July 20th, 2011 --

MR. PEEK: Which is merits discovery.

THE COURT: I understand.

MR. PEEK: And you're saying that those should be inclusive for jurisdictional discovery and we should search those. And then I guess you will determine whether we should or should not redact for personal data, names.

THE COURT: No. I've told you you can't redact for personal data --

MR. PEEK: Okay. I just want to make sure. You're saying --

THE COURT: -- but if you decide that because of your risks in Macau you want to redact for personal data, then I weigh that in my wilfulness balancing of issues.

MR. PEEK: Or we may come back to you and say in an appropriate objection, appropriate motion or something, or we just do. And then you weigh that on -- is that what I understand?

THE COURT: What I'm trying to convey to you, and I hope this is really clear is, I am not ordering you to produce at this time documents responsive to the ESI search that you do that would only relate to merits discovery. If you choose to withhold those at this time, great. It's --

MR. PEEK: Choose to withhold those. What do you mean "those"? I don't know what "those" is.

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THE COURT: A document that talks about why Mr. Jacobs was terminated. Remember how I have the who, what, where, when, how --

MR. PEEK: I do.

THE COURT: -- but we can't ask about why?

MR. PISANELLI: And, Your Honor, if I can make the record clear --

MR. PEEK: So we're just --

MR. PISANELLI: I'm sorry, Mr. Peek. Go ahead.

THE COURT: Wait. We've got to let Mr. Peek finish, Mr. Pisanelli.

MR. PISANELLI: Yes.

MR. PEEK: Thank you. I wasn't because, Your Honor, the -- that type of discovery of the who, what, where, when, how has not been the subject matter of their request for production. And we have search terms associated with those requests for production. That's how we came up with the search terms, was based upon the specific jurisdictional discovery that you allowed in you March 8th order, not what propounded but what you allowed. So --

THE COURT: So are you telling me that it's your position that Luis Melo has nothing to do with any of the requests for production that were served?

MR. PEEK: We are, Your Honor. We are telling you that.

Q Okay.

A But that's -- you're right, people do have that belief, but acute has nothing to do with severity, it has to do with when it occurred. Acute is --

Q Okay.

A -- recent and chronic is long term.

Q Okay. So every -- every hepatitis virus transmission, if -- every -- whenever I got it then, like, using six months as an arbitrary cutoff, I'm acute for six months; thereafter chronic, if I still have it?

A That's correct.

Q Okay. And so that -- every person who had -- contracts hepatitis C has acute hepatitis C, but --

A That's correct; however, frequently it's never recognized because they have no symptoms or they don't seek --

Q Okay.

A -- medical attention. They thought they had the flu or something.

Q Okay. And so then we get into the, what we've called symptomatic and nonsymptomatic, right?

A That's correct.

Q Okay. So I -- I could contract hepatitis C and whether I have -- well, just suppose I got it today, and then whether I demonstrate symptoms or not has nothing to do with acute or chronic.

Q And then if they don't get rid of it either themselves, naturally, or through treatment, they then will have chronic thereafter?

A Correct.

Q Okay. And then the -- the symptomatic/nonsymptomatic [sic], that -- and symptomatic, as you said, is normal -- it occurs in acute hep C, first six months --

A Yes.

Q -- if it occurs?

A Now, we do have patients with chronic hepatitis C that are fatigued, and it probably is because of the viremia, the ongoing viral replication.

Q Okay.

A But usually the most pronounced symptoms are in the acute hepatitis.

Q Now -- colonoscopies without anesthesia, okay? And we've heard a lot in this courtroom about CRNAs and the vast majority of the people get propofol and go to sleep and then wake up and don't remember. Are -- do some patients get colonoscopies without anesthesia?

A Yes.

Q And how frequent is that?

A Maybe once a month I'll do one without sedation.

Q Okay. And does -- what -- why? Are they

recall her as a patient?

A Yes.

Q Okay. And I wanted to go through that because that is a successful treatment of a hepatitis C patient; is that correct?

A Correct.

Q Okay. And do you -- do you recall that it was in November of 2007 when you first got Gwendolyn?

A I can't remember the exact time, but it was either late 2007/early 2008.

Q Okay. And can you -- without -- if -- I don't want to -- I don't intend to drag this out and go through all of your records, and the dates really are not significant, but if you do want to look at your records, I'll give you a copy of the deposition that I'm talking about and your records are there.

A Okay. Thank you.

Q Would you like -- did you float through there? You recognize those as your records?

A Yes.

Q Okay. And when she -- you're -- you are a gastroenterologist who treats people who have hepatitis C?

A Yes.

Q And so Gwendolyn Martin came to you, and at the time had acute hepatitis C?

Q Okay. And so was hers on the low end?

A Yes.

Q Okay. And do you recall that -- first let me back up a minute. She has acute hepatitis C?

A Yes.

Q And of course, before you put her on the treatment, she elected to take the treatment, correct?

A Yes.

Q Tell the jury about the discussion you have with the patient about what it -- just like, I'm a new patient, I'm in, I got acute hepatitis C and I'm scared to death.

A Well, I told Mrs. Martin that I had not seen acute hepatitis C before. This is a fairly rare thing to be able to treat because there are so few new cases of hepatitis C, we're generally not seeing them. Most of what we see, in fact, all prior to Mrs. Martin coming in to see me, was chronic hepatitis C.

Our experience with treating hepatitis C -- when I say," "our experience," the worldwide experience with treating hepatitis C is -- that's acute is fairly limited. But it was felt that theoretically an early intervention with the hepatitis C gave the best possibility of having a favorable long-term response.

Q Okay. But I'm scared to death. What are the side-effects going to be for me?

C?

A There's a 20 percent chance that you go on to cirrhosis and death of the liver if the hepatitis C is chronic and not treated.

Q Okay. So if I just do nothing, get past the symptoms, most probably I'm going to die of old age and not hepatitis C?

A Yes.

Q Okay. And there is a 20 percent chance I'll get cirrhosis of the liver -- I mean, this is from the statistics and studies -- within, is it 20 years of --

A Well, we've seen it as little as five or even two or three years, but generally this takes decades of ongoing inflammation of the liver. But, you know, everybody's got a different immune system and, you know, as you're older your ability to fight off infections might not be as vigorous as a younger person and who, you know, may have a more accelerated progression of disease.

Q Okay. Cognitive deficits. I'm worried I have hepatitis C now. I just caught it and I have symptoms. What cognitive impact is this going to have on me?

A Well, in the acute phase a person would have the same type of cognitive deficits that you'd have, like, with a virus or a cold. Your ability to concentrate is impaired. Attention to detail might fall off. But as you became more

A Well, you know, I've only known Gwendolyn Martin since she had her bout of hepatitis C and I didn't know her beforehand, so I can't say, you know, whether there was a change in her skillsets or cognitive abilities. I don't know.

Q Okay. He said that the disease -- and he -- we were talking about hepatitis C. He said the disease and the treatment of the disease cause dementia, and that hepatitis C is neuro viral and affects your brain before the liver. You ever hear of that?

A No.

Q He said the neuro not -- cognitive impairment is independent from the Interferon treatment, and that the Interferon treatment is a double-whammy. It sort of accelerates one's brain dysfunction caused by the hepatitis C. Have you ever seen or heard anything like this in the studies you've read about --

A No.

Q It -- with hepatitis C, even the treatment -- I opt to take the treatment, I've got hepatitis C, I'm going to go through 48 weeks of Interferon, whatever side-effects I have, even if cognitive from the treatment, those are going to cease when I'm done with the treatment; is that fair?

A Well, you know, I would hope so, but, you know, I think you need to understand that there are all sorts of unintended consequences of the therapies we give patients, and

Q GI tech?

A Yes.

Q Okay. In that procedure room, who is in charge of that procedure room?

A The gastroenterologist.

Q So that would be you?

A Yes.

Q If you were performing the procedure. Is that standard and customary?

A Yes.

Q And in fact, the CRNA doesn't need an anesthesiologist to supervise them in Nevada, correct?

A No, they do not.

Q An M.D. can supervise a CRNA --

A That's correct.

Q -- such as yourself? You're the supervisor of that CRNA in that procedure room?

A Yes.

Q You talked about -- maybe you didn't talk about it here, but I was reading in your grand jury transcript about the procedures that you use in logging in information about a patient after the procedure?

A Yes.

Q Do you use electronic devices to do that?

A Yes.

A It occasionally will happen, yes.

Q And it can be very messy?

A When there's a bad prep, yes.

Q When you say a "bad prep," that means the patient hasn't prepped properly?

A Sometimes they prep properly but the prep did not have its desired effect. There's residual fecal material within the colon.

Q Okay. And related to that you talked about scope cleaning in your -- in your grand jury testimony --

A Yes.

Q -- right? And, I believe you testified that there was -- in your practice the scope cleaning takes 55 minutes?

A Correct.

Q That's relatively new since the hep outbreak?

A No, I think that's been fairly standard.

Q Okay.

A I mean, there is a timer on the scope washer and, you know, by the time you get the prewashing and brushings done and get it into the cleaner and then do all the due diligence to make sure the scope is clean, that's how long it takes.

Q And I believe you testified that you cleaned two scopes at a time in the enzymatic fluid?

(Court recessed for the weekend at 4:45 p.m.)

Q I wonder why.

A Because, you know, what they really want to do, most providers, is they just want to practice medicine. They just want to give anesthesia. They just want to practice medicine. But there's more to it than that. We're -- you know, we're back to the quality of care and the health record, you know, how important that is. We're back to being accurate and have sufficient documentation to support what you want these people to bill for you.

It -- it's just being responsible, it's being accurate, it's being appropriate; and if you don't know it, don't understand it, then I think you should seek out that information from those who have it and keep asking until you do understand it because that is what insurers expect and certainly Medicare does, and their language can be difficult at times.

Q At times?

A Frequently.

Q All right.

A It can be difficult, but that doesn't release us from the responsibility of trying to find out and there's many ways to find out so that you will be accurate in what you're doing.

Q Great. Thank you.

A You're welcome.

Q I'm showing you what has been marked as Proposed State's 219 to 227. And just flip through those generally, and we'll go through them in a little more detail. Yeah, flip through them, and you can go ahead and just tell me -- tell us if you're familiar with them, if, you know, the records of your organization and if those are the ones you provided to us?

A (Witness complied.) Yeah.

Q And exactly what are these records?

A These are documents that we provided in response to a subpoena. The subpoena requested information related to a series of documents and a letter that was issued by the AANA, the president of the AANA in, I believe it was 2002 in response to a hepatitis outbreak that had taken place, and it also included some membership regarding -- information regarding two members and a press release related to that same outbreak.

Q The records that you just looked at, are they records of your organization?

A Yes, they're records from the AANA.

Q Are they kept in the ordinary course of business?

A They are.

Q Do you rely upon those records in the duties and things that you need to do as -- in conducting your business?

A Historically and consistently the AANA, the membership represents over 90 percent of nurse anesthetists.

Q As far as the -- your organization what kinds of things do you do as an organization for your membership?

A It's an advocacy organization. It's a professional -- a professional organization, so it advocates on behalf of the profession. It provides continuing education. It provides guidance policies. It sets standards for the practice of nurse anesthesia.

Q The membership as it is constituted, I mean, what kinds of things do you do for the members as -- as sort of members of your organization?

A There are multiple annual meetings that are open to the public; the board establishes policies, guidelines; there are -- there's an AANA journal which publishes information for members; there are newsletters, and then there's obviously political advocacy with regards to legislation, both on a national level, but also to assist state by state.

Q Now, you mentioned journal. Is there -- is there other -- another professional organization for nurse anesthetists besides yours?

A The -- well, there are other professional nursing associations. The only nursing association dedicated to nurse anesthetists is the AANA.

was when it was finalized for mailing.

Q So this one says September 30th of 2002, correct?

A Correct.

Q Now, I'll show you what is listed as Bates No. 3. And this one has a date that is September 23rd of 2002; is that correct?

A Correct.

Q Is this the second letter that you were talking about?

A It was. Yes, it is.

Q Okay. And if you need to -- me to bring anything back to you so you can -- I know I'm giving you kind of a window to look at on the screen. If you need it in better context, I can return it to you to look at, okay?

The same language, though, appears in this secondary letter?

A Yes.

Q Now, what was the purpose of having two separate letters; if you know?

A My understanding is the only difference in the dating of the letters is when they were prepared to be sent out versus when it was posted on the website.

Q Okay. So --

MR. SANTACROCE: I didn't hear the last part of that.

document here -- Bates No. 50. A conclusionary section of that document. Go ahead and read for us these sections if you would.

A When --

Q And the highlighted portion is all you need read.

A The assumption is made that all patients are potentially infectious. Acceptance of this concept requires anesthesia providers to approach the risk of infection, transmission of organisms, and cross-contamination in a careful, consistent, and logical -- I'm assuming it finishes "manner." It is clearly unacceptable to adopt the practice of standard precautions at one time and disregard it or apply its practices in part at other times.

Q You can go -- go ahead and read it since it's just two paragraphs. Read the entirety of that.

A The unique requirements of decontamination, disinfection, and sterilization for anesthesia equipment, ancillary devices, and accessories requires nurse anesthetists to fully understand and minimize the actual risks present for all parties. Anesthesia equipment mandates specialized attention as to how each product is processed to effectively destroy potentially infectious organism without destroying the integrity, performance, and safety of the product.

Decisions regarding the level of decontamination for

members?

A It does.

Q Do you have other mailings and the like during the course of, you know, a year that gets sent to members and so forth?

A There's newsletters, there's emails, there's various, you know, just advocacy issues or things that might be of interest or note for the membership, so yes.

Q So the information that was contained in the document -- the letter that I had showed you earlier, as well as the accompanying pamphlets, the infection control guy, the code of ethics, all of that kind of thing -- did -- did those items actually make it into -- I mean, some form to get to the -- every one of the members? I mean, as far as either emailed, mailed, both, what? How did you get them out?

A The -- in this instance these were all hard-copy mailed to all members, along with the letter from President Lester.

Q So to be an active member, do you have to continue to give your address information and so forth? I mean, do you have to know where these people are?

A I mean, it certainly helps, yes.

Q Okay. I mean, can you --

A The AANA --

Q -- communicate with them --

Ethics, correct?

A That is correct.

Q Now, the last one that I want to go through with you is a document that is entitled Scope and Standards for a Nurse Anesthesia Practice; do you see that?

A Yes.

Q And this is Bates No. 78 for counsel. Now, specifically, Bates No. 80. And these are the standards, correct?

A Correct.

Q If we go to standard 6, can you read that for us?

A Standard 6, There shall be complete, accurate, and timely documentation of pertinent information on the patient's medical record. And then it includes an interpretation, Document all anesthetic interventions and patient responses. Accurate documentation facilitates comprehensive patient care.

Q Okay. And then the last page of that, which is Bates No. 81. And I think there is the section here -- let's just go ahead and start over with section -- Standard 8.

A Standard 8. The highlighted portion reads, Adhere to appropriate safety precautions.

Q And then -- and you can read the whole paragraph. That's fine.

hepatitis C outbreak where?

A I believe it was in Oklahoma.

Q Okay. And in 2002, correct?

A Yes.

Q And it was set out -- I believe the predicate in there was that there was a widespread misunderstanding; is that correct?

A That is what the document says, yes, sir.

Q And what was that widespread misunderstanding?

A There -- so, I can speak to what the records that I have provided and reviewed show --

Q Sure.

A -- which is in the press release it shows there was differing opinions with regards to the reuse of needles and whether -- amongst all anesthesia providers, and other physicians.

Q Okay. Do you know more specifically what that misunderstanding was? Was it -- I guess, was it contrary to what you set forth in this letter?

A Well, but what was set forth in the letter was the policy of the AANA, which has always been consistent that needles shouldn't be reused.

Q So it was a misunderstanding that CRNAs were reusing needles and syringes?

A I guess I'm not understanding the --

to get a clarification as to what this means. Standards for office-based anesthesia practices, what does that mean? What's an office-based anesthesia practice?

A As compared to a hospital-based.

Q Okay. So you have hospital-based and office-based?

A Yes, sir.

Q Is that correct?

A Yes.

Q Oh, okay. And what -- what is the distinction? Are there different rules for hospitals and different rules for offices -- office-based practice?

A Again, not wanting to get into clinical differences, as I'm not a nurse anesthetist, but there are distinct things that are reflected in the practices to reflect the environment in which the anesthesia is being administered.

Q Can you give me some specifics?

A Again, I think it's going to depend on the equipment available and it's going to depend on who is involved in the administration of anesthesia. But again, I would also submit that the practice -- or the -- excuse me, the policy would speak for itself.

Q What does this mean -- this sentence mean here, Most office-based practice settings are not regulated. What does that mean?

BY MR. SANTACROCE:

Q What was the percentage of CRNAs that were reusing needles and syringes?

A Again related to this survey, 18 percent.

Q So you have nearly half of the M.D. anesthesiologists reusing, but only 18 percent of CRNAs; is that what the survey said?

MR. STAUDAHER: And, Your Honor, of the sample that he said, I would object to it if he says, "all" anesthesiologists. He said --

BY MR. SANTACROCE:

Q And when I say "all," I'm talking about the sample survey.

A That --

Q My comments are related to the survey, okay? Just so we understand.

A And, yes, then we're on the same page. That is what the survey showed.

Q Okay. And then it goes on to talk about oral surgeons, 15 percent, and then less common among nurses, correct?

A Yes, sir.

Q Now, go on to the third bullet point and remembering that this was a key finding in the survey. The third bullet point?

correct?

A Correct.

Q So you can use multi-dose vials?

A Utilizing a new needle each time and a new syringe.

Q So as long as you have aseptic practices?

A That's what the -- that's what the, excuse me, Standard 2 says.

Q And that's not contrary to the 2002 letter?

A I don't believe it is, no.

Q Okay. So is it the AANA guidelines that multi-use vials or multi-dose vials are okay to be used as long as aseptic practices are employed?

MR. STAUDAHER: Objection.

THE WITNESS: Well, I mean, the --

MR. STAUDAHER: Mischaracterizes his testimony, Your Honor.

THE COURT: Well, I think --

THE WITNESS: The procedure --

THE COURT: -- he --

THE WITNESS: -- speaks for itself. It -- what it says, It should be limited to single pace [sic] use unless a strict aseptic technique is used and a new sterile syringe and access device are used each time the vial is penetrated. So it's not just the aseptic technique, but it's also using a new

Q Just whatever you feel comfortable so that you get a handle on what this is about.

A (Witness complied.)

Q Are you familiar with this 2009 policy of the AANA?

A Not to be a lawyer, but I'd -- it was a position statement, not a policy. So it was just a statement reflecting what the current position state was -- position was regarding the safe practices of needles and syringes.

Q What?

A That's a -- there -- simply put, it's just there are things that are labeled policies as, you know, it said the infection control policy. This is identified a position -- as a position statement. So...

Q How you guys take a stand on something? Is that what "position" means?

A Making it clear what the position of the AANA is.

Q This document was prepared in -- what's the date on that?

A The first page of the document shows it in 2009.

Q And am I -- the -- describe for the jury what this position of AANA is.

A It reflects the position of the AANA on the safe practices for needles and syringes, and it reflects the fact

knowledge about standard care changes.

MS. STANISH: Let me rephrase it.

THE COURT: Yeah, rephrase it.

BY MS. STANISH:

Q You wouldn't have had -- AANA wouldn't keep having to send out these kind of position papers in -- if the standard of care had changed in September 2002.

A To be clear, I think you're misrepresenting. This -- this -- the document reflected what the policies were of the AANA, and therefore they put out the fact that the position of the AANA was, not to reuse needles. I mean, that's what the documents --

Q And he -- you can -- the AANA has to -- has continued to try to emphasize and refine its policies because in the past we have seen that there's at least a disagreement or a misunderstanding about what is appropriate and what is not.

MR. STAUDAHER: Is there an --

THE COURT: Is that a --

MR. STAUDAHER: -- an outright question?

THE COURT: -- question?

THE WITNESS: Yeah, I --

BY MS. STANISH:

Q Correct?

A -- I think the issue is that there seems to be

find out whether or not he was -- I mean, there was any problem at all with his address when these things were sent out?

A I looked at a screen shot that had changes of address, and that was what I was testifying regards -- that with regards to Mr. Lakeman there was in 2004 a change of address, and then again in 2007 the address -- the move to Georgia.

Q So in 2004 there was a change of address, and then 2007 there was a change of address?

A Correct. That was what the -- again, when I say a screen shot, when you go on the computer you can print out what you're seeing on there, so I printed that out.

Q But you didn't have anything about a change of address around 2002 that was an issue?

A No. The only changes of address -- there was two on the same day, which appeared to be -- speculating, on a correction of a typo because it started with two numbers and then corrected the address in 2004, and then a change in 2007 to Georgia.

Q But again, nothing --

A Nothing.

Q -- in 2002?

A No changes in that time, no.

MR. STAUDAHER: Nothing further, Your Honor.

address that it shows there is No. 3 Mallard Court. There was a change here at -- and -- oh, goodness, in -- on May 3rd of 2004 that switched to 6361 Goody Court.

When I referenced that I thought there was a type. It was because 63 Goody Court was entered in, and then that same day it was changed to 6361.

BY MR. SANTACROCE:

Q What was the "Oh, goodness" that you just said?

A Just the arrow popped up. Sorry.

Q Oh, I didn't know if there was something --

A No. No.

Q -- there was a revelation here I should know about.

A And then, finally, if you'll look in 2007, that was when the address that you and I spoke about earlier, Highlands Drive, which I believe to be in Georgia. And so with regards to your prior questioning, nothing would have been sent to that Highlands Drive address in 2007 -- or excuse me, 2002, because that address didn't go on file until 2007.

Q Okay. So --

MR. SANTACROCE: -- go ahead, Your Honor.

THE COURT: Oh, I was just going to say, so the 2002 address would have been the Mallard Court address?

THE WITNESS: Correct.

THE COURT: Okay.

facing that lady right there.

FRANK NEMEC, STATE'S WITNESS, SWORN

THE CLERK: Thank you. Please be seated. And please state and spell your name.

THE WITNESS: Frank Nemec, N-E-M-E-C.

THE CLERK: Thank you.

THE COURT: All right. Thank you.

Ms. Weckerly?

DIRECT EXAMINATION

BY MS. WECKERLY:

Q Sir, how are you employed?

A I'm a gastroenterologist.

Q And can you explain to the members of the jury your educational background that allows you to work as a gastroenterologist?

A I did my undergraduate work at the University of California Berkeley, studied bacteriology and immunology. Then I went to the UCLA School of Medicine. And after that an internship at USC and a residency and fellowship at University of California Davis.

Q And when did you start practicing in Las Vegas?

A 1984.

Q And in 1984 did you have your own practice, or were you with other partners?

A I was initially in solo practice.

I think probably a more important metric to determining whether or not you've got a quality colonoscopy program is the adenomatous polyp detection rate, looking for adenomatous polyps of at least 15 percent of men and 25 percent of women.

Q Would you say, though, there's any correlation between the amount of time taken during a procedure and the discovery of disease or -- or other issues?

A Well, that's what Dr. Rex found is that there was a correlation between the scope withdraw time and the ability to identify these polyps.

Q In your -- you have a gastroenterology practice, correct?

A Yes, ma'am.

Q How many colonoscopies could you perform in an hours' time?

A Probably two to three.

Q And are -- is there -- I assume there's a turnover time for the procedure rooms?

A Let me just clarify that. If I was confined to one examining room, it would be two to three. I think it's possible to do three or four an hour if you had two different examining rooms at -- at your disposal.

Q Okay. And that would include, like, the -- the turnover time for the room?

A Well, one room could be turned over while

only go to one decimal place so it's still just 1 unit because it would be 1.0 whatever.

THE COURT: So if it's 1.5 or higher you round up, and if it's -- is it that rule we learned, you know, in school, 1.4 or lower you round down; is that how you do it?

THE WITNESS: You round the time unit to one decimal place. So if it was 1.49 then yes, you would round it to 1.5.

THE COURT: 1.5, and then you'd go to 2 units, correct? Or do you keep it at 1 point --

THE WITNESS: You keep the decimal -- one decimal place.

THE COURT: -- you keep the decimal. So it's not that you round up to the largest whole number --

THE WITNESS: Right.

THE COURT: -- you round to the --

THE WITNESS: To the decimal place.

THE COURT: -- the decimal point --

THE WITNESS: Mm-hmm.

THE COURT: -- so 1.47 would be 1.5, 1.42 would be 1.4?

THE WITNESS: Right.

THE COURT: Is that what you're saying?

THE WITNESS: Correct.

THE COURT: Okay.

THE WITNESS: Correct.

A Modifiers or modifying units?

Q Modifying units that you would --

A Okay.

Q -- actually add to this formula.

A Yes, for the ASA -- the anesthesia classification.

Q Okay. And the -- so we would have to have additional information on whether the patient requires -- has some condition that supports closer monitoring or something like that?

A Yes, the medical records should contain sufficient documentation to support the ASA classification that anesthesia is giving.

THE COURT: And is that something the anesthesiologist or the anesthetist would then calculate, like, you know, I have a 92 year old with a heart condition or whatever they're going to consider, they then calculate the modifying units?

THE WITNESS: I don't -- I doubt very seriously if a physician or a CRNA --

THE COURT: Would do that.

THE WITNESS: -- would be involved in the billing. It -- they could --

THE COURT: Okay.

THE WITNESS: -- be. Whoever does the billing --

Is there more?

A Sometimes there may be modifiers on codes -- the CPT codes. For instance, if it's a CRNA, they would have a certain modifier on the -- the anesthesia code. If it's an anesthesiologist, an M.D., there would be a certain modifier for that.

Q You know, since we're talking about CRNAs in this case, you -- do you know whether the CMS has a particular modifier for a CRNA without supervision?

A Yes, they do.

Q What is that modifier -- do you know how many points it is? Or maybe I misspoke --

A Q -- I think it is Q -- QX for with supervision -- QZ.

Q Okay.

A QZ.

Q And is that QZ worth any points or -- according to CMS?

A Not to my --

Q What --

A -- knowledge. It just --

Q -- so it does nothing?

A -- differentiates who gave the anesthesia.

Q All right. So it doesn't affect our -- our math here on what is the value of anesthesia service?

what you -- we agreed on or what is it?

A Unit price is what I --

Q Okay.

A -- always --

Q Price.

A -- referred to it as.

Q And that -- so basically if I -- if I wanted -- well, I don't know if I have to go that far. So total units multiplied by whatever the unit price is is going to give me the value of anesthesia service?

A To my recollection, yes.

Q And that's going to be the check that's sent to the provider?

A Yes, it's usually -- if it's Medicare -- well, a lot of large insurers do it as well -- it's a once-a-month check. And this is a very large check, say $10,000. And then attached to the check is an explanation of payment. And on the explanation of payment it will have each individual patient listed where you file the claim, here's what you file for this date of service when the procedure was done, and here's what you billed, and here's what we're going to pay you, and here's what -- if there's secondary insurance, you know, you can bill it, and here's what you've got to write off it's noncovered.

Q Okay. So they kind of bundle all --

That -

A Okay.

Q -- but that charge that the provider puts in whatever block that is that I can't see, it is not that charge that they get. They don't get that amount that they put on the Form 1500, correct?

A It's very rare. It's very rare.

Q Okay. They get what is the bottom line on that equation that we just discussed?

A Based on that formula, so to speak, and based on the fee schedule.

Q Okay. And do some providers, if you know, simply say time doesn't matter, you get a flat fee?

A Well, many services rendered it is a flat fee based on the code. Some services are based on time and other services are -- it is what it is. Whatever that thing is, that's all it is. There's no -- it's not based on time.

Q Is that something that's just determined by the insurance company or agency that instead of using this formula from CMS because it's just too complicated or whatever, we're going to give you a flat fee for anesthesia service?

A I am not familiar with anyone that does that. It may occur, but I am not familiar with that at all.

Q In your experience, do most medical groups have third-party billing companies to deal with all these numbers

Q And are there -- I bet there's requirements for credentialing --

A Absolutely.

Q -- all right. And do you know in the world of GI -- ambulatory surgical centers, is there a particular agency that does the credentialing, if you know?

A There are so many agencies out there with many different acronyms that certify, inspect and then certify all different kinds of places, and it's supposed to indicate then to the insurer, to the public, that quality care would be given if they meet all the standards of care.

Q Well, thank you kindly.

MS. STANISH: I have no further questions.

THE COURT: All right. Mr. Santacroce?

MR. SANTACROCE: I have nothing further to add.

THE COURT: All right. Ms. Weckerly, any redirect?

MS. WECKERLY: Yes. Margaret?

MS. STANISH: Yeah.

MS. WECKERLY: Can I have your value [inaudible]?

MS. STANISH: My -- this thing?

MS. WECKERLY: I -- yeah.

MS. STANISH: No, sure you can.

MS. WECKERLY: Just for a minute.

MS. STANISH: If you can read it, there you go.

MS. WECKERLY: I can read it.

Q Mm-hmm.

A -- so I reviewed 9/21. But as an auditor -- a medical record auditor and reviewer, whatever is there I'm going to review and frequently it's because you want to always give the benefit of the doubt to the provider. So I want to review everything they've got so that I can try to, again, give them every benefit of the doubt that you're documenting -- that your documentation is sufficient --

Q Okay.

A -- to support codes that would be billed. So I looked at 9/21 for --

Q Gwendolyn Martin?

A -- yes, it was an endoscopy with a biopsy. And the ASA classification, anesthesia classification was a 2. There was no documentation of any systemic disease at all, which should be, if it's a 2. So in reviewing the file -- and again, that was 9/21 -- there was 9/20, the day before, the patient had a colonoscopy and the ASA classification was a 1. So it would be very unusual that in 24 hours you would go from a 1 to a 2 as far as anesthesia is concerned, unless the evening of the 20th you had a heart attack or something, I don't -- you know, some catastrophic event would occur.

And I found that in several records, by the way, you know, where just within one week or one day the ASA classification would change. And that lends itself to very

two days apart? But at least it was the same classification that time.

Q Right. So she's a 2, no documentation, but also no enhancement because it's not yet a 3.

A Correct.

Q Okay. And just --

A So that really is a -- has to do with a quality-of-care issue rather than a billing issue since no units were added, but, you know, what about the quality of care? You know, on one hand you're saying this person is a little sicker, but yet there's no documentation of why they're sick.

Q And this is 47I, and this is Stacy Hutchinson. And what's her classification?

A She had a -- on 9/21 her classification is a 2. And it's marked hypertension. But no units would be added for that; it would be zero.

Q Okay. And this is Michael Washington. And that's 47J.

A This was July 25th and his classification is a 3. Well, when I see an ASA classification going up, then you definitely need to see documentation of medical history. So one thing I do is I look at the age. That's not always an indicator because this patient was 67 years old, but that doesn't mean that you're sick just because you're 67. You

THE COURT: And that goes to this next -- a juror question -- were you done? I'm sorry.

MS. WECKERLY: No, if I -- I'm almost done. If you -- you can interrupt me if you want.

THE COURT: Well, okay. Since I already have. So the juror in this just goes into what Ms. Weckerly has said. Anesthesia time in the increments of 15 minutes, 15 minutes equals 1 unit. So say, for example, you had a 22-minute procedure -- impressed the juror did all the math -- that would be 1.4. So would that equal one unit?

THE WITNESS: Well, you bill it with one decimal place.

THE COURT: So it would be --

THE WITNESS: So it would be 1.4.

THE COURT: Okay. Let me make this easy then. Let's just say a unit is equal to $100.

THE WITNESS: Okay.

THE COURT: So for 22 minutes would that be reimbursement at $100 or reimbursement at $140?

THE WITNESS: To tell you the truth, I never got into that end of it.

THE COURT: Okay.

THE WITNESS: You know, I would know that here's the fee schedule --

THE COURT: Okay.

A Absolutely.

Q Was that the definition back in 2007?

A Yes, to my knowledge it has been the definition for the start and end of anesthesia since 1994. You know, I didn't find anything prior to that.

Q Okay.

A But after 1994 that was the definition of the start and end of anesthesia time.

Q And you, I think, testified yesterday that you're not allowed to be billing for two patients at the same time, or you can't overlap time in terms of anesthesia except for that one example of a doctor supervising CRNAs?

MR. SANTACROCE: I'm going to object. This has been asked and answered on direct. She's just going through direct all over --

THE COURT: Well --

MR. SANTACROCE: -- beyond the scope of cross.

THE COURT: -- overruled.

BY MS. WECKERLY:

Q It -- your -- my understanding is you can't overlap or bill for two patients at the same time?

A No, you cannot.

Q Was that the rule back in 2007?

A That's -- yes, that's always been the rule.

Q Okay. And you told us that you can't bill for

consultation files, what have you, be it in computer form or in paper form that the anesthesiologist or CRNA would have access to, you would want to know about that document?

A Yes, I would want to know, but why would it be separate from the -- like, those look like patient charts to me. Like those green folders, they look like patient chart. So why would everything not be in there? I mean, that's what I would be asking.

Q If you had -- if the CRNA had access to the other documents, because they were accessible would you want to see those documents before you judged whether the ASA codes were appropriate?

A Yes.

Q In your review you were given these -- did you actually get this -- this file to review, a green folder?

A There was approximately 130 electronic medical records that I reviewed, and there were 11 in green folders that I reviewed.

Q Did you -- do you know that you did not -- you did not receive the medical doctor's consultation form -- document where the doctor visited -- the patient visited with the doctor prior to getting the procedure done? Did you --

A Are you talking about the preanesthesia evaluation or the gastroenterologist's documentation?

Q Gastro.

A Those are my words, yes.

Q With -- or in bold, in capital?

A They could be either/or.

Q And --

A Or both --

Q -- sure --

A -- I guess.

Q -- is it the -- is it the case that providers, or the people doing the charting do not understand the set of rules that are -- the set of rules by CMS?

A There are many providers that do not understand all the guidelines, rules, and regulations; however, it is incumbent upon them to know them if you're going to be billing.

Q And going back to your comment that as far as you knew the CMS standards for the end time of anesthesia had not changed for many years, do you know whether there had been -- what was the term you called it, like, clarification definitional -- what did you call it before?

A Guidelines?

Q Yeah, guidelines. Let's call it guidelines because am I right to understand from your -- when you had chatted with me earlier on cross-exam that CMS oftentimes revises the guidelines to try to clarify terminology?

A Yes.

E X H I B I T S

quick ruling on the record about his bail because it's --

THE COURT: Yeah, I mean, I'll --

MR. SANTACROCE: -- the bail bondsman is driving me crazy.

THE COURT: -- I'll reduce it to 25,000 on this case.

MR. SANTACROCE: Okay. Can we put that on the record so I have something --

THE COURT: Yeah, Ms. Husted is doing it right now. She's putting it on the record.

MR. SANTACROCE: Awesome. Thank you.

THE CLERK: There's double.

THE COURT: And Ms. -- Ms. Olsen is recording.

THE CLERK: So it's reduced to 25,000?

THE COURT: Right.

THE CLERK: And it's -- so that's the third time it's been on the record at court.

MR. SANTACROCE: What is that?

THE CLERK: Nothing.

(Off-record colloquy.)

THE COURT: Is everybody ready? Would you tell Kenny to --

Oh, just while we're waiting for the jury, did you folks, Ms. Weckerly, have an opportunity to show this memo to Scott Mitchell yesterday?

MS. WECKERLY: Not yet.

know, public use to my colleagues.

Q And I -- you testified as an expert before in the area of neuropsychology and that sort of testing that's associated with it?

A Yes.

Q In your practice and in -- over the years of -- that you worked since your training have you had the occasion to examine, treat, or even test people who have contracted hepatitis C?

A Yes.

Q And from your overall practice of those -- treatment of those patients and testing of those patients have you seen any associations between hepatitis C and loss of brain function?

A Yes.

Q Can you explain to the members of the jury how it is that hepatitis C would affect the brain?

A Well, it's sort of a complicated process, but hepatitis C is neuro-virulent. It's a virus that affects the nervous system much like AIDS or HIV. And the research clearly shows that you don't have to be in the later stages of liver disease to have brain damage and brain dysfunction. So there's been quite a few studies that show that people were complaining of cognitive impairment even prior to the onset of any liver disease. And those studies clearly showed that

Q Okay.

A 1A, 2B, 3C. So that -- that is a frontal-lobe activity. Your -- you know, for flexibility. And she couldn't do it. We had to abort it after about 3, 4 minutes. The average person can do Trails Making A within 30 seconds, and the average person could do Trails Making B within 60 seconds and she did Trails Making A in 105 seconds, which is 3 times the average individual for her age, and B, we had to abort after 3 or 4 minutes. She just, you know, she --

Q She couldn't complete it?

A -- right.

Q Now, you said, I think, that her fine motor skills are intact and normal for a woman in -- who is 70?

A Yes.

Q And so there's nothing physically wrong with her in terms of, like, I guess a structural brain damage or a muscular problem or anything like that?

A No, let me rephrase that for you. There's the -- in terms of motor, okay, she's able to grip, she's able to do fine motor ability, but she has organic brain damage. I mean, there is something physically wrong with her and -- and she has organic brain damage, you know, she can't process her world quickly. She's incredibly slow. Both visual and auditory memory is severely impaired.

Q And when you say her memory is severely impaired

Q Okay. Thank you. And the --

A It's okay to email it to you? I'm happy to --

Q That's fine.

A -- email you the folder.

THE COURT: Doctor, there's a copy machine in the -- I'm kidding.

THE WITNESS: Oh.

BY MS. STANISH:

Q Get to work. The -- moving to -- as I understand your testimony you're saying that the dementia can be attributed to one of two issues. Either the hepatitis C itself or the drug treatment; is that correct?

A Or the combination.

Q Okay. And the -- as far as Ms. Grueskin's medical records, I understand that you said that she had no family history of Alzheimer's. Do you know if her parents -- how her parents died?

A I don't. I can't recall right offhand. I'd have to look at my notes.

Q Isn't it the case that many people who have genes for Alzheimer's die before Alzheimer's even manifests itself?

A Well, that could be true, yeah. But the -- the gene doesn't necessarily play out that you would get Alzheimer's, it's only a -- you know, it's only a, sort of,

got a notice from him. And he was interested in the, you know, the work that I had done on those people.

Q Okay. I saw that at the one -- the -- one of the two articles that you cited it was a article from some European medical journal, recall that? It dealt with the treatment of -- the drug treatment, and the effects on the -- the mental-health effects during drug treatment --

A Yes.

Q -- do you recall that --

A Sort of.

Q -- study? Pardon?

A I said sort of. There's quite a bit.

Q Well, here, I'll --

A Let me see if I --

Q -- just -- let me just show you --

A -- may have a hard copy.

Q -- your report. I got it right here.

MS. STANISH: If I may approach, Your Honor.

THE COURT: That's fine.

BY MS. STANISH:

Q Just to refresh your memory. It's -- that's your report, okay?

A Oh.

Q I just want it to go to the part where you cite the two tests.

Q Okay. Why -- can I ask you why aren't -- why didn't you cite any of these 11 or numerous studies in your report? Because you only cite this one that you have there on your iPad and -- from 2005 and then one additional one that looks like it's dated in 2009, but I don't know what the publication is?

A I don't know. I -- you know, I've done 19 reports plus a master grid and you just can't, you know, cite everything.

Q Okay.

A You know, I was trying to deal with the issue at hand. This study was important because it said that there were -- I'm not supposed to read from it -- it said that there were, you know, disturbances in the prefrontal cortex and the hippocampus.

Q That -- I don't -- all I really asked was why you didn't cite it, and I understood your answer to be that you -- you did -- wrote a bunch of other reports and you didn't think it was necessary; something to that effect?

A Well, not that it wasn't necessary. You just have a certain amount of time available, you know, and so --

Q Correct. And you were doing these -- Ms. Grueskin was -- and a plaintiff's attorney hired you to represent her in a lawsuit; is that correct?

A Yes.

Bethel, Alaska --

Q Okay.

A -- but I didn't --

Q But when you worked for the county attorney's office in Salt Lake City, what did you do?

A Oh, there we were designing an alternative-treatment program to incarceration. So the idea was, you know, if we could test these people -- I tested them, and -- and if there were some other factors involved and they were candidates for rehabilitation maybe that was a viable alternative to then imprisoning them and that's what I did.

Q Okay. So you didn't work for the prosecution and the county attorney's office in Salt Lake City?

A It was -- yeah, it was the -- it was the county attorney's office of Salt Lake City. And then the county attorney's office of Santa Clara hired me once as a consultant for a case.

Q In this particular outbreak in Clark County Nevada, you were retained on Carole Grueskin, Patty Aspinwall; is that fair?

A No, Patty who?

Q Okay. Well, then you have Stacy Hutchinson?

A Yes.

Q Rodolfo Meana?

A Yes.

went to high school. They're able to know the year. They're able to know -- it was 4:00 in the afternoon and I asked her to draw a clock and she wasn't able to do it and she put, you know, 10 minutes to 10.

People that have brain fog don't wander around the neighborhood, you know, confused and disoriented. And in addition to that, you know from my report that after this treatment, including the report of the treatment that the medical records reported dementia. There were several entries in her medical records where it said, dementia, dementia, dementia, dementia. It wasn't just me, you know. Before she even saw me all the practitioners reported that she was demented.

Q Are you familiar with the University of Alberta Canada's study of 2000 -- October 7, 2010?

A I'm sure that --

Q I mean, there's a lot of studies --

A -- I'm sure there's hundreds of --

Q -- I'm not -- I'm not trying --

A -- studies.

Q -- to put you on the spot, I'm just trying to understand this, you know.

A Does it have a title?

Q The lady might have dementia. I'm just trying to understand it, I don't know, so in my research of this

Q Four percent of the population?

A And?

Q I'm asking you, as a person that studies this, can you tell me how many people in the United States are walking around with hepatitis C?

A I don't know.

Q You told me you studied 19 people, and from 19 people you're telling me that's a scientific study or sampling?

A Well, it's not a -- it's not a random sampling. It's a sampling of people from this community, you know. It's not a -- it's not a -- I didn't go out and sample, you know, the American population who have hep C, you know. It was a random -- it was a sample from this community of 19 individuals that I happened to test. And there was a remarkable consistency amongst these genetic strangers in terms of their brain dysfunction.

Q So I'm supposed to accept that as scientific data that you studied 19 people, and the jury is supposed to accept that as scientific data that you studied 19 people?

A Well, you don't have to accept anything. I'm not asking you to accept anything. The point of the matter is is that Carole Grueskin is demented, okay? And out of this context, if I told you that she was demented, you wouldn't challenge it. She's demented. And all the medical people

permanent dementia?

A No, I didn't say she had dementia. I just --

Q Oh, okay.

A -- I didn't say dementia. Let's see what the diagnosis -- what I wrote in the diagnosis here. She had moderate brain dysfunction. Well, she had frontal, temporal, and occipital dementia also, but not to the same degree as Ms. Grueskin.

Q And does that mean --

A And she had post traumatic stress disorder.

Q Your eyes are better than mine.

A Here, I can make it bigger --

Q Yeah, do that.

A -- for you.

Q Yeah, that's good. And --

A I don't know if I can --

Q -- oh, no, that's okay. I got it. That -- this frontal, temporal occipital --

A Occipital.

Q Yeah, that's what I said. Dementia?

A Yes.

Q Is that permanent?

A It's permanent. Well, she was permanently disabled at the time that I saw her. Is it permanent? Let's see. You know, the brain has plasticity. It can improve over

In Ms. Grueskin's case it seemed to be almost at the time that she took the treatment -- the Interferon treatment, that's what the medical records say, it was at the time that she took the treatment. In fact, she had to stop the treatment because it was noted as one of its side effects, you know, in the medical records that she became demented as a result of that treatment.

There is a bit of overlap. Individuals, for example, with traumatic brain injury will have -- they could become demented too in quote, like the NFL players could have early dementia. But the pattern of results, brain function results are different. The genetic variety affects all functions, including reading ability, vocabulary and comprehension. You know, your language stuff, left hemisphere stuff.

Some of the other types of dementia will only, you know, pick and choose so to speak, but not affect all functions.

THE COURT: Okay. And a juror wants to know: Does the type of dementia you're talking about affect just the frontal lobe or the whole brain function?

THE WITNESS: Well, in -- you mean specifically Ms. Grueskin or --

THE COURT: Well, talk about Ms. Grueskin and then also hepatitis C related dementia, the -- what part of the

THE COURT: All right. Thank you. Does the State -- Ms. Weckerly, do you have any follow-up to anything?

MS. WECKERLY: No.

THE COURT: The last juror questions or where Ms. Stanish left off?

MS. WECKERLY: No, thank you.

THE COURT: All right. Ms. Stanish, do you have any follow-up to those last juror questions?

MS. STANISH: No, Your Honor. Thank you.

THE COURT: Mr. Santacroce.

MR. SANTACROCE: No.

THE COURT: Any additional juror questions before we excuse the witness? All right. I see no further juror questions. Thank you for your testimony. You are excused at this time.

THE WITNESS: Thank you.

THE COURT: And the State may call it's next witness. Everybody okay? Or does anybody need a break? No?

MS. WECKERLY: Your Honor, it's Ms. Syler, and I -- she's on cross, but I'll get her.

THE COURT: Okay.

MS. WECKERLY: Just -- just so --

THE COURT: All right.

MS. WECKERLY: -- where we're at.

THE COURT: And, ladies and gentlemen, we're now

Q Okay. I was wondering about that. So thanks for answering that without me asking. But the -- what I -- what I was trying to get at was whether you reviewed the CMS -- the CPT codes that relate to anesthesia?

A I -- for my personal review I did, but I did not review any codes associated with those records that I reviewed.

Q I guess what I'm trying to understand -- I want to -- you discussed yesterday how anesthesia billing works, and I'm going to discuss that with you in a moment. I just want to understand what your foundation was for that testimony, what you studied in order to testify about the base units, the timing, et cetera.

A Basically, it's my experience and a quick review on research, just to ensure that my knowledge base was still as it should be.

Q Fresh?

A Fresh.

Q And did you specifically look at the CMS requirements, the CPT codes that were in place in the year 2007?

A I attempted to -- to locate those codes because I no longer have my book from 2007. So I researched trying to find 2007 anesthesia codes. I could easily locate the 2007 codes for the actual GI procedure, such as the endoscopy or

A They use the Medicare fee schedule as a guideline. Sometimes the fee will be the same, sometimes it's different, but they do utilize the Medicare fee schedule as a guide.

Q All right. And as I understand it the -- you had mentioned yesterday that part of this equation is contract negotiations, correct?

A Yes.

Q And so to the extent that you have a provider who might be a -- a large, private group there's going to be negotiations between the medical group and the insurance company to define how the procedure should be reimbursed?

A They have contract negotiations, but as to what all that entail,s, I've never actually been involved in contract negotiations so I couldn't say what it entails but there are contract negotiations. Usually they're done annually.

Q And is that -- when they are negotiating, does that necessarily -- it can affect the rate of reimbursement?

A It's possible. You know, like I said --

Q You're not sure --

A -- I've never been involved --

Q -- okay.

A -- in contract negotiations, so...

Q All right. So pleasant to have a witness from

IN THE SUPREME COURT OF THE STATE OF NEVADA

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LAS VEGAS SANDS, CORP., a Nevada corporation, and SANDS CHINA LTD., a Cayman Islands corporation, Petitioners, vs. CLARK COUNTY DISTRICT COURT, THE HONORABLE ELIZABETH GONZALEZ, DISTRICT JUDGE, DEPARTMENT 11, Respondents, and STEVEN C. JACOBS, Real Party in Interest.	Supreme Court Case No. 62489 REAL PARTY IN INTEREST'S SUPPLEMENTAL APPENDIX VOLUME 5 OF 5

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ALPHABETICAL INDEX

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of Pisanelli Bice, and that on this 19th day of March, 2013, I electronically filed and served a true and correct copy of the above and foregoing REAL PARTY IN INTEREST'S SUPPLEMENTAL APPENDIX VOLUME 5 OF 5 properly addressed to the following:

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/s/ Kimberly Peets
An employee of Pisanelli Bice, PLLC

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