is especially important for the Court to ensure that this code of professional conduct is followed during our trial. Over the past few years, the defense bar has alarmingly abused the "argue within the evidence" rule in injury cases. With juries regularly returning verdicts in the millions of dollars on these cases in Clark County, the defense bar — at the direction of the insurance companies that employ them — now espouse a "win at all costs" trial strategy.[16] Rather than arguing the case on the merits, defense attorneys routinely ignore the evidence from **all** expert witnesses in closing argument, and instead, engage in a systematic poisoning of the jury by interjecting personal opinion into the jury's decision making processes.

For instance, oftentimes without any supporting medical evidence from the defense experts, defense counsel will insinuate in closing argument that the plaintiff is a malingerer. Without any supporting medical evidence, defense counsel will insinuate that plaintiff is a fake, a liar, and a cheat. Without any supporting evidence, defense counsel will insinuate that the plaintiff has secondary gain motives because she hired an attorney and filed a lawsuit. Without any supporting evidence, defense counsel will insinuate that there is a conspiracy between

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[14] Nevada Rule of Professional Conduct 3.4.

[15] Id.

[16] See generally Lioce v. Cohen, 174 P.3d 970 (Nev. 2008).

doctors and lawyers based on the fact that there is an outstanding medical lien. And defense counsel will insinuate that the case is nothing more than "attorney driven" litigation because the attorney "directed" the plaintiff to a doctor soon after the injury.[17]

These insinuations can only serve one purpose: defense counsel seeks to mislead the jury, and to ultimately invite the jury to a conclusion that is tantamount to jury nullification. In other words, defense counsel is saying, "ignore all the evidence from their experts and my experts, and speculate as to what all this really means."

According to the Nevada Supreme Court decision in Lioce, such arguments are overtly improper, and are designed to do nothing more than play on the built-in prejudices of some jurors (i.e. plaintiffs are faking, trying to cheat the system, and have the "misconception that most personal injury cases are unfounded and brought in bad faith by unscrupulous lawyers").[18] Several courts across the country agree with our Supreme Court that such tactics are unacceptable in closing argument.[19]

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[17] Plaintiff files this omnibus motion in limine to include the issues of secondary gain, medical liens, and the now-common plaintiff-lawyer-doctor conspiracy theory. Although this specific motion in limine includes those items to a lesser extent, the primary focus of this motion in limine is aimed at precluding those insinuations in closing argument.

[18] Lioce v. Cohen, 174 P.3d 970, 983 (2008).

[19] See generally Kern v. St. Luke's Hosp., 273 N.W.2d 75, 81-82 (Mich. 1978) (new trial granted because defense counsel continuously insinuating "outside the evidence" of a conspiracy between the doctors and lawyers); Commonwealth v. Carter, 649 N.E.2d 782 (Mass. 1995) (misconduct for prosecutor to tell jury in closing argument that witness didn't testify because of intimidation when there was no evidence to support such an insinuation); Khatib v. McDonald, 410 N.E.2d 266 (Ill. 1980) (improper for defense counsel to insinuate in closing argument that plaintiff sustained injuries in previous accident when no evidence was introduced to support comment); Terracina v. Castelli, 400 N.E.2d 27 (Ill. 1979) (improper to insinuate in closing argument that medical records would have indicated pre-existing injury if defense counsel had subpoena power over out-of-state medical records since there was no indication of evidence to support insinuation); Guess v. Maury, 726 S.W.2d 906, 917 (Tenn. Ct. App. 1986) (improper to argue doctor-lawyer conspiracy in closing argument that was unsupported by evidence); U.S. v. Badger, 983 F.2d 1443, 1451 (7th Cir. 1993) (improper to mislead jury with insinuations unsupported by evidence).

This Court should rule likewise. As the Court is aware, the jury must decide the case based on admissible evidence.[20] "Conduct which erodes these basic tenets will be presumed prejudicial."[21] Thus, manufactured attorney conjecture has no place in the courtroom and should be strictly precluded by the Court.

Furthermore, it is important to note that injury defense experts rarely support the allegations and insinuations raised in closing argument by defense counsel who argue "outside the evidence." For instance, defense medical experts invariably refuse to support the conspiracy theories espoused by defense counsel. Despite closing argument to the contrary, those defense experts **will not allege** that the plaintiff's attorney joined with the treating physicians to direct unnecessary medical care because such actions suggest medical fraud.

Those experts **will not allege** that plaintiff is a liar, a fake and a cheater of the system by seeking medical care because there is almost always a medical basis for the plaintiff's treatment through MRI, discography, EMG/NCV testing, and through the physician's physical examination of the plaintiff.

In sum, the defense experts will rarely follow defense counsel into the morass of conjecture and insinuation. Fraud and perjury carry serious consequences — fines, potential prison sentences, and loss of medical licenses. Defense experts take these allegations seriously. The Court should require defense counsel to do so as well. If the defense experts will not support these loose insinuations through their own testimony, why then should defense counsel be permitted to insinuate in closing argument that Plaintiff, her counsel, and Margie's treating physicians engaged in these nefarious tactics? For defense counsel to make these unsupported

[20] See Rowbottom v. State, 105 Nev. 472, 487, 779 P.2d 934, 943 (1989) (reversed on other grounds).

[21] Id.

statements is in violation of the Nevada Rule of Professional Conduct 3.4 and several recent case decisions by the Nevada Supreme Court. This Court should not permit this blatant abuse of the rules and the law.

In light of the fact that there is no supporting evidence for these allegations in this case, Defense counsel must be instructed **PRIOR TO TRIAL** that no such arguments can be made.

7. **Suggesting Abuse of Narcotic Pain Medication When There is None.**

In this case, Margie has suffered for several years from crash-related pain. During the course of treatment, various medical providers found it necessary to prescribe narcotic pain medication. Importantly, Margie did not suffer from addiction to narcotic pain medication prior to the crash. And no treating provider has testified that Margie has abused narcotic pain medication since the crash.

Many times, however, defense counsel will suggest to the jury that consumption of these properly prescribed medications leaves the plaintiff under the influence, that the plaintiff is chemically dependent, or that the plaintiff is "addicted." These improper references are unduly prejudicial and not probative to the issues to be considered and decided by the jury; they are simply designed to impugn the plaintiff's character.

Numerous courts have ruled that such inferences — without expert medical support — must be excluded.[22] This Court should rule likewise. Any potentially dependence on pain

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[22] See generally Smith v. Pennsylvania Gen. Ins. Co., 1991 WL 172164, *3 (E.D. Pa.) (whether Plaintiff had addictive personality, which made her more apt to become dependent on drugs, was irrelevant to question of causation since drug use would not have occurred but for the accident); see also Schwaller v. Maguire, 2003 Ohio App. LEXIS 6227 (holding that the trial court properly excluded evidence of prescription painkiller abuse based on relevancy grounds); Boom v. Robinson, 2001 Ohio App. LEXIS 3007 (excluding evidence of a doctor's drug addiction as irrelevant and unfairly prejudicial where there was no nexus between [the doctor's] drug abuse and his actions in treating [the patient]); State of Hawaii v. Sabog, 2005 Haw. App. LEXIS 135 (holding that trial court properly excluded witness's drug addiction and use on the date of in question when drug use did not affect the witness' ability and capacity to observe the events in question).

medication as a result of the crash is due to Defendant's own negligence. Defendant should not benefit from that negligence by impugning Margie's character because she required narcotic pain medication during her treatment. Any reference to narcotic pain medication dependence as an "addiction," or as "being under the influence," should be excluded.[23]

8. **Allowing Voir Dire Questioning Regarding Tort Reform Exposure.**

By this Motion in Limine, Plaintiff seeks an Order from the Court allowing voir dire questions to ascertain whether prospective jurors were exposed to tort reform propaganda that could bias the jury verdict.

Insurance companies regularly inject the issue of insurance into the consciousness of every potential juror through high priced advertising campaigns. The insurance companies' advertising blitz often leads jurors to believe that large verdicts directly result in higher insurance premiums, increased business costs, and awarding plaintiffs millions of dollars in frivolous lawsuits.

As a result of this media blitz, at least one court has determined that an insurance company's tort-reform propaganda "threaten[s] every plaintiff's right to an impartial jury."[24] The best means to overcoming partiality based on tort-reform propaganda is for the Court to allow "liberal voir dire."[25]

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[23] See NRS § 48.035(1); NRS § 48.035(2).

[24] Borkoski v. Yost, 594 P.2d 688, 694 (Mont. 1979).

[25] Id.; see also Barrett v. Peterson, 868 P.2d 96, 99 (Utah Ct. App. 1993) (counsel permitted to voir dire jury as to media campaigns funded by insurance companies that were designed to convince the public of the impact of large damage awards on insurance premiums).

Such questioning must be permitted. The jury must base its verdict on the evidence in our case — and nothing else.[26] It is the law in Nevada. If a panel member believes that a larger verdict will somehow influence his own insurance premiums, his own business costs, or any thing else unrelated to our case, that panel member could be struck for cause for refusing to follow the law.

As the Court is aware, a trial court will be deemed to have abused its discretion if the parties are prevented from effectively exercising peremptory and cause challenges.[27] The parties are prevented from effectively exercising peremptory and cause challenges when the trial court, in the exercise of its discretion, precludes voir dire from adequately testing the qualifications and competency of the jurors.[28]

To uncover potential bias, counsel must be allowed to question prospective jurors as to these issues.[29]

9. Allowing Voir Dire Questioning Regarding Verdict Amounts.

By this motion in limine, Plaintiff seeks to uncover any bias to award damages in voir dire by asking the jurors whether they have any preconceived bias regarding damages. Plaintiff's counsel seeks to ask whether any panel member is troubled by awarding damages in excess of $1Million if the evidence dictated such a result. As a matter of fairness, Plaintiff's counsel also seeks to ask whether any panel member is troubled by awarding less than $50 if the

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[26] Nev. J.I. 1.00.

[27] See Darbin v. Nourse, 664 F.2d 1109, 1113 (9th Cir. 1981).

[28] See id; see also Evans By & Through Evans, 824 P.2d 460, 462 (Utah Ct. App. 1991) ((trial court must also allow counsel the opportunity to hear responses to questions that may indicate hidden or subconscious attitudes); Garcia v. Estate of Wilkinson, 800 P.2d 1380, 1382 (Colo. Ct. App. 1990) (same).

[29] See Evans By & Through Evans, 824 P.2d at 466.

evidence dictated such a result. The purpose of Plaintiff's questioning is not to condition the panel as to a result. It is to ferret out any preconceived bias as to an amount of damages.

As the Court is aware, a trial court will be deemed to have abused its discretion if the parties are prevented from effectively exercising peremptory and cause challenges.[30] The parties are prevented from effectively exercising peremptory and cause challenges when the trial court, in the exercise of its discretion, precludes voir dire from adequately testing the qualifications and competency of the jurors.[31]

While there is little doubt that voir dire questions seeking to pledge prospective jurors to a specific verdict amount are improper — and Plaintiff will not do that — questioning jurors as to potential prejudice relating to higher damage amounts has routinely been deemed appropriate.[32] This Court should rule likewise.

10. Permitting Treating Physicians to Testify as to Causation, Diagnosis, Prognosis, Future Treatment, and Extent of Disability — Without a Formal Expert Report.

It is anticipated that Defendant may seek to strike testimony from Margie's treating physicians based solely on the fact that these physicians failed to provide expert reports pursuant to NRCP 16.1. Case law from around the country — including Nevada's federal

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[30] See Darbin v. Nourse, 664 F.2d 1109, 1113 (9th Cir. 1981).

[31] See id; see also Evans By & Through Evans, 824 P.2d at 462 (trial court must also allow counsel the opportunity to hear responses to questions that may indicate hidden or subconscious attitudes); Garcia v. Estate of Wilkinson, 800 P.2d 1380, 1382 (Colo. Ct. App. 1990) (same).

[32] See generally Davenport v. Kutner, 366 S.E.2d 813, 814 (Ga. Ct. App. 1988) (questions seeking to probe jurors' minds with respect to the amount of a potential verdict are appropriate to qualify them as to any preconceived prejudice against awarding large sums of money to a prevailing party."); Geehan v. Monahan, 382 F.2d 111, 115 (7th Cir. 1967); Murphy v. Lindahl, 165 N.E.2d 340 (Ill. 1960); Jines v. Greyhound Corp., 197 N.E.2d 58, 59 (Ill. Ct. App. 1964); Bunda v. Hardwick, 138 N.W.2d 305 (Mich. 1965); Dehn v. Otter Tail Power Co., 251 N.W.2d 404 (N.D. 1977); City of Cleveland v. Cleveland Elec. Illuminating Co., 538 F. Supp. 1240, 1250 (D.C. Ohio 1980).

district court — makes clear, however, that expert reports **are not required** by treating physicians who testify as to their own care, and who testify as to topics such as "causation, future treatment, extent of disability and the like."[33]

Here, Margie's treating physicians intend to testify as to their own treatment, future treatment, causation, and the reasonableness of other medical care and costs associated with the crash. In light of the fact that such testimony is permitted without expert reports, there are no grounds to strike this testimony.

a. Treating Physicians are Considered Expert Witnesses regardless of Expert Designation.

As medical practitioners, there is little doubt that treating physicians possess special knowledge, skill, and training to evaluate medical treatment, the reasonableness of the treatment, the cost of the treatment, and the causation of injuries. These attributes qualify the treating physicians as experts at trial.[34]

The Nevada Supreme Court agrees. According to our state's highest court, it makes no difference whether treating physicians are named as expert witnesses.[35] The threshold test is "whether the expert's specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue."[36] Based on the Nevada Supreme Court's decision in

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[33] Piper v. Harnischfeger Corp., 170 F.R.D. 173, 174-75 (D. Nev. 1997).

[34] See NRS § 50.275.

[35] Prabhu v. Levine, 112 Nev. 1538, 1546-47, 930 P.2d 103, 109 (1996).

[36] Id. (citing Townsend v. State, 103 Nev. 113, 117, 734 P.2d 705, 708 (1987)); see also NRS § 50.275.

In Prabhu, a treating physician was identified as a witness during the course of discovery, but was never identified as an expert. The treating physician ultimately provided critical expert testimony at trial. On appeal, defendant contended that he was prejudiced at trial because the treating physician provided expert medical testimony without being disclosed as an expert. The Court determined, however, that a treating physician's expert knowledge was sufficient to overcome any lack of pre-trial disclosure pursuant to NRS § 50.275.

Prabhu, and the clear statutory instruction of NRS § 50.275 — Plaintiff's treating physicians must be permitted to testify as experts.

b. Nevada's Federal Courts have Rejected Limitations to Treating Physicians' Testimony.

Nevada's federal courts first dealt with this issue in 1997.[37] In Piper, the defendant sought to strike the plaintiff's treating physicians from testifying at trial because none of the physicians provided expert reports under FRCP 26. The defendant's basis to strike was simple. The defendant argued that treating physicians could testify as to their "factual percipient observations," but any additional observations such as causation and future disability required an expert report.[38] Because the plaintiff failed to provide the additional observations, the defendant argued that any testimony in those areas must be precluded.

Importantly, the defendant's position was squarely rejected. The Piper Court cogently reasoned that limiting the physicians' testimony to percipient observations made little sense. Treating physicians develop opinions about the plaintiff and the plaintiff's injuries from several areas beyond the percipient medical examination.[39] As long as the opinions were learned during the course of treatment, no expert report was required.

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[37] See Piper, 170 F.R.D. at 174.

[38] Id. at 174.

[39] Piper cited several cases as authority for the ruling. See Baker v. Taco Bell Corp., 163 F.R.D. 348, 349 (D. Colo. 1995) (holding that treating physicians are not retained for trial and therefore no expert report required for opinions developed within course of treatment); Wreath v. United States, 161 F.R.D. 448, 449 (D. Kan. 1995) ("Clearly, treating physicians testifying only to the care and treatment afforded to a party were intended to be excluded from the requirements of Fed.R.Civ.P. 26(a)(2)(B)."); Bucher v. Gainey Transportation Service of Indiana, Inc., 167 F.R.D. 387, 390 (M.D. Penn. 1996) ("With respect to the claim that treating physicians do not need to submit expert reports, the plaintiffs are correct in so far as treating physicians are not required to submit expert reports when testifying on their 'opinion as to the cause of an injury based upon their examination, diagnosis and treatment of the patient.'"); Salas v. United States, 165 F.R.D. 31, 33 (W.D.N.Y. 1995) ("The relevant question is whether these treating physicians acquire their opinions as to the cause of the plaintiff's injuries directly through their treatment of the plaintiff."); Mangla v. University of Rochester, 168 F.R.D. 137, 139 (W.D.N.Y.1996) ("Experts

> It is common place for a treating physician during, and as part of, the course of treatment of a patient to consider things such as the cause of the medical condition, the diagnosis, the prognosis and the extent of disability caused by the condition, if any. Opinions such as these are a part of the orMargiery care of the patient and do not subject the treating physician to the extensive reporting requirements of Fed.R.Civ.P. 26(a)(2)(B).[40]

The Nevada federal court followed up their decision with an identical ruling one-year later in Elgas v. Colorado Belle Corp.[41] In Elgas, the treating physician intended to testify as to several areas, including future care costs, but failed to provide expert materials. The defendant sought to strike that testimony based on the FRCP 26 expert disclosure requirement. But the court's decision remained the same. As in Piper, the court determined that that the key issue was the timeframe in which expert opinions were formed — **not the scope** of the treating physicians percipient observations.

> [The expert disclosure ruling] contemplates two different classes of experts: those retained or specially employed to give testimony in the case [NRCP 16.1 witnesses], and other witnesses who may qualify as an expert but are not retained or specially employed [NRS § 50.275 witnesses].
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> Since a treating physician's opinion on **matters such as causation, future treatment, extent of disability and the like are part of the orMargiery care of a patient, a treating physician may testify to such opinion without being subject to the extensive reporting requirements of Rule 26(a)(2)(B)**. However, if a physician, even though he may be a treating physician, is specially retained or employed to render a medical opinion based on factors that were not

are retained for purposes of trial and their opinions are based on knowledge acquired or developed in anticipation of litigation or for trial. A treating physician's testimony, however, is based on the physician's personal knowledge of the examination, diagnosis, and treatment of a patient and not from information acquired from outside sources.").

[40] Id. at 275.

[41] See 179 F.R.D. 296, 299 (D. Nev. 1998).

> learned in the course of the treatment of the patient, then such a doctor would be required to present an expert written report.[42]

If two prior decisions were insufficient, Nevada's federal courts completed the trifecta one year later by reaffirming its prior holdings in Kirkland v. Union Pacific Railroad.[43] With an identical fact pattern as Piper and Elgas, the court made clear a final time that treating physicians are not subject to the strict expert disclosure requirements if their opinions were framed during the course of treatment.

> Treating physicians can appropriately have opinions as to the cause of an injury, based upon their examination of the patient, or to the degree of injury, or the extent of disability, in the future. The prognosis of the patient and what tasks a patient will be able to perform are legitimate opinions which come within the parameters of opinions required to be made by treating physicians, without subjecting them to the requirements of Rule 26(a)(2)(B).[44]

Circumscribing the expert disclosure requirement for treating physicians makes sound judicial sense. Doctors do not operate in a vacuum. Much of a treating physician's testimony is gained through personal knowledge and medical experience.[45] Unlike the Defense Medical Examiner who conducts a forensic evaluation of the plaintiff's care strictly for the defendant's litigation purposes, the treating physician's primary concern is to make the plaintiff better rather than testifying at trial. Accordingly, the treating physician routinely investigates numerous areas as part of the treatment process and should be permitted to testify as to this knowledge.[46]

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[42] Id. at 298; see also Sprague v. Liberty Mut. Ins. Co., 177 F.R.D. 78 (D.N.H. 1998); Matsuura v. E.I. Du Pont De Nemours & Co., 2007 WL 433115 (D. Haw.) (holding same).

[43] See 189 F.R.D. 604 (D. Nev. 1999).

[44] Id. at 608 (citing Baker v. Taco Bell Corp., 163 F.R.D. 348, 349 (D. Colo. 1995)).

[45] See Elgas, 179 F.R.D. at 299 (citing Piper, 170 F.R.D. at 175).

[46] See Oakberg v. Zimmer, 2006 WL 3478318 (9th Cir.) (district court abused discretion by excluding orthopedic surgeons when surgeons testified outside the medical records without expert report).

For instance, the treating physician may testify as to medical records review and to causation because the physician developed these opinions as a direct result of assessment of the scope of the injury.[47] The treating physician may testify regarding past and future care needs because the physician must make these determinations in order to assess long-term care needs.[48] And the treating physician may testify as to past and future costs of treatment because the physician is directly involved in patient billing.[49]

This treatment, and the resulting personal knowledge of the physician, should not shock Defendant. Indeed, it is within the normal range of duties for a health care provider to develop opinions regarding causation and prognosis during the orMargiery course of the examination. "To assume otherwise is a limiting perspective, which narrows the role of a treating physician."[50]

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[47] See McCloughan v. City of Springfield, 208 F.R.D. 236, 242 (C.D. Ill. 2003) ("In order to treat and diagnose a patient, the doctor needs to know, establish, or reach a conclusion regarding the cause of the patient's injuries. The Court believes that causation, diagnosis, and prognosis would be based upon the treating physician's personal knowledge"); Mangla v. University of Rochester, 168 F.R.D. 137, 139 (W.D.N.Y. 1996) (holding that treating physician's testimony "may include opinion[s] as to the cause of an injury based upon their examination of the patient or to the degree of injury in the future. These opinions are a necessary part of the treatment of the patient . . . [and] do not make the treating physicians experts"); Fielden, 482 F.3d 866, 869-70 ("doctors may need to determine the cause of the injury in order to treat it"); Odum v. Rayonier, Inc., 2007 WL 2002445 (S.D. Ga.) (treating physician may testify as to causation without expert report); Shapardon v. West Beach Estates, 172 F.R.D. 415, 417 (D. Haw. 1997) (treating physician considers diagnosis, prognosis, and cause of plaintiff's injuries).

[48] See Zurba v. United States, 202 F.R.D. 590, 592 (N.D. Ill. 2001) (holding that "[t]he fact that a treating doctor proposes to give an opinion regarding the causation and permanency of his patient's injuries does not by itself make him a retained expert for purposes of [the expert disclosure requirement]. Indeed, it is common for a treating physician to consider his patient's prognosis as well as the cause of the patient's injuries").

[49] See Martin v. CSX Transportation Inc., 215 F.R.D. 554, 555 (S.D. Ind. 2003) (court allowed testimony of physicians without expert report when testimony was based on "treatment of plaintiff as well as . . . extent of plaintiff's condition, its cause, permanency, and pain and suffering associated with that condition as well as the necessity and cost of future medical costs").

[50] Martin, 215 F.R.D. at 557.

The Court should not limit the treating physicians in this case. Margie's treating physicians intend to testify as to opinions learned through treatment — nothing more. Accordingly, opinions as to causation, diagnosis, prognosis and extent of disability are appropriate without the need for the expert disclosure requirement, even if such information was not contained in their treatment file or elicited during deposition testimony.

11. Precluding Negative Inference for Failing to Call Cumulative Witness.

Margie was treated by several physicians. It is unnecessary and duplicative to offer trial testimony from each and every one of these witnesses. Plaintiff will make the strategic decision regarding which physicians' testimony to offer, and Defendant should be precluded from offering argument or insinuating that negative inferences should be made based on Plaintiff's decision not to call cumulative witnesses. There is no evidence to support such an argument and it should be precluded on relevancy grounds.[51]

12. Precluding References to Collateral Sources.

Any medical and other treating expenses paid by lien or by private health insurance is not relevant and must be excluded. Such evidence (1) violates the collateral source rule; (2) would be unduly prejudicial to Plaintiff; and (3) would not assist the trier of fact with any appropriate determinations in this case.

According to the collateral source rule, the jury is precluded "from reducing Plaintiff's damages on the ground that he received compensation for his injuries from a source other than the tortfeasor."[52] The purpose behind this well-settled rule is clear: if the jury believes that a plaintiff's medical bills were already paid (through health insurance) or if the jury believes that

[51] See id.

[52] Proctor v. Castelletti, 112 Nev. 88, 90 n.1, 911 P.2d 853, 854 n.1 (1996).

a plaintiff's medical bills will be reduced or altogether forgiven (through lien), the jury is less likely to compensate the plaintiff for the full value of these expenses.[53]

To eliminate this potential bias, the Nevada Supreme Court recently adopted "a **per se** rule barring the admission of a collateral source of payment for an injury into evidence **for any purpose**."[54] Thus, there is no longer any discretion to find that the relevance of collateral source evidence outweighs its prejudicial effect.[55]

Limiting a jury's knowledge of collateral source information — like a medical lien — is of paramount importance and makes sound judicial sense. The obligation to pay for medical services rests squarely with the plaintiff, regardless of the outcome at trial. A lien merely allows a plaintiff to wait until the conclusion of the trial to make payment. Information about any liens, therefore, is far more prejudicial than probative since a reasonable jury could erroneously conclude that a doctor could reduce the lien or entirely waive payment — thus violating the collateral source rule.

Moreover, evidence of health insurance is strictly precluded at trial.[56] If Defendant is permitted to discuss lien agreements during trial, the jury will clearly be made aware that health insurance was not available to cover all of Margie's treatment. This is no different than Defendant directly injecting collateral source information into the trial through a backdoor method — thus violating the collateral source rule.

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[53] See id.

[54] Id. (emphasis added).

[55] See id.

[56] See NRS § 48.135(1).

Further, Defendant will presumably seek to ask questions of Margie's doctors regarding lien reductions. Regardless of whether the doctors choose to reduce their medical bills, this type of questioning goes directly to a collateral source benefit that is strictly prohibited from trial discussion.

In sum, no discussion of collateral source information can be allowed at trial pursuant to Proctor.

13. Precluding Defendant from Referencing Injuries/Non-Injuries from Any Individuals Involved in Crash Other than Margie.

Any evidence or statement that Defendant sustained no injuries as a result of the crash should be excluded. The medical conditions at issue in this trial are those of **Margie**. Defendant will seek to argue that because the **other** driver suffered no injuries, the force of impact was insufficient to injure Margie to the degree she alleges. This argument must be barred.

Force of impact on one occupant of a vehicle is not indicative of force of impact on another occupant. And, mechanism of injury is predicated upon seat position, body position, and rotational forces on the body from the impact, age, pre-existing conditions, and a variety of other factors. If this were not so, there would be no explanation for why one driver is severely injured or suffers death from a crash and another driver walks away without harm.

In sum, evidence that any parties in the crash were not injured or injured to a lesser degree than Margie is inadmissible pursuant to NRS § 48.015 in that it is irrelevant and NRS §

48.035 in that any probative value it may have is substantially outweighed by the potential for jury confusion.[57]

14. Excluding Evidence of PRIOR Unrelated, Injuries, Conditions or Medical Treatment.

Any evidence or reference to Margie's prior medical treatment should be excluded unless: (1) such condition was symptomatic at the time of the injury at issue in this case; or (2) it was a latent pre-existing condition that was made symptomatic by the injury at issue in this case.[58]

Before the subject crash, Margie received treatment for the following conditions/injuries:

- Low blood pressure;
- Bunions;
- Foot and ankle pain;
- Miscarriages;
- Hysterectomy;
- Breast lumps;
- Abdominal pain;
- Hormone imbalance;
- Endometriosis;

[57] See also Uniroyal Goodrich Tire Co. v. Mercer, 111 Nev. 318, 890 P.2d 785 (1995) (overruled on other grounds).

[58] See Cancio, 697 N.E.2d 749 ("Absent competent and relevant medical proof of a causal connection between the preexisting condition and the injury complained of, evidence of plaintiff's preexisting condition is inadmissible"); Bennett v. Messick, 457 P.2d 609 (Wash. 1969); Vojas v. K-mart Corp., 727 N.E.2d 397, 404 (Ill. Ct. App. 2000) ("Unless the prior injury has some relevant relationship to the injury at issue, it is not admissible").

- Ovarian cyst;
- Irritable bowel syndrome;
- Mitral valve prolapse;
- Anxiety;
- Thyroid nodule; and
- Syncope.

In 1981 and 1985 — more than 20 years before the subject accident — Margie was involved in prior motor vehicle accidents where she complained of neck and low back pain. Following the 1981 accident, she sought holistic treatment and resolved shortly thereafter. Following the 1985 accident, Margie sought chiropractic and physical therapy treatment. Again, she resolved shortly thereafter and there is no record of Margie seeking treatment for neck or low back pain between the time she resolved for the 1985 accident and the subject crash.

In September 2004, Margie hit her head on the hatchback of her vehicle, causing a concussion. Then, in December 2004 she hit her head again on a towel dispenser while cleaning a bathroom at her church. Following both of those incidents, Margie complained of headaches and temporary memory loss. She sought treatment for these symptoms and was asymptomatic prior to the subject crash.

In March 2008, Margie sought treatment for left chest wall pain associated with numbness and tingling bilaterally in both arms. She was referred for a work-up of the chest pain and x-rays of her cervical spine. Importantly, Margie did not have any complaints of neck pain. After the cervical x-ray was taken, no further treatment or work-up was recommended or

sought in relationship to any neck condition or to the arm complaints, which resolved prior to the subject crash.

Any medical visit or treatment that is not relevant or related to the injuries that were sustained as result of the subject accident must be excluded.[59] They have nothing to do with this case — and are of no probative value to any issue in this action. Therefore, evidence of these conditions and treatment should be excluded at trial.[60]

Additionally, Defendant must have expert testimony **to a reasonable degree of medical probability** that any of Margie's prior symptoms/conditions are the cause of her current injuries and pain.[61] Defendant has failed to meet this burden of proof and, thus, cannot offer any evidence of Margie's unrelated prior conditions.[62]

15. Precluding Reference to Prior Incidents.

As discussed above, Margie was involved in prior motor vehicle accidents in 1981 and 1985. She also hit her head twice in 2004. However, there is absolutely **no evidence** that any of these prior incidents have any relationship to the injuries Margie suffered as a result of the subject crash. And, none of Defendant's medical experts have testified to a reasonable degree

[59] See NRS § 48.015; § 48.025.

[60] See NRS § 48.015; NRS § 48.035.

[61] See Brown v. Capanna, 105 Nev. 665, 671-72, 782 P.2d 1299, 1304 (1989) (citing Orcutt v. Miller, 95 Nev. 408, 595 P.2d 1191 (1979)) (stating that medical experts are "expected to testify only to matters that conform to the reasonable degree of medical probability standard"); see also Morsicato v. Sav-On Drug Stores, Inc., 121 Nev. 153, 156, 111 P.3d 1112, 1116 (2005); Banks ex rel. Banks v. Sunrise Hospital, 120 Nev. 822, 102 P.2d 52 (2004); United Exposition Services Co. v. SIIS, 109 Nev. 421, 424, 851 P.2d 423, 425 (1993).

[62] See August 1, 2012 Expert Report of Dr. J. Pablo Villablanca, attached as Exhibit 1; see also October 15, 2012 Expert Report of Dr. J. Pablo Villablanca, attached as Exhibit 2; July 12, 2012 Expert Report of Dr. John Siegler, attached as Exhibit 3; October 9, 2012 Expert Report of Dr. John Siegler, attached as Exhibit 4; August 25, 2012 Expert Report of Dr. Joseph Schifini, attached as Exhibit 5; October 15, 2012 Expert Report of Dr. Joseph Schifini, attached as Exhibit 6; February 25,2013 Expert Report of Dr. Joseph Schifini, attached as Exhibit 7; April 3, 2013 Expert Report of Dr. Joseph Schifini, attached as Exhibit 8.

of medical probability that any of these prior incidents caused Margie's current symptoms.[63] Accordingly, evidence of the 1981 and 1985 car accidents and 2004 head incidents must be excluded on relevancy grounds and based on the unfairly prejudicial effect they will have on Plaintiff.[64]

16. Precluding the Responding Police Officer from Providing Biomechanical Opinions.

Officer Todd Conn responded to the scene of the subject accident and subsequently completed the Traffic Accident Report. Importantly, Officer Conn did not take any measurements at the scene; did not do any testing of the roadway; did not do any speed estimates; and did not calculate the forces sustained by Margie as a result of the crash.[65] Further, he has never taken any courses in biomechanics to perform the type of analysis needed to come to any biomechanical opinions regarding the crash.[66] Inexplicably — despite the lack of any scientific basis for biomechanical opinions — Officer Conn indicated in the Traffic Accident Report that "the injuries claimed by Seastrand are not consistent with being caused during this collision."[67]

During deposition, however, Officer Conn was forced to concede that he would defer to the qualified experts in this case to form opinions as to whether or not Margie could have sustained injuries in the crash.[68] Based on his lack of knowledge, skill, experience, training, or

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[63] See id.

[64] See NRS § 48.015; § 48.035.

[65] See Deposition of Officer Todd Conn, attached as Exhibit 9, at pp. 17-25; 31:13-22; 39:4-5; 59:9-60:23.

[66] See id. at pp. 45-48; 51:3-5; 53:11-12.

[67] Traffic Accident Report, attached as Exhibit 10.

[68] See Exhibit 9 at 62:3-.23.

education in the field of biomechanics, Officer Conn is not qualified to provide expert biomechanical testimony regarding whether the subject crash could have caused Margie's injuries.[69] Biomechanical opinions are clearly outside the scope of lay witness testimony, therefore, Officer Conn must be precluded at trial from offering any opinions regarding whether Margie's injuries were or were not consistent with, or caused by, the subject crash.[70]

17. **Preclusion of Margie's Prior Civil Lawsuit.**

After the subject crash, Margie was involved in civil litigation regarding an insurance claim made after a theft occurred at her business. Jerry Busby, Esq. — Margie's neighbor — represented Margie's business in this unrelated case. (Mr. Busby has been named as a witness in this case based on his knowledge, as Margie's neighbor, of Margie's physical conditions and limitations.) The litigation exclusively involved insurance benefits related to property loss. There were no allegations of personal injury by Margie. Accordingly, this unrelated civil litigation is entirely irrelevant to the instant litigation and should be excluded.[71]

During the EDCR 2.47 conference regarding this issue, defense counsel indicated that Defendant would stipulate to excluding reference to the unrelated litigation, however, Defendant wanted to reserve the right to inform the jury that Mr. Busby represented Margie's business in the unrelated litigation. There is no basis for introducing this information.

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[69] See NRS §50.275.

[70] See id.; see also NRS § 50.265.

[71] See NRS §48.015; §48.025.

Mr. Busby has been Margie's neighbor for over 20 years.[72] The fact that he is an attorney and represented her business in unrelated litigation is ancillary to their relationship as neighbors and members of the same church. Their attorney/client relationship provides no probative insight into any of the facts at issue in this matter. Accordingly, it must be excluded on relevancy grounds.[73] Further, if the unrelated litigation is precluded from reference at trial — which the parties agreed to — allowing Defendant to inform the jury that Mr. Busby was Plaintiff's prior attorney is an open invitation for the jury to speculate that the prior litigation is somehow related to the instant matter. This inevitable speculation would be unfairly prejudicial to Plaintiff and certainly outweighs any potential relevance that Mr. Busby's attorney-client relationship with Margie has.[74] Accordingly, the prior litigation and Mr. Busby's involvement in the prior litigation must be excluded.

18. Precluding Defendant's Medical Experts from Referring to the Crash as "Minor" or Making Reference to the Property Damage Sustained by the Vehicles.

Defendant designated three medical experts — Dr. John Siegler, Dr. J. Pablo Villablanca, and Dr. Joseph Schifini — to provide testimony regarding their "review of Plaintiff's medical records."[75] None of these experts are experts in the field of biomechanics and none have been designated as biomechanical experts. Despite this lack of expertise,

[72] See Deposition of Jerry Busby, attached as Exhibit 11, at 4:9-16.

[73] See NRS §48.015.

[74] See NRS § 48.035.

[75] See Defendant Raymond Riad Khoury's Designation of Expert Witness, attached as Exhibit 12 (without original attachments).

Siegler, Villablanca, and Schifini make repeated references in their reports to the accident as being "minor," and as causing minimal property damage.[76]

During the EDCR 2.47 conference regarding this matter, the parties agreed that "treating doctors and medical experts" may not offer "biomechanical opinions at trial."[77] Plaintiff requests that this stipulation be clarified so as to exclude reference by these medical experts to the purported severity of the crash or the property damage. Information regarding property damage has no relevance to their medical opinions and can only be offered as a back-door method to implying biomechanical opinions. This should not be allowed, as it exceeds the scope of their expertise.[78]

19. Precluding Dr. Schifini from Offering Testimony Regarding Alleged Secondary Gain by Margie.

As discussed above, in an attempt to refute Margie's claims of injury, Defendant retained pain management specialist, Dr. Joseph Schifini to conduct a records review of Margie's crash-related treatment. Dr. Schifini indicates that only a minor portion of Margie's treatment is related to the crash.[79] He also indicates that Margie minimized her "prior conditions" and that "the medicolegal context of (Margie's) complaints are also suspicious for secondary gain behavior."[80] Importantly, however, Dr. Schifini is **not** psychologist or

[76] See Exhibits 1-8.

[77] April 23, 2013 correspondence, attached as Exhibit 13. A Stipulation regarding this issue is forthcoming.

[78] See NRS §50.275.

[79] See Exhibits 5-7.

[80] Exhibit 5 at pp. 7-8.

psychiatrist.[81] And, most importantly, he is not a human lie detector. He does not know with any certainty the bases for Margie's pain complaints. Dr. Schifini's opinions are troubling in light of the fact that he did not examine Margie and has never spoken to or met her.

Secondary gain is to "seek social advantage indirectly due to organic illness."[82] If there is allegation of secondary gain, these motives must be supported by a medical doctor to a reasonable degree of medical probability.[83] Dr. Schifini makes reference to Margie's "secondary gain motives" throughout his reports and deposition testimony; however, he fails to provide **any** medical evidence to support such diagnosis.[84] And, he failed to perform any testing on Margie to determine if she was exhibiting secondary gain behaviors.[85] Without meeting Margie, without examining her, and without performing any testing, Dr. Schifini simply reviewed the medical records and speculated that Margie was exhibiting secondary gain behavior. Any testimony regarding secondary gain behavior must be excluded on that basis alone.

Moreover, Nevada law makes clear that expert testimony is admissible when it will "assist the trier of fact to understand the evidence or to determine a fact in issue."[86] Conversely, where the subject matter is within the knowledge or experience of lay people,

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[81] See Deposition of Dr. Joseph Schifini, attached as Exhibit 14, at 35:10-13; see also Curriculum Vitae of Dr. Schifini, attached as Exhibit 15.

[82] See Steadman's Medical Dictionary.

[83] See Brown, 105 Nev. at 671-72; see also Morsicato, 121 Nev. at 156; Banks ex rel. Banks, 120 Nev. 822; United Exposition Services Co., 109 Nev. at 424.

[84] See Exhibits 5-7.

[85] See Exhibit 14 at 35:14-17.

[86] NRS § 50.275.

expert testimony is superfluous.[87] The test for determining the appropriateness of expert testimony is "the common sense inquiry whether the untrained layman would be qualified to determine intelligently and to the best possible degree the particular issue without enlightenment from those having a specialized understanding of the subject involved in the dispute."[88]

In this case, Dr. Schifini is no more qualified than **anyone** on the jury to speculate as to Margie's motivation for treatment. Dr. Schifini is not a human polygraph. While Dr. Schifini may be free to comment on whether Margie's injuries are substantiated from diagnostic testing or examination, allowing him to comment on Margie's alleged secondary gain motivation allows the jury to "indulge in **improper speculation and guesswork**."[89] Such speculation should not be permitted — it goes directly to the heart of the jury's determination regarding the believability of Margie's subjective pain complaints.[90]

Additionally, because the credibility of a witness lies **exclusively** within the province of the triers of fact, "expert testimony regarding the credibility of a witness improperly invades the jury's function by placing a stamp of scientific legitimacy on the expert's allegations."[91] Likewise, an expert is precluded from passing "judgment on a witness' truthfulness in the guise

[87] See Prabhu v. Levine, 112 Nev. 1538, 1546-47, 930 P.2d 103, 109 (1996).

[88] Pelster v. Ray, 987 F.2d 514, 526 (8th Cir. 1993) (quoting FRE 702 Advisory Note).

[89] Dahlin v. Holmquist, 766 P.2d 239, 241 (Mont. 1988) (emphasis added) (failure to exclude all secondary gain testimony constituted an error of sufficient magnitude to warrant a new trial).

[90] See Nichols v. American Nat. Ins. Co., 154 F.3d 875, 883 (8th Cir. 1998) (opinions of this type create a serious danger of confusing or misleading the jury, causing it to substitute the expert's credibility assessment for its own common sense determination).

[91] Benjamin v. Torgerson, 985 P.2d 734, 740 (Mont. 1999).

of a professional opinion."[92] Dr. Schfini is attempting to do so in this case and he must be precluded.

Finally, allowing experts to engage in speculation of secondary gain behavior is more prejudicial than probative. And such testimony should be excluded under NRS § 48.035.[93]

Based on the foregoing, this Court must exclude Dr. Schifini's references to secondary gain behavior at trial.

20. Precluding Dr. Schifini and Dr. Siegler from Offering Testimony Regarding Margie's Spine Surgeries.

Margie sustained major spine injuries as a result of the crash. And, numerous invasive tests and procedures were performed to determine the sources of Margie's ongoing symptoms. After Margie's pain-generators were identified — and after non-surgical treatment — Margie's orthopedic surgeons recommended cervical and lumbar fusion surgeries.

Defendant's experts, Dr. Schifini and Dr. Siegler are not spine surgeons — they are anesthesiologist/pain management specialists.[94] They do not perform fusion surgeries and they do not determine the type of spine surgery that should be performed on patients. They are not qualified to do so. Nonetheless, Schifini and Siegler confusingly criticize the surgeries performed by Margie's board-certified spine surgeons, Dr. William Muir and Dr. Yevgeniy Khavkin.[95] Dr. Schifini and Dr. Siegler are **not** a spine surgeons. As such, they should be

[92] Westcott v. Crinklaw, 68 F.3d 1073, 1076 (8th Cir. 1995).

[93] See generally Rodgers v. CWR Const. Inc., 33 S.W.3d 506, 511 (Ark. 2000) (secondary gain evidence excluded).

[94] See Exhibits 15 and 16.

[95] See Exhibit 14 at

precluded from offering testimony or opinions regarding this specialized area, which is clearly outside of their expertise.

a. Standard for Expert Testimony.

NRS § 50.275 establishes qualifications for expert witnesses to testify in Nevada. First, the witness must be qualified in an area of "scientific, technical or other specialized knowledge" (the qualification requirement).[96] Second, the witness must be able to "assist the trier of fact" in understanding the evidence at issue (the assistance requirement).[97] And third, the witness may only testify as to "matters within the scope" of the witness' expertise (the limited scope requirement).[98]

The focus of this motion is the second prong of NRS § 50.275 — the assistance requirement. Expert testimony will only assist the jury if that testimony is relevant.[99] The concept of relevancy is basic to the law of evidence as it circumscribes admissibility.[100] Evidence is relevant if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence."[101] Testimony grounded in guess, surmise, or conjecture – not being regarded as proof of a fact — is irrelevant since it has no tendency to make the existence of a fact more or

[96] See Hallmark, 189 P.3d at 650 (citing NRS § 50.275).

[97] Id.

[98] Id.

[99] See id. at 651.

[100] See NRS § 48.025 (only relevant evidence is admissible).

[101] NRS § 48.015; see also Desert Cab Inc. v. Marino, 108 Nev. 32, 35, 823 P.2d 898, 899-900 (1992).

less probable.[102] It follows that expert opinions based upon the witness's guess, speculation, or conjecture must also be inadmissible.[103]

For over 45 years, the Nevada Supreme Court has made clear that expert testimony based on guess and speculation must be stricken at trial.[104] This Court should rule likewise.

b. Dr. Schifini and Dr. Siegler's Testimony Will Not Assist the Trier of Fact; Hallmark Precludes Their Testimony.

In Hallmark v. Eldridge, the Court held that expert testimony based on conjecture, rather than science, substantially affects the rights of a party and such testimony must be excluded at trial.[105] Although Hallmark addressed expert testimony in the field of biomechanics, the same rationale applies to medical expert testimony as well.

In Hallmark, the expert failed to provide "reliable science" in his investigation and relied instead on assumptions of fact and unsupported conjecture. As a result, the Court held that his testimony was "highly speculative," and was "based more on supposition than science."[106] Therefore, the expert testimony should not have been admitted at trial.

Courts across the country make clear that a medical degree "alone does not qualify [an expert] to give an opinion on every conceivable medical question."[107] To the contrary, numerous courts have limited expert testimony to the expert's **specific** practice/knowledge

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[102] See Modelski v. Navistar Intern. Transp. Corp., 707 N.E.2d 239, 245 (Ill. Ct. App. 1999).

[103] See Gordon v. Hurtado, 91 Nev. 641, 643, 541 P.2d 533, 534 (1975) (trial court committed reversible error by allowing accident reconstructionist to testify based on conjecture).

[104] See Levine v. Remolif, 80 Nev. 168, 390 P.2d 718 (1964); see also Choat v. McDorman, 86 Nev. 332, 486 P.2d 354 (1970); Gordon, 91 Nev. 641; Hallmark, 189 P.3d 646.

[105] See 189 P.3d at 653 at 654.

[106] Id. at 653.

area(s).[108] To do otherwise would ignore the modern realities of medical specialization, and eliminate the trial court's role of ensuring that those who purport to be experts truly have expertise to support their opinions.

Our case is no different. Dr. Schifni and Dr. Siegler — who are **not** educated, experienced, or board-certitifed in spine surgery — reviewed Margie's medical records, performed no physical examination, and provided speculative conclusions that her spine surgeries were not medically necessary or indicated.[109] They have no basis for their conclusions because they are not knowledgeable or experienced in spine fusion surgeries. More is required.

In sum, Dr. Schifini and Dr. Siegler's opinions fail to employ **any** of the scientific and reliable techniques required by the Nevada Supreme Court.[110] As a result, their conclusions are "based more on supposition than science" and this Court has no choice but to exclude such testimony from evidence in this matter.[111]

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[107] Christophersen v. Allied-Signal Corp., 939 F.2d 1106, 1113 (5th Cir. 1991).

[108] The following is a brief list of cases in support of this position: Nunley v. Kloehn, 888 F. Supp. 1483, 1488 (E.D. Wis. 1995) ("The focus, then, is on the 'fit' between the subject matter at issue and the expert's familiarity therewith, and not on a comparison of the expert's title or specialty with that of the defendant or a competing expert"); Whiting v. Boston Edison Co., 891 F. Supp. 12, 24 (D. Mass. 1995) ("Just as a lawyer is not by general education and experience qualified to give an expert opinion on every subject of the law, so too a scientist or medical doctor is not presumed to have expert knowledge about every conceivable scientific principle or disease"); O'Conner v. Commonwealth Edison Co., 807 F. Supp. 1376, 1390 (C.D. Ill. 1992) ("[N]o medical doctor is automatically an expert in every medical issue merely because he or she has graduated from medical school or has achieved certification in a medical specialty"); Levesque v. Regional Medical Center Bd., 612 So. 2d 445, 449 (Ala. 1993) (obstetrician without knowledge of the causes of a condition could not testify regarding causation); Hall v. Hilbun, 466 So. 2d 856, 875 (Miss. 1985) ("Our trial judges are admonished to ascertain that the witness really is an expert in the particular field at issue. Not every M.D. is a qualified expert in every malpractice case"); Gilman v. Choi, 406 S.E.2d 200, 204 (W. Vir. 1990)("[I]t is clear that a medical expert may not testify about any medical subject without limitation").

[109] See Exhibits 3-8.

[110] See id.

[111] See id.

c. **Dr. Schifini and Dr. Siegler Are Not Qualified as Experts in Spine Surgery.**

The Nevada Supreme Court has clearly determined that a medical provider may only provide expert testimony "if the physician's or provider's **experience**, **education**, and **training** establish the expertise necessary to perform the procedure(s) or render the treatment(s) at issue."[112]

Here, there is no dispute that Dr. Schifini and Dr. Siegler are not trained or experienced in spine surgery.[113] The case authority is clear. Dr. Schifini and Dr. Siegler are not qualified as experts in the specialized field of spine surgery, therefore, they must be precluded from offering any testimony outside of their respective scopes of expertise.[114]

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[112] Staccato, 123 Nev. 526, 170 P.3d 506.

[113] See Exhibits 15 and 16.

[114] See Staccato, 123 Nev. 526, 170 P.3d 506; see also Hallmark, 189 P.3d at 650 (citing NRS § 50.275).

Dr. Schifini and Dr. Siegler's "field of expertise" is clearly limited to pain management — nothing more.[115] As such, this Court must preclude them both from offering rendering opinions regarding Margie's spine sugeries. To allow such speculative testimony would be contrary to the rulings of the Nevada Supreme Court.[116]

DATED this 27th day of April 2013.

RICHARD HARRIS LAW FIRM

By: _____

Richard A. Harris, Esq.
Nevada Bar No. 505
Joshua R. Harris, Esq.
Nevada Bar No. 9580
Alison Brasier, Esq.
Nevada Bar No. 10522
801 South Fourth Street
Las Vegas, Nevada 89101
Attorneys for Plaintiff

RICHARD HARRIS LAW FIRM

[115] See id.

[116] See Staccato, 123 Nev. 526, 170 P.3d 506; Hallmark, 189 P.3d at 650; Townsend v. State, 103 Nev. at 119, 734 P.2d at 209.

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I hereby certify that I am an employee of RICHARD HARRIS LAW FIRM and that on the 29 day of April 2013 I caused the foregoing **PLAINTIFF'S OMNIBUS MOTIONS IN LIMINE** to be served as follows:

[X] by placing a true and correct copy of the same to be deposited for mailing in the U.S. Mail at Las Vegas, Nevada, enclosed in a sealed envelope upon which first class postage was fully prepaid; and/or

[ ] pursuant to EDCR 7.26, by sending it via facsimile; and/or

[ ] by hand delivery

to the attorneys listed below:

Steven T. Jaffe, Esq.
Jacob S. Smith, Esq.
HALL JAFFE & CLAYTON, LLP.
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Defendant

Selenne Alvarez
An employee of the RICHARD HARRIS LAW FIRM

RICHARD HARRIS LAW FIRM

EXHIBIT 1

August 1, 2012

Steven T. Jaffe
Jacob S. Smith
Hall Jaffe & Clayton, LLP
7455 West Washington Avenue, Suite 640
Las Vegas, NV 89128

Re: Khoury adv. Seastrand
J. Pablo Villablanca, M.D. Neuroradiology Expert Report

Dear Mr. Jaffe and Mr. Smith:

At your request, per retention letter dated April 25, 1012 I have reviewed the medical records and imaging studies pertinent to this action.

Medical Synopsis:

The case arises from an automobile accident on March 13, 2009, when the defendant, Raymond Khoury rear-ended Ms. Margaret Seastrand. Per the retention letter, property damage to both vehicles was minimal, consisting only of a small puncture defect in the rear bumper of Ms. Seastrand's Honda, and a small crack on the bumper of Mr. Khoury's Infinity QX56 sport utility vehicle. Evidence of minimal external vehicular damage is confirmed by the photographic evidence provided for both vehicles (Khoury-00001-00005). Both occupants were belted. There was no airbag deployment in either vehicle (CF-00197). The State of Nevada Traffic Accident Report filed by officer T. Conn dated 3/13/09 indicated Ms. Seastrand informed the officers at the scene that she had prior neck and back injuries caused by a previous vehicle accident years before the subject accident (CF-00197). Officer T. Conn opined in his report that "the injuries claimed by Ms. Seastrand are not consistent with being caused during this collision" (CF-00197). While not a medical expert, officer Conn's comments do provide a common sense appraisal of the trivial nature of this accident.

Ms. Seastrand has a history of two previous automobile accidents. Per report, these appear to be of much greater severity than the subject accident. As a consequence of those two prior accidents, the Plaintiff suffered neck, mid- and lower back injuries.

After the accident of 3/13/09 the Plaintiff immediately complained of neck and back injuries which required medical treatment. She eventually underwent cervical fusion at the C5-6 disc level, and lumbar fusions at the L4-5 and L5-S1 disc levels. The indication for the surgical fusion at the C5-6 disc level is provided as disc herniation of the cervical spine at the C5-6 disc level requiring anterior decompression, discectomy and interbody fusion with cage and plate. The indication for the plasma disc decompression and subsequent lumbar fusion is provided as internal disc disruption of the lumbar spine at the L4-5 and L5-S1 disc levels. Total medical costs to date are approximately $400,000. A post-operative complication of displacement the anterior

fusion construct occurred. It is the opinion of Drs. Grover and Khavkin that the patient will require an additional future posterior fixation fusion at a cost of $122,200.

Imaging Studies:

Chest Radiograph dated 10/27/08: The lung fields are clear and of normal volume. The cardiomediastinal silhouette is normal. There is no hilar adenopathy or mass. The visualized bony structures are normal. There are no visible rib or other bony fractures.

Cervical Spine Radiographs dated 10/27/08:

Findings: There is a straightened cervical lordosis and preserved cervical alignment. A straightened cervical lordosis suggests muscle spasm. Vertebral body height and density is normal. There is mild narrowing of the C5-6 disc space with evidence of anterior and posterior vertebral body endplate osteophytes. There is also neural foraminal narrowing that is due to uncovertebral joint osteophytes. There are no cervical fractures. No prevertebral soft tissue swelling is seen.

Impression: The radiographs were interpreted by Dr. S. Robert Hurwitz, M.D. I concur with the interpretation.

Cervical Spine Radiographs dated 3/13/09:

Findings: A normal cervical lordosis is present. There is no reversal of the normal cervical lordosis to suggest muscle spasm. Also identified is a normal cervical alignment, without evidence of subluxation. Cervical vertebral body height and density is normal. There are no cervical compression fractures. There is mild to moderate loss of disc space height at the C5-6 disc level, again associated with small anterior and posterior vertebral body endplate osteophytes. The degree of disc space height loss at the C5-6 disc level has progressed when compared to the prior radiographs of 10/27/08, indicating further degeneration of the C5-6 disc level. The cervical spine is visible through C7. The levels below this are obscured by the overlying shoulders. The facet joints are normal in appearance. The craniovertebral junction is normal in appearance. There is no prevertebral soft tissue swelling or posterior paraspinous muscle contour abnormality.

Impression: The cervical spine series demonstrates moderate disc space degeneration at the C5-6 disc level, progressed in the interval of time since the prior radiographs of 10/28/08. There is no evidence of vertebral compression fracture or bony subluxation. The soft tissues are normal in appearance. No indirect evidence of cervical muscle spasm is identified. The radiographs were interpreted by Dr. David P. Gorczyca, M.D. and are under interpreted with respect to the degree of degeneration of the C5-6 disc. In the absence of comparison films, it was not possible for Dr. Gorczyca to observe interval progression of disease at the C5-6 disc level.

Noncontrast CT scan of the Brain dated 3/13/09:

Findings: The cerebral sulci, ventricles and basal cisterns are normal in size and shape. The density of the cerebrum, brainstem and cerebellum is normal. There is no evidence of brain contusion, parenchymal hematoma, subarachnoid, subdural or epidural bleeding. The basal cisterns are open. There is no scalp hematoma or skull fracture. The paranasal sinuses and mastoid air cells are clear.

Impression: Negative noncontrast CT scan of the brain. No evidence of traumatic brain, soft tissue or bony injury

Noncontrast MRI of the Cervical Spine dated 4/3/09:

Findings: There is mild reversal of the normal cervical lordosis centered at the C5-6 disc level. There is a normal cervical alignment. Vertebral body height remains normal, without evidence of vertebral body or posterior element fracture.

Disc space height and signal intensity is normal, except for trace loss of disc space height at the C4-5 disc level, and moderate loss of disc space height at the C5-6 disc level, indicating disc degeneration at these levels. Bony marrow signal intensity is normal, except for mild Modic type I discogenic endplate changes at the C5-6 disc level.

Mild proximal left and mid-foraminal right neural foraminal narrowing is identified at the C5-6 disc level due to uncovertebral joint osteophytes.

Mild circumferential disc bulging is noted at the C5-6 disc level, with anterior disc material noted and no focal posterior disc abnormality. The posterior C5-6 disc bulge is associated with a small posterior vertebral body endplate osteophyte off the inferior endplate of C5 that together cause mild partial effacement of the ventral subarachnoid space. Dorsal subarachnoid space at the C5-6 disc level is preserved. There is no evidence of cord compression at the C5-6 or any other cervical disc level.

The remaining cervical levels are normal.

There is no evidence of facet joint degeneration. There is no prevertebral soft tissue swelling, paraspinous muscle edema, intraspinal hematoma or other evidence of acute or subacute soft tissue trauma.

The cervical cord is normal in contour, caliber and signal intensity at all levels.

Impression: There is mild reversal of the normal cervical lordosis centered at the C5-6 disc level that may be related to muscle spasm of indeterminate chronicity. There is essentially single level degenerative disc disease, consisting of moderate degenerative disc space height loss at C5-6, associated with mild anterior Modic type I degenerative discogenic endplate change, and circumferential disc osteophyte complex that is degenerative in nature and causes mild spinal canal stenosis. Mild neuroforaminal

narrowing is identified bilaterally due to degenerative uncovertebral joint osteophytes. There is no facet degeneration.

There is no evidence of acute disc herniation, bony or soft tissue abnormality aside from possible paraspinal muscle spasm. The study was interpreted by Dr. George Mulopulos, M.D. I generally concur with the findings of Dr. Molopulos.

An addendum prepared by Dr. Keith Lewis, M.D. appears grossly over-interpreted. The report concludes bone contusions without fractures are present at the C5-6 disc level. This is an interpretational error that is not supported by the remaining findings in the scan, including the absence of prevertebral soft tissue swelling or posterior paraspinous muscle edema that would be expected if the Modic type I discogenic endplate degenerative changes present in the anterior vertebral endplates had in fact been bone contusions. Further, there is no evidence of torticollis. Finally, no disc protrusion is present at the C4-5 disc level on either the sagittal or axial images.

Noncontrast MRI of the Lumbar Spine dated 4/3/09:

Findings: There is a normal lumbar lordosis and alignment. Lumbar vertebral body height and marrow signal intensity is normal. There is no evidence of remote or acute lumbar compression fracture. The T12-L1 through L3-4 disc levels are normal. The L4-5 and L5-S1 disc levels show decreased T2W signal, with preserved disc space height, compatible with disc desiccation.

The L4-5 disc level demonstrates mild circumferential disc bulging. A small right L4-5 foraminal focal marginal annular ligament defect is identified, not in contact with or displacing, the exiting right L4 nerve root. The left L4-5 neural foramen is widely patent.

The L5-S1 disc level shows mild circumferential disc bulging, without focal disc herniation. A prominent ventral epidural venous plexus mimics a small focal disc herniation.

There is evidence of moderate bilateral L4-5 and L5-S1 facet joint degeneration, as evidenced by hypertrophic changes, sclerosis and articular irregularity.

There is no paraspinous muscle edema. No paravertebral soft tissue hematomas are noted. There is no epidural or subdural bleeding in the spinal canal, and the conus medullaris and nerve roots of the cauda equina are normal in appearance.

Impression: There is no evidence of acute bony or soft tissue injury. The scan was interpreted by Dr. Keith Lewis, M.D. The scan is over-interpreted. There is no evidence of focal posterior disc abnormality at the L4-5 disc level, only a small right foraminal disc abnormality. The age of the small right L4-5 foraminal disc abnormality is indeterminate. The abnormality is not associated with compromise of exiting right L4 or traversing right L5 nerves, and would not be considered actionable. Further, there is no disc herniation at L5-S1, only circumferential disc bulging and disc desiccation that

appear degenerative in nature, along with a prominent prevertebral venous plexus that mimics a disc abnormality on the axial T2W images. This is confirmed by the absence of any focal disc contour abnormality on the sagittal T1W or T2W sequences. Finally, there is no evidence of scoliosis to suggest muscle spasm.

Noncontrast MRI scan of the Lumbar Spine dated 10/13/09:

Findings: The scan continues to show a normal lumbar lordosis. Lumbar alignment is now remarkable for 1-2 mm of anterolisthesis of L4 on L5 that was not present on the prior scan of 4/3/09. The height and signal intensity of the lumbosacral vertebra remains normal. The T12-L1 through L3-4 disc levels remain normal. Again seen is disc desiccation involving the L4-5 and L5-S1 disc levels, unchanged when compared to the prior MRI of 4/3/09. Minor circumferential disc bulging is redemonstrated at the L4-5 and L5-S1 disc levels. The right intraforaminal annular ligament defect identified on the prior MRI of 4/3/09 is redemonstrated, unchanged. There is again no evidence of exiting rightL4 or traversing right L5 nerve impingement. Facet joint degeneration at the L4-5 and L5-S1 disc levels is again seen, now moderately severe at the L4-5 and L5-S1 disc levels, as evidenced by more sclerosis, larger degenerative osteophytes, and mild facet joint distraction at the L4-5 disc level.

Impression: The scan again demonstrates facet joint degeneration at the L4-5 and L5-S1 levels, progressed from moderate on the scan of 4/3/09 to moderately severe on the current scan. At L4-5, the progressive facet joint degeneration is associated with joint space widening and increased fluid within the joint spaces, leading to minimal anterolisthesis of L4 on L5. A small right foraminal annular ligament defect remains unchanged at the L4-5 disc level, and does not impinge upon the exiting L4 or traversing right L5 nerves. The L4-5 and L5-S1 disc levels again show early degeneration that is unchanged in degree when compared to the prior scan of 4/3/09. The scan was interpreted by Sonny A. Pratidar, M.D. and is overinterpreted with respect to neural foraminal narrowing at the L4-5 disc level and the presence of bulges and protrusion from L3-4 through L5-S1, while being underinterpreted with respect to the severity of facet degeneration and hypertrophy at the L4-5 and L5-S1 disc levels.

Chest frontal and lateral radiographs dated 1/22/10:

Findings: There is a normal cardiomediastinal silhouette. The lung fields are clear and normal lung volumes are identified. There is no blunting of the costophrenic angles or medial heard border to suggest an infiltrate or effusion. There is evidence of mild to moderate multilevel mid and lower thoracic degenerative disc disease and cervical spondylosis, as evidenced by loss of disc space height and anterior and posterior vertebral body endplate osteophytes. The visualized osseous structures are otherwise normal in appearance. No soft tissue opacities are seen.

Impression: Unremarkable chest radiographs.

Cervical spine frontal and lateral radiographs dated 1/25/10:

Findings: There is a normal cervical lordosis. The patient has undergone interval C5-6 anterior discectomy and anterior fusion via a C5-6 interbody graft and an anterior C5-6 vertebral plate and dual C5 and C6 vertebral body screws. Cervical alignment is preserved. The cervical column below the level of C6 is obscured by the shoulders and therefore not evaluated. The anteroposterior diameter of the bony cervical spinal canal appears within normal limits. The posterior elements, including the facet joints, are normal in appearance. There is no prevertebral soft tissue swelling.

Impression:

Noncontrast CT scan of the Lumbar Spine dated 9/23/10:

Findings: There is a normal lumbar lordosis and alignment. The patient has undergone interval L4-5 and L5-S1 disectomy and anterior interbody graft fusion. An anterior metallic plate spans from L4 through S1 and is secured to the L4, L5 and S1 bodies via dual vertebral body screws. There is no bridging bone between the bone grafts and the L4 through S1 vertebra to suggest solid bony fusion. There is no lucency about the vertebral body screws to suggest loosening or infection involving the fusion hardware. The bone grafts are anteriorly displaced relative to the lumbar column and are blocked from further anterior displacement by the anterior metallic plate which is itself positioned anteriorly relative to the anterior margin of the lumbosacral vertebral column. At L4-5, severe bilateral facet joint degeneration is redemonstrated, further progressed. There is no bony spinal canal or neural foraminal narrowing. There is no vertebral compression fracture.

Impression: The scan was interpreted by Dr. Lawrence Bogle, M.D. The radiologic interpretation provided by Dr. Bogle contains numerous perceptual errors and reveals evidence of both overinterpretation and underinterpretation. Evidence of overinterpretation is provided by an erroneous claim of spinal stenosis due to disc bulges at the L4-5 and L5-S1 disc levels where prior discectomies have been performed, and neural forminal narrowing where none is present. Evidence of underinterpretation is provided by failure to note severe bilateral lumbar facet joint degeneration at the L4-5 disc level. In fact, there is no mention of the facet joints at any lumbar level.

Noncontrast CT scan of the Lumbar Spine dated 11/2/11:

Findings: There is a normal lumbar lordosis. The patient has undergone an interval L4-5 and L5-S1 anterior discectomy and fusion via anterior metallic plate and dual vertebral body screws. The interbody grafts and anterior metallic plate are anteriorly displaced relative to the lumbar column. There is no lucency about the vertebral body screws to suggest loosening or infection. The fusion appears solid at L4-5 and likely solid at L5-S1. Lumbar alignment is anatomic.

Impression: Interval anterior L4 through S1 fusion, as described above.

Discussion/Impression:

Cervical Spine:

The cervical radiographs of 10/28/08 which predate the accident of 3/13/09 by nearly five months demonstrate clear imaging evidence of typical degenerative changes at the C5-6 disc space and evidence of pre-existing bilateral C5-6 neural foraminal narrowing. The cervical radiographs of 3/13/09, taken on the day of the accident in question, show clear evidence of progressive degenerative changes that could not be related to the accident in question, as such degenerative changes require months or years to develop. These include enlarging bony C5-6 level vertebral body endplate osteophytes. Importantly, the radiographs of 3/13/09 reveal no direct or indirect evidence of bony or soft tissue trauma.

The follow-up MRI of the cervical spine performed on 4/3/09 confirms the expected circumferential disc bulging that frequently accompanies a degenerated cervical disc, forming a disc-osteophyte complex that in this case, causes mild spinal canal stenosis and no evidence of cord compression. Critically, no focal or acute disc herniation is identified on the MRI of the cervical spine dated 4/3/09. Further, there is no evidence of subacute soft tissue, facet joint, or ligamentous injury, indicating that to a reasonable degree of medical probability, the accident of 3/13/09 contributed no additional pathology to the cervical spine of this Plaintiff. Mild reversal of the normal cervical lordosis may be related to an element of muscle spasm, which may or may not be related to the accident in question, since paraspinal muscle spasm is a frequent finding in patients with natural disc degeneration. Bilateral C5-6 neural foraminal narrowing was present to a comparable degree on both the pre-accident radiographs of 10/28/08 and on the MRI of the cervical spine of 4/3/09. Further, the radiographs and MRI studies both indicate that the neural foraminal narrowing at this level is due to degenerative bony uncovertebral joint osteophytes, and not to an intraforaminal disc herniation, proving that the foraminal disease is due to degenerative causes unrelated to the accident of 3/13/09. This is because such bony osteophytes require years to develop, not three weeks.

If the indication for surgery of the cervical spine is "disc herniation at the C5-6 disc level", then to a reasonable degree of medical probability, the imaging studies provided to me for review in this matter, fail to establish a causal connection between the disc pathology at the C5-6 disc level, the surgical procedure performed at that level, and the accident of 3/13/09.

Lumbar Spine:

The small intraforaminal annular ligament defect identified on the scan of 4/3/09 at the L4-5 disc level on the right side is of indeterminate age and remains unchanged in the interval on the follow-up MRI of the lumbar spine dated 10/13/09. The annular defect is

very small is not close to, or touching, the exiting right L4 or traversing right L5 nerves. Therefore, to a reasonable degree of medical probability, the L4-5 foraminal annular ligament defect would not cause a right sided lumbar radiculopathy. Because the scan of 4/3/09 was performed nearly three weeks after the accident of 3/13/09, absence of soft tissue or ligamentous cannot reliably be used to age the annular ligament defect. However, numerous studies have shown that annular ligament defects can persist for years, may occur spontaneously and in the absence of trauma, and may resolve completely. In the absence of any focal disc herniation or associated compromise of exiting L4 or traversing L5 nerves, a small isolated annular ligament defect does not generally cause severe or lasting symptomatology and is not considered actionable.

Aside from early disc degeneration, the L5-S1 disc level shows no focal disc pathology, and from an imaging perspective, would be expected to be completely clinically silent.

The other lumbar levels are normal in appearance. Evidence of progression of degenerative changes at the L4-5 and L5-S1 disc levels on the follow-up MRI of 10/13/09 speak to the natural history of degenerative disc disease in the lumbar spine in this individual, and to a reasonable degree of medical probability, cannot through direct or indirect imaging findings be causally connected to the accident of 3/13/09.

If the indication for an IDET procedure followed by fusion surgery at the L4-5 disc level is "internal disc disruption" then, to a reasonable degree of medical probability, the imaging findings fail to establish a causal relationship between the accident of 3/13/09 and these surgical procedures.

Brain:

There is no evidence in the written medical record of head trauma, altered sensorium of loss of consciousness. There is no evidence of closed head injury, traumatic brain injury, or other traumatic cerebral, soft tissue or bony pathology on the CT scan of the brain dated 3/13/09. Therefore, based on the imaging studies provided to me for review, and to a reasonable degree of medical probability, no accident related claims of head injury are supported for this Plaintiff.

Please do not hesitate to contact me if you have any questions. I reserve the right to modify my impressions should additional imaging studies or medical records warrant.

Sincerely,

J. Pablo Villablanca, M.D.

J. Pablo Villablanca, M.D.
Professor of Radiological Sciences
Chief, Diagnostic Neuroradiology
Medical Director of MRI
Director, Interventional Spine Service

EXHIBIT 2

October 15, 2012

Steven T. Jaffe
Jacob S. Smith
Hall Jaffe & Clayton, LLP
7425 Peak Drive
Las Vegas, NV 89128

Re: Khoury adv. Seastrand
J. Pablo Villablanca, M.D. Neuroradiology Supplemental Report

Dear Mr. Jaffe and Mr. Smith:

At your request, per letter dated October 8, 1012 I have reviewed the additional medical and legal records pertinent to this action. Below are my additional comments and observations:

In his Supplemental Report dated 9/29/12 Dr. Gross repeatedly indicates that the report authored by myself dated 8/1/12 fails to consider the issue of susceptibility to injury stemming from Mr. Seastand's prior accidents in his evaluation of the imaging studies. Yet Dr.Gross impeaches his own argument when he notes that there is no imaging support of disc pathology prior to the accident of 3/13/09, and that the presence of pre-existing cervical and lumbar spondylosis as demonstrated on the post-accident spinal imaging studies, is to be expected in this Plaintiff. Degenerative changes are precisely the only imaging abnormalities that I was able to identify on the spinal imaging studies of this Plaintiff. If these degenerative changes rendered Ms. Seastrand more susceptible to traumatic injury, there are no findings on the post-accident imaging studies to support this contention as the degenerative changes occur in the absence of any acute or subacute traumatic soft tissue, ligamentous or bony abnormality.

In his Supplemental Report, Dr. Gross argues that is it illogical and inappropriate to measure potential injuries to a person by virtue of the damage to vehicles involved. While this may be true to some extent, it defies common sense to argue that a collision resulting in minor vehicular damage would be likely to result in major bodily injury requiring both cervical and lumbar spinal fusion surgery.

Dr. Gross indicates that the presence of progressive disc degeneration at the C5-6 disc level on the post-accident scan of 10/28/09, as compared to the pre-accident cervical radiographs of 10/27/08 implies that the progression is somehow causally related to the accident of 3/13/09. This argument is not supported by the natural history of cervical degenerative disc disease, which commonly progresses with time, in the absence of any traumatic injury. The argument is also unsupported by the medical record, which indicates the presence of pre-accident symptoms that required radiographic imaging of the cervical spine approximately five months prior to the subject accident.

Dr. Gross suggests that comparatively rapid progression of facet joint degeneration at the L4-5 and L5-S1 disc levels on the scan of 4/3/09 from moderate to moderately severe on the scan of 10/13/09, as identified in my report of 8/1/12, somehow implies a causal relationship between the lower lumbar facet joint degeneration and the accident of 3/13/09. Yet, in his Supplemental Report Dr. Gross himself notes that the medical records reveal that Ms. Seastrand is at the 92nd percentile for body fat for her age, height and gender. A total body fat of 44% of whole body weight alone provides ample and sufficient explanation for the progression in facet joint degeneration in this patient from moderate to moderately severe over this period of time. That is because the lower lumbar spine must carry the weight of the entire abdomen, trunk, arms and shoulders, and when body weight is excessive, lumbar spinal degeneration is often accelerated.

Dr. Gross is critical of the fact my report refers to various scans as having been over-read or under-read, and suggests that this renders my ultimate conclusions skeptical. As a board-certified sub-specialty trained neuroradiologist working in a major academic center, my report of 8/1/12 renders a detailed interpretation of the imaging findings in the setting of a medical-legal proceeding. It is common knowledge that a more superficial interpretation of routine imaging studies may be rendered by a general radiologist when interpreting a scan in the course of daily work, and that these reading may omit or misinterpret imaging findings and small but important forensic details. In fact, my report makes reference to lumbar disc pathology, including the presence of annular ligament defect, and other findings not mentioned by other readers. The radiographic interpretations reflect a complete list of the actual abnormalities present on each study and are prepared independent of correlation to clinical symptoms. In order to avoid clinical bias, correlation of clinical symptoms to imaging findings occurs after image interpretation, not before.

There is repeated critique in the Supplemental Report prepared by Dr. Gross of a lack of discussion of susceptibility and clinical correlation between the imaging and clinical findings in the report submitted by myself dated 8/1/12. A review of the medical record indicates an absence of objective neurologic findings, including weakness, numbness or abnormal reflexes in this Plaintiff to correlate with the degenerative changes present on the post-accident imaging studies. With respect to the issue of susceptibility, Dr. Gross himself neutralizes his own arguments by noting that imaging studies of the cervical and lumbar spine show changes which we both believe are degenerative in nature. Further, I note that progression of degeneration in the time period after the accident of 3/13/09 does not imply causation, since the natural history of spinal degeneration is progression, particularly in the setting of excessive body weight.

In his supplemental report, Dr. Gross concurs with my findings that the imaging studies of the cervical spine of 10/28/08 show degenerative changes and no direct or indirect evidence of bony or soft tissue trauma. However, Dr. Gross suggests that such imaging findings are generally visible by MRI only in cases of catastrophic trauma, and implies therefore, that their absence does not exclude bony or soft tissue trauma. As a subspecialty neuroradiologist working in a Level I Trauma Center, I have witnessed over the course of the past 18 years, the full range of imaging abnormalities resulting from

the full range of traumatic mechanisms, and will emphatically attest that MRI is capable of showing both mild and subtle degrees of direct and indirect soft tissue and bony injury resulting from even modest injury mechanisms. Such changes were not present on any of the post-accident cervical spine, lumbar spine or brain imaging studies of Ms. Seastrand.

Dr. Gross goes on to suggest that imaging evidence of bony or soft tissue abnormalities are not always present or required for a patient to develop post-traumatic painful disc and related symptoms. He further suggests that Ms. Seastrand's degenerative spine changes render her more susceptible to injury. However, in the same paragraph, Dr. Gross acknowledges that such injuries are not evident on this Plaintiff's imaging studies. If it is possible to divorce clinical conclusions from objective evidence as Dr. Gross appears to contend, then any clinical conclusion can be reached in the absence of objective supporting evidence. Fortunately for all of us, medicine remains an evidence-based practice.

My report dated 8/1/12 is further criticized by Dr. Gross as lacking clinical correlation to patient symptoms. Specifically, he objects to the lack of correlation between my observation of a small annular ligament defect at the L4-5 disc level on the right and patient symptoms. In my report, I indicate that this small defect does not displace or compress the exiting right L4 nerve. Because of the complete absence of nerve impingement, a correlation to clinical symptoms was not deemed necessary. In his own Supplemental Report, Dr. Gross indicates that the medical record indicates the Plaintiff was complaining of low back with radiation to both legs. The small defect described in my report certainly does not explain pain in either the right or left leg. While he suggests that positional anatomic changes could somehow cause nerve impingement, if he were correct, such positional impacts would at best give rise to intermittent and/or occasional symptoms. Because Ms. Seastrand reports constant bilateral lower extremity symptoms, the nature of her symptoms effectively rule-out the possibility that this minor disc abnormality is responsible for her symptoms. He further invokes the concept of chemical radiculitis to suggest that nerve irritation may have been caused by this mechanism. The difficulty with this postulate is that most annular defects are clinically silent, and if symptomatic, symptoms resulting from a unilateral defect of this minute size are often intermittent, never bilateral, resolve spontaneously and are not of a surgical nature. Finally, as time goes on, when the Plaintiff does complain of more unilateral right lower extremity pain, the pain is in an L5 dermatomal pattern. If symptomatic, an intraforaminal annular ligament defect at L4-5 would give rise to a right L4 radiculopathy, not L5, thus effectively excluding this findings as causally related to the Plaintiff's right lower extremity symptoms. Therefore, there is a failure of correlation between the Plaintiff's symptoms and the imaging findings. The Plaintiff's low back symptoms are mechanical in nature, as is typical of facet joint degeneration. Chronic progressive lumbar facet degeneration is an anatomic abnormality that is clearly established by the imaging studies at both the L4-5 and L5-S1 disc levels.

With respect to the claim of head injury, Dr. Gross correctly notes that all post-accident imaging studies of the brain show no evidence whatsoever of recent or remote

traumatic brain injury. He goes on to add that mild traumatic brain injury does not require any abnormal findings on brain imaging studies. I would argue that per Dr. Gross' own Supplemental Report, Ms. Seastrand already carries the pre-accident diagnoses or prior concussions, chronic post-traumatic headaches and chronic dizziness, yet there is no persuasive evidence in the medical record post subject accident of a change in this symptom complex that would suggest any accident related worsening of her baseline complaints. To my knowledge, there is also no pre- and post-accident neurocognitive testing to demonstrate an objective worsening of her cognitive functional status subsequent to the accident of 3/13/09. Finally, per the Plaintiff's own report, the accident of 3/13/09 did not result in trauma to her head, loss of consciousness, or any abnormality on post-accident neurologic testing, rendering the contention of subject accident related mild traumatic brain injury without medical evidentiary support.

It is important to note that patient suffers from medically documented neurogenic syncope and an anxiety disorder with somatization including stress related chest and arm pain, and as exemplified by an episode on 10/27/08 when the patient presented with chest pain, numbness and tingling in the arms and pain in the left arm. After an extensive evaluation, the patient was diagnosed with atypical chest pain, numbness and anxiety and prescribed anxiolytics and sedatives. Any patient with such a history should undergo careful psychological evaluation prior to any contemplated interventional procedures, especially a major surgery, in order to ensure that symptomatic complaints are not due to ongoing psychological disease. I have not been provided with medical records that indicate this patient was afforded the benefit of a psychological evaluation prior to undergoing invasive cervical and lumbar spinal surgery.

In a Supplement to his Medical Report dated 8/28/12, Dr. Gross indicates that based on his history, physical examination findings and image review he concludes that the numerous therapeutic and surgical procedures performed on this Plaintiff were medically necessary as a consequence of the subject accident of 3/13/09. I strongly disagree with his opinion for the numerous reasons outlined in my primary report dated 8/1/12 and in this document. While the interventional procedures and spinal fusion procedures may have been necessitated by pre-existing degenerative disease of the cervical and lumbar spine, there is to a reasonable degree of medical probability, no evidence causation with respect to the accident of 3/13/09. Specifically, based on the medical records provided to me for review, and to a reasonable degree of medical probability, there are no findings in the medical record nor in the imaging studies that establish a causal relationship between the accident of 3/13/09 and the extensive therapeutic injections, plasma disc decompression procedures and cervical and lumbar spinal fusion procedures undertaken on Ms. Seastrand.

In summary, opinions rendered to a reasonable degree of medical probability in my primary expert report dated August 1, 2012 are not altered by the additional medical records since provided to me for review, including the Supplemental Reports authored by Jeffrey D. Gross, M.D. and other documents forwarded as enclosure to the letter dated 10/8/12.

Please do not hesitate to contact me if you have any questions. I reserve the right to modify my impressions should additional imaging studies or medical records warrant.

Sincerely,

J. Pablo Villablanca, M.D.

J. Pablo Villablanca, M.D.
Professor of Radiological Sciences
Chief, Diagnostic Neuroradiology
Medical Director of MRI
Director, Interventional Spine Service

EXHIBIT 3

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

Board Certified American Board of Physical Medicine and Rehabilitation
Board Certified American Board of Electrodiagnostic Medicine
Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
Fax: (702) 878-7463

July 12, 2012

Steven T. Jaffe
Hall Jaffe & Clayton,LLP

Re: **Khoury adv. Seastrand**
Date of Loss: March 13, 2009

Dear Mr. Jaffe,

Per request, I have reviewed the provided records on Margaret Seastrand and recorded my opinions below.

Records Reviewed:

01-19-2005	I reviewed a dictation from Dr. Lambert. Diagnosis of postconcussive headache, low blood pressure.
01-25-2005	I reviewed a dictation from Dr. Lambert recommending starting Florinef.
03-11-2005	I reviewed records from Dr. Lambert. Recommended adjusting medications.
03-15-2005	I reviewed a dictation from Dr. Diez. Evaluation for posttraumatic headaches.
05-16-2005	I reviewed an EKG report. Mild to moderate changes.
06-23-2005	I reviewed records form Dr. Lambert. Clear to return to Weight Watchers.
	I reviewed pharmacy records from CVS Pharmacy.
01-19-2006	I reviewed a note from Dr. Lambert recommending Holter monitoring and salt loading.

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

Board Certified American Board of Physical Medicine and Rehabilitation
Board Certified American Board of Electrodiagnostic Medicine
Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

2510 Wigwam Parkway, Suite 201
Henderson NV 89074

Phone: (702) 45-SPINE (457-7463)
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03-22-2006 I reviewed a note from Dr. Lambert who is treating mitral valve prolapse and neurogenic syncope.

11-07-2007 I reviewed notes. Hallux valgus bilaterally from Affiliated Podiatry.

02-12-2008 I reviewed a note. Suture removal.

02-21-2008 I reviewed a procedure note from Dr. Leavitt. Bunion deformity, excision of exostosis.

10-27-2008 I reviewed a dictation from Dr. Kermani. Presented with complaint of chest pain.

11-21-2008 I reviewed a dictation from Dr. Lally. Chest pain and shortness of breath. Recommended a stress test.

12-15-2008 I reviewed a stress test read by Dr. Taylor. No reverse defects noted.

03-13-2009 I reviewed a State of Nevada Traffic Accident Report describing the accident where Ms. Seastrand was stopped at the time she felt the impact. There is a note in the report that Ms. Seastrand reported prior neck and back injuries. Vehicle 1 had minor damage to the front. Vehicle 2 had minor damage to the rear and was the vehicle of Ms. Seastrand.

I reviewed colored photographs of what appears to be a red vehicle with damage to the rear.

I reviewed hospital clinical report. Notes history of neck pain, degenerative disc disease and concussion, complaints of headache and neck pain. She was given morphine and Zofran and was discharged with Lortab and Soma.

I reviewed a history and physical by Physician Assistant Knauff. Recommended for rehabilitation, trigger point injections. She was given Fioricet and Valium.

JOHN B. SIEGLER, M.D.

SPINE AND PAIN MANAGEMENT

Board Certified American Board of Physical Medicine and Rehabilitation
Board Certified American Board of Electrodiagnostic Medicine
Diplomate, American Board of Pain Medicine
Board Certified Independent Medical Examiner

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03-13-2009	I reviewed a Fire and Rescue EMS report. Complained of neck, back and pelvic pain noted.
03-20-2009	I reviewed records from Dr. Lurie. Complaining of headache, neck pain, midback pain, low back pain, bilateral shoulder pain.
03-25-2009	I reviewed a progress note from Dr. Olmstead, chiropractor. Modalities performed.
03-27-2009	I reviewed a progress note from Dr. Olmstead. Modalities. No change in symptoms. Continue chiropractic treatment.
03-30-2009	I reviewed a progress note from Dr. Olmstead. Continued treatment.
03-31-2009	I reviewed records from Dr. Olmstead recommending MRI of the cervical and lumbar spine.
04-03-2009	I reviewed a progress note from Dr. Olmstead recommending chiropractic treatment.
04-08-2009	I reviewed a chiropractic progress note from Dr. Fisk.
04-15-2009	I reviewed a note by Dr. Olmstead.
04-17-2009	I reviewed a chiropractic progress note by Dr. Fisk.
04-21-2009	I reviewed a chiropractic progress note by Dr. Weekes.
04-24-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
04-28-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-01-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-05-2009	I reviewed a note by Dr. Belsky recommending injections in the cervical and lumbar spine.

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05-06-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-11-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-13-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-15-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-18-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
05-20-2009	I reviewed a procedure note from Dr. Belsky. Dr. Belsky did a bilateral L5-S1 epidural and L4-5 facet injection.
05-26-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
06-01-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
06-03-2009	I reviewed a chiropractic progress note by Dr. Olmstead.
07-21-2009	I reviewed a chiropractic progress note by Dr. Webber.
07-22-2009	I reviewed a chiropractic progress note by Dr. Webber.
08-04-2009	I reviewed records from Dr. Belsky recommending a cervical epidural.
08-24-2009	I reviewed an initial evaluation by Dr. Muir recommending discography and a cervical injection.
08-26-2009	I reviewed records from Dr. Belsky. Performed a right C5-6 epidural steroid injection.
08-28-2009	I reviewed a dictation from Dr. Muir recommending plasma disc decompression for the lumbar spine.
09-16-2009	I reviewed a procedure note, discography by Dr. Belsky. No pain at L3-4, L4-5 concordant pain, L5-S1 concordant pain.

IN THE SUPREME COURT OF THE STATE OF NEVADA

RAYMOND RIAD KHOURY, Appellant, vs. MARGARET SEASTRAND, Respondent.	Supreme Court Case No. 64702 Supreme Court Case No. 65007 Supreme Court Case No. 65172

APPEAL

from the Eighth Judicial District Court, Clark County

The HONORABLE JERRY WEISE, District Court Judge

District Court Case No. A-11-636515-C

APPELLANT'S APPENDIX

VOLUME II

STEVEN T. JAFFE, ESQ.
Nevada Bar No. 007035
JACOB S. SMITH, ESQ.
Nevada Bar No. 010231
HALL JAFFE & CLAYTON, LLP
7425 Peak Drive
Las Vegas, Nevada 89128
Attorneys for Appellant Raymond Riad Khoury

VOLUME INDEX

VOLUME II