UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

UNITED STATES OF AMERICA,

Plaintiff,

vs.

D-1 DR. RAJENDRA BOTHRA
D-3 DR. GANIU EDU
D-4 DR. DAVID LEWIS
D-5 DR. CHRISTOPHER RUSSO,

Defendants.
_____/

Case No. 18-20800
Hon. Stephen J. Murphy, III

JURY TRIAL EXCERPT: VOLUME 6

BEFORE THE HONORABLE STEPHEN J. MURPHY, III
United States District Judge
Theodore Levin United States Courthouse
231 West Lafayette Boulevard
Detroit, Michigan 48226
Tuesday, May 24, 2022

APPEARANCES:

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(Appearances continued next page)

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BY MR. CHAPMAN:
Q. Good morning, Dr. Mehta. My name is Ron Chapman. I represent Dr. Lewis. I'm going to ask you some questions.
A. Good morning.
Q. First, you've never met Dr. Lewis before?
A. I have not.
Q. Before this case you had no idea who he was?
A. That's correct.
Q. Okay. But you did author a report in this case as we've discussed thoroughly?
A. Correct.
Q. And that report --
THE COURT REPORTER: Mr. Chapman?
MR. CHAPMAN: Sure.
BY MR. CHAPMAN:
Q. And that report was finalized on October 31st, 2020?
A. Correct.
Q. Approximately how long did it take you to draft that report?
A. Off the top of my head, I don't remember the hours, but it was a significant amount of time.
Q. Did you personally draft it?
A. Yes.
Q. Every word?
A. I tried to as much of it as -- in terms of the exact

language. I asked for help with the government to understand if I was writing something appropriate for the specific counts, but for the language of the medical portion, that is my -- my authorship.

Q. Okay. I -- I don't understand the answer. I'm going to reask the question. Did you draft every word?

A. I did, yes.

Q. You personally drafted every word?

A. I typed every word.

Q. Okay. But there are times where you sent this report to the government?

A. Correct.

Q. And they added portions?

A. No.

Q. They made suggestions about what should be modified?

A. They made suggestions, yes, at -- at -- at top -- at particular points, correct.

Q. Approximately how many times did that occur?

A. Probably five times or so.

Q. And it's your testimony that those modifications were only related to legal portions of the report?

A. Correct.

Q. Did one of those portions that was modified by the government relate to the standard that you use to analyze these cases?

A. No.
Q. Well, I'm curious about that because it appears that the standard that you used in this case was a carbon copy of the exact language the government always uses in these reports. Did you base this standard portion of your report on other government reports?
A. It's -- it's language that, yes, to help understand how to write out the standard, but it's a medical standard that I believe to abide myself by and by other physicians.
Q. Let's try that again. The portion in your report where you discuss the standard that you apply to this case, did every word come from your mind?
A. No, not -- not every word.
Q. Where did you get those words?
A. From previous reports, yes.
Q. Previous government reports?
A. Correct.
Q. Reports that were issued against other physicians?
A. Correct.
Q. Okay. So the standard that you applied was not a standard that you created or that you know as a medical professional?
A. I did use that. The language to help articulate that is what I looked for reference.
Q. Again, it's important to listen to the question. The standard that you used was not a standard that came from your

mind but was one that came from the mind of the government?
A. I'm going to disagree with that.
Q. Okay. So you knew what the standard was before you wrote this report, each and every word, but you also reviewed government reports and that seemed to magically match your -- your thinking about the standard in this case?
A. The terminology and the way to articulate something can be written in -- in a few different ways, as you probably would recall, so -- or know, so yes, the language would match what a previous report had said.
Q. Okay. So every word of the standard in your report matches a prior government report but those are actually your words, is that your testimony?
A. It was written from another document, yes.
Q. Okay. It was copied from another document?
A. Correct.
Q. Thank you.
Doctor, how much did this report cost the government?
A. It's a significant amount of time. So I apologize, I don't have my exact billings, but I think that it's to the tune of -- all the work provided could be about 25,000 if I -- if I tried to recall.
Q. How many hours did you spend reviewing this case?
A. A large number of hours.
Q. Your rate is 500 an hour?

A. Correct.
Q. Okay. And you charged 25,000?
A. For all the effort that has been put into this case.
Q. Is that up to date, 25,000?
A. Not for the time spent in these past couple of days.
Q. Okay. So it's an additional cost for appearing at trial?
A. Correct.
Q. Hoping one of my esteemed colleagues can tell me how many hours in total.

So you would estimate that you spent about 50 hours in total, right?
A. On the case.
Q. Up -- up to -- up to now?
A. Yes.
Q. And during those 50 hours it's your testimony that you reviewed six charts in detail, right?
A. Correct.
Q. And you reviewed a hundred charts with less detail?
A. Correct.
Q. Okay. And of those six charts that you reviewed in detail, you've already identified a number of mistakes that you made in your report, right?
A. Correct.
Q. There were seven or eight mistakes regarding the use of caudal versus cervical?

A. Correct.
Q. There was a mistake where you -- you mentioned back instead of neck for one of Dr. Edu's patients, right?
A. Correct.
Q. There's a -- there was a mistake where you -- you indicated that there was no conversation about patient Jack Lacey's urine drug screen when, in fact, there was a conversation, there was a pill count, there was an indication of discharge, and then there was a weaning dose of medication prescribed, right?
A. I'll disagree with the latter portion of that statement, but there was a conversation.
Q. Okay. That was a mistake.
A. The -- the conversation and the action did not match.
Q. It was a mistake to say there was no conversation when, in fact, there was a conversation?
A. Correct.
Q. It was a mistake to say there was no action when, in fact, there was an action?
A. I'll disagree with that.
Q. Okay. It was also a mistake where you appeared to copy and paste entries of your report related to one patient in two portions of your report related to another patient, right?
A. You're referring to a specific area?
Q. The part that Mr. Harrison just walked through with you

where you copied and pasted and you admitted to doing so.
A. On the count, yes.
Q. Yeah. Okay. You've got about 13, 14 mistakes?
A. Correct.
Q. Okay. And those are mistakes that have impacted these physicians that are sitting right here, right?
A. Correct.
Q. How do you feel about charging the government $25,000 for a document that at least contains 14 mistakes?
A. I feel terrible.
MS. McMILLION: Your Honor?
THE COURT: I -- I think that's sustained.
Go ahead, Mr. Chapman.
MR. CHAPMAN: Thank you, Your Honor.
BY MR. CHAPMAN:
Q. Are there any other corrections that you would like to make to your report before we proceed?
A. In similar nature, I -- I think we've talked about there are similar type mistakes of caudal versus cervical in other patients.
Q. And that's the only additional mistake that you'd like to point out to the jury today?
A. Also on the Andrew Peterson portion, there was visits with other providers prior to the one I documented on, Dr. Lewis.
Q. I really appreciate you telling me about that because

we're going to have to have a conversation about that.

Any -- any other mistakes you'd like to point out?

A. As far as I know, that's it.

Q. When did you first realize these mistakes were made?

A. As I began to prepare for this case in this last, you know, week or so.

Q. And specifically what day?

A. Probably last Wednesday or so.

Q. Did you notify the government of those mistakes?

A. Not on Wednesday.

Q. When did you notify the government of those mistakes?

A. On Sunday.

Q. Did you modify your report on Sunday?

A. I did not modify it in my notes that I took about the mistakes.

Q. Did you feel the need to mention those mistakes in your direct testimony in front of this jury?

A. Whenever being asked about it, I did -- I did disclose it.

Q. You disclosed mistakes during your direct exam testimony?

A. During the direct exam testimony, no, I did not.

Q. You didn't notify any of the defense counsel that they were in possession of a 31-page report that cost $25,000 that appears to be riddled with mistakes?

A. I did not acknowledge the mistakes to anyone there.

Q. Okay. We'll get to Andrew Peterson soon, but I want to go

back to discussing the standard that is applied in these types of cases. First, let's just frame this. You're aware that Dr. Lewis is only charged with conduct related to two patients, correct?

MS. McMILLION: Objection, Your Honor. Misstates the charges against Dr. Lewis.

MR. CHAPMAN: I should restate that, Your Honor.

THE COURT: Okay. Restate. Go ahead.

BY MR. CHAPMAN:

Q. You're -- you're aware that Dr. Lewis is only charged with -- with substantive counts, healthcare fraud and drug trafficking, related to conduct to two patients, right?

A. Two patients, yes.

Q. There's a conspiracy count for both healthcare fraud and drug trafficking, but the only substantive counts relate to two patients?

A. Correct.

Q. Thank you. And there's a standard that you use to evaluate each one of those charges, healthcare fraud and drug trafficking, right?

A. Correct.

Q. Let's talk about the drug trafficking standard first, and feel free to reference your report. I believe the portion we're going to look at is on page 2. But, well, let me just preface this by asking, you don't believe that minor

noncompliance with guidelines would be considered a criminal violation of the drug trafficking statute, right?
A. I would say that's an open-ended answer or question so I -- I -- I don't know how to answer that.
Q. My -- my question is about your belief. You don't believe that minor noncompliance with guidelines triggers your standard and creates criminal conduct?
A. Minor in -- like in terms of -- perhaps you can define what minor is.
Q. We can go into some specifics. With respect to the drug trafficking standard here, you state the following: "References in this report to activity or conduct being outside the course of professional medical practice or outside the standard of care is activity or conduct that does not comport with any accepted standard of medical care in the United States." Is that what you say in your report?
A. Correct.
Q. Now, you -- you've testified in cases before, right?
A. Correct.
Q. You testified four times?
A. Yes.
Q. And all four were civil cases?
A. Yes.
Q. And in civil cases, the standard that is used to judge a doctor's conduct is the standard of care, correct?

A. Correct.
Q. And the standard of care is what any reasonable physician would do?
A. Correct.
Q. If a physician violates the standard of care, they may have to pay the patient some damages for their treatment?
A. Correct.
Q. All right. Simply deviating from the standard of care is not alone something that triggers the standard that you've created here, right?
A. Simply deviating from the standard of care, correct.
Q. Yes. So -- so if a physician departs from the standard of care, you wouldn't automatically opine that they have prescribed outside the course of professional practice?
A. Depends on what the deviation is.
Q. Okay.
A. So that's -- that's what we're -- I think the case is is looking at this pattern.
Q. So it's looking at how severe the deviation from the standard of care is?
A. Severe, frequency, so forth, yes.
Q. So you believe that if a physician -- if a physician deviates from the standard of care enough, that conduct would be enough to trigger criminal responsibility?
A. I'm looking at the utilization of the -- what the clinical

treatment is, right. So there is a standard. And I'm also looking at the responsibility of particular -- if we're talking about opioids, then the responsibility and legal liabilities of using opioids.

Q. I think it's important to listen to the question. It's your testimony that if a physician violates the standard of care enough, they have triggered your criminal standard?

A. No, I would disagree with that.

Q. You disagree with that. So much more is required to become a criminal as a physician than just deviating from the standard of medical care?

A. We're looking at medical necessity for these, right, so we're looking at this -- that's what I'm trying to explain.

Q. Do you state the words medical necessity anywhere in the standard that you've put in your report?

A. No, not there.

Q. Okay. But now on the stand you say we're looking for medical necessity?

A. It's -- it's part of what I'm trying to look at in this overall case.

Q. But you don't state it in your report?

A. No.

Q. Okay. In fact, what you state in your report is conduct that is outside the course of professional practice, the criminal standard here, or outside the standard of care is

activity that doesn't comport with any accepted standard of care. What you're essentially saying, Doctor, is that if a physician deviates from the standard of care, they trigger your criminal standard and can face liability. Isn't that what you say in your report?

A. It's what I've articulated there. I'm trying to say that it's beyond -- we're -- we're not talking about a malpractice type standard.

Q. Okay. But you state and give a malpractice standard in your report, don't you? You've said in your report that "if a reasonable physician wouldn't engage in this conduct, I'm considering it criminal in nature." Isn't that what you've said?

A. Yes.

Q. Yeah. So this --

MS. McMILLION: Objection, Your Honor. That misstates the report.

THE COURT: Well --

MR. CHAPMAN: He -- he said it doesn't, Your Honor.

THE COURT: Yes. That's a redirect question. Go ahead.

BY MR. CHAPMAN:

Q. So the 31 pages that we have here, as far as they relate to drug trafficking, are 31 pages of your view of violations of a civil standard?

A. No, that's -- I apologize. You know, I -- I'm trying to process what you're trying to say to me and it's coming quickly. I'll take time to -- to respond to you, but no, that is not the case.
Q. Okay. You apply some other standard that requires a more serious deviation, right?
A. Correct.
Q. And where do you apply that standard in your report, where do you state that?
A. In here, in the standards portion here.
Q. You go on to state, "If the activity or conduct at issue involves issuance of a prescription outside the course of professional medical practice or outside the standard of care, it means that the prescription was issued without any legitimate medical reason or would not have been issued by a doctor acting in accordance with standards of practice generally accepted in the United States." That's what you state in your report?
A. Can you refer to where you're reading from?
Q. Same page 2, the standards portion. I just continued on from where we read before.
A. Okay.
Q. Do you need me to read it again?
A. It's what I stated, yes.
Q. Okay. So you say if conduct by a doctor is different than

what is generally accepted in the United States, they trigger your criminal standard.

A. That's not what I've stated there but...

Q. You say, "If a prescription is issued outside the course of professional practice or outside the standard of care, it was issued without a legitimate medical reason or would not have been issued by a doctor acting in accordance with the standards of practice generally accepted in the United States."

A. Yes, that's what I've said.

Q. You're saying that if a doctor doesn't prescribe in accordance with what is generally accepted in the United States, they become criminals?

A. That's -- that is true.

Q. That's what you put in your report. That's identical to the civil malpractice standard you used in your four cases, right?

A. No, that's not fair.

Q. You're free to disagree, sir. Thank you.

Now, in order to create your generally accepted in the United States standard, you use a couple of documents and your own experience, is that right?

A. Correct.

Q. Okay. So basically what you're saying is when we look at the ASIPP guidelines, the CDC guidelines and also your experience as a physician, that creates a standard of generally

accepted conduct?
A. Correct.
Q. All right. And if these physicians deviated from that generally accepted conduct, then you think that's a departure from your standard and they should be liable?
A. That's how I use it for review.
Q. That's how you looked at the case?
A. Yes.
Q. Okay. So let's go to the only substantive count --
THE COURT: Are you finished with the standards now?
MR. CHAPMAN: I am, Your Honor, yes.
THE COURT: I think that'd be a good -- good time to break for lunch. So it's 11:28. Let's take 30 minutes and try to point toward a noon return. Don't talk about the case among yourselves, ladies and gentlemen. If you want to take a little stroll or get some fresh air or some food, now's the time. I know many of you brought your lunches. Have a good lunch break and we'll see you back here in about 30 minutes.
Let's all rise for our jurors.
(Jury excused at 11:29 a.m.)
THE COURT: And we'll take our midday recess.
THE LAW CLERK: Court is now in recess.
(Court in recess at 11:29 a.m.)
(Proceedings resumed at 12:12 p.m., all parties present)

THE LAW CLERK: All rise for the jury. The Court is back in session.

(Jury entered the courtroom at 12:23 p.m.)

THE COURT: Okay. All jurors back, everyone's in their spots, all may be seated.

And we'll continue to press on. Mr. Chapman is at the mic and ready to go. Yes, sir.

MR. CHAPMAN: Thank you, Your Honor.

BY MR. CHAPMAN:

Q. Dr. Mehta, I'd like to now turn your attention to the section of the report dealing with patient Andrew Peterson. Just by way of reference, and I don't want you to read from it right now, but feel free to flip to page 31. That's where you talk about Andrew Peterson.

Dr. Mehta, you're aware that Dr. Lewis is charged with unlawfully prescribing hydrocodone to Andrew Peterson, right?

A. Correct.

Q. And you're aware that that prescription was issued on June 28th, 2018?

A. I believe so, yes.

Q. Okay. It's the first sentence in your report?

A. Yes, but you asked me not to read it so I --

Q. I know.

A. Yeah.

Q. Okay. And you believe that that prescription was issued outside the course of professional practice?
A. Correct.
Q. All right. Now, during your direct exam there were three reasons you indicated that the prescription was outside the course of professional practice and I want to go through those. First, that you believed that the patient complained of only minor pain during that visit, right?
A. Correct.
Q. Second, you believed that conservative treatments were not attempted?
A. Or offered.
THE COURT REPORTER: I'm sorry, did you say were offered or or offered?
THE WITNESS: Or offered.
Q. So conservative treatments were not attempted or offered?
A. Correct.
Q. All right. And then you also believed that his urine drug screen was negative?
A. Correct.
Q. Okay. Addition -- in addition, there was some mention of this patient asking for Soma and you thought that was concerning?
A. Correct.
Q. All right. Now, we talked a bit about the standard, and

the way that you evaluated that prescription was by utilizing your experience as a physician, the ASIPP guidelines and the CDC guidelines, correct?
A. Correct.
Q. Okay. Can you please -- well, let's go back and talk about those guidelines. Two of the documents you mentioned, the CDC guidelines and the ASIPP guidelines, specifically indicate that they do not create a standard of care, correct?
A. Correct.
Q. And before finding fault with a physician's conduct, as you indicated in the standard section of your report, you want to ensure that that physician is deviating from at least a standard of care?
A. Correct.
Q. Because if their conduct is above the standard of care, we shouldn't even be here, right?
A. Correct.
Q. And specifically, you've talked about the ASIPP guidelines in your report, and it's your belief that Dr. Lewis deviated from the ASIPP guidelines when issuing that prescription?
A. Well, not in -- in whole in that it was part of what I looked at in terms of the whole practice and Dr. Lewis's practice.
Q. We're going to need to be a lot more specific than that, Doctor. Do you believe that Dr. Lewis deviated from the ASIPP

guidelines in issuing that prescription to Andrew Peterson?
A. Yes.
Q. Okay. And you believe that because of that, that was a violation of the standard of care?
A. Not just solely because of that, but it was in part of the entire opinion that I make.
Q. Okay. Like to read a portion of the ASIPP guidelines and see if you agree with me that the guidelines state that. "These guidelines are developed for use by physicians practicing interventional pain management and do not constitute inflexible treatment recommendations." Do you agree with that statement?
A. Yes.
Q. Did you apply the ASIPP guidelines as inflexible treatment recommendations?
A. As inflexible? Yes.
Q. Okay. You applied them as inflexible recommendations?
A. I'm sorry. Trying to -- I'll go slower for your questions. They are -- they are part of what I looked to review but I didn't solely apply those.
Q. Okay. Can you please tell me where in the ASIPP guidelines, and I'm happy to provide a copy for you if you need, it states that if a patient has a negative urine drug screen, they should be immediately refused a prescription for pain medication?

A. It doesn't say that specifically.
Q. Okay. So in prescribing medication to Andrew Peterson in absence of a positive urine drug screen, Dr. Lewis didn't violate the ASIPP guidelines?
A. It is part of the overall medical decision making that you make. So in the absence of -- of the opioid present in a urine drug screen, the guidelines will go to say one should consider the appropriateness of continued opioid therapy.
Q. Is it your belief that in absence of specific deviations from guidelines, you can simply just say the spirit of the prescription violated the guidelines, is that what your testimony is?
A. The spirit? Maybe you can...
Q. Maybe I can rephrase. Do you have any specific deviations of the guidelines that you can point to for the prescription to Andrew Peterson?
A. It's -- there are -- I'll have to refer to perhaps the notes that you have or the actual guidelines, but there are overall impressions of how to evaluate and treat these patients with opioids. So it is not a specific line by line as the way you're describing, but it's the overall decision making on the appropriateness of the opioid and interpretation of results.
Q. So you'd agree with me that you can't point a specific deviation of the ASIPP guidelines?
A. It's not a specific line, that's what I will say.

Q. Thank you.

Are you able to point to any specific deviation of the ASIPP guidelines where a prescription was provided to a patient who presented with three out of ten pain radiating down to the legs?

A. It is not specific to the number.

Q. Okay. So no specifics.

Let's talk about the CDC guidelines. Are you able to point to a specific portion of the CDC guidelines that says when a patient tests negative for a prescribed controlled substance, they should immediately be refused medication?

A. Again, it would be what I offered before, which is that it's not a specific line like that.

Q. Do you believe personally that a patient should be refused medication when they test negative?

A. It's definitely a red flag that I should be further thinking about the appropriateness of ongoing opioid therapy.

Q. That wasn't my question. We can talk about red flags later. Do you believe that a patient should be refused medication automatically because they tested negative for a prescribed controlled substance?

A. No.

Q. In fact, what all the guidance says is that when a patient tests negative, and you mentioned this on direct, there should be a conversation between the physician and the patient?

A. Correct.
Q. And you're aware that there was a conversation between Dr. Lewis and Andrew Peterson?
A. Correct.
Q. You saw the video?
A. Correct.
Q. And during that conversation Dr. Lewis said, "You were negative for the hydrocodone we prescribed to you."
A. Correct.
Q. That's the type of statement that a physician would make when they've reviewed a urine drug screen or test and want to inquire as to why it was negative?
A. Correct.
Q. So you can tell by that question that Dr. Lewis looked at the urine drug test?
A. Correct.
Q. Now, Andrew Peterson, and we don't need to replay the videos unless your memory needs to be refreshed, responded with the fact that he couldn't get in for his appointment on time and it took a while to reschedule, correct?
A. Correct.
Q. And, in fact, it would have been a red flag in your mind if Andrew Peterson tested positive for the medication as opposed to negative, right?
A. It would be -- if he had tested positive and he had had a

long period of time, yes, that would also be a red flag.
Q. Because where did he get the additional medication?
A. It's something that's not a definitive answer, but perhaps he -- it's not -- let me stop by saying that. If he had taken the medication closer to the time of the test and not taken it earlier, then yes, that may have also led to that result.
Q. So red flag if he tests positive and a red flag if he tests negative?
A. To be able to interpret in the context, yes.
Q. Okay. Andrew Peterson's response to the negative urine drug test was a reasonable response given by a patient who wasn't able come in within the month, right?
A. Correct.
Q. Patients have said that to you before, right?
A. Correct.
Q. And they've tested negative before, right?
A. Correct.
Q. And you didn't cut them off of their medication before, right?
A. Correct.
Q. Is it your testimony that Dr. Lewis's conduct, which appears to be identical to your conduct, is concerning?
A. Again, it's the overall concern of the practice, not -- not just this one individual circumstance.
Q. Okay. Now we see. It's your overall concern with the

practice, not specifically with the conduct of Dr. Lewis as it relates to Andrew Peterson, that's your issue, right?
A. On that particular episode, correct.
Q. Okay. You mentioned as part of your critique of Dr. Lewis that conservative treatments weren't offered or attempted, correct?
A. Correct.
Q. I want to talk about your review in this case. When you first entered into a contract with the government to provide a review, you would have agreed to use the best of your medical abilities and knowledge to review this case, right?
A. Correct.
Q. And in order to provide an opinion about a physician and their conduct, you would have wanted to look at everything that the physician would have known about in order to analyze whether the prescription was legitimate?
A. Correct.
Q. You would have wanted to look at patient files?
A. I would like to look at as much as available, that's correct.
Q. Patient files?
A. Correct.
Q. Videos?
A. Videos of?
Q. Undercover visits.

A. Oh, yes.
Q. Okay. If -- if they were available?
A. Correct.
Q. And you did look at patient files and videos in this case?
A. Correct.
Q. And you scrutinized those patient files and videos to see if Dr. Lewis did the things that are required by your standard?
A. Correct.
Q. You looked at all the videos?
A. All the videos that were offered to me.
Q. All the videos related to Andrew Peterson?
A. Correct.
Q. That were offered to you?
A. (Nods in the affirmative.)
Q. But there were some videos that weren't offered to you, isn't that right?
A. I'm not sure.
Q. There are some videos of Andrew Peterson during his initial visits to the clinic that the government didn't supply you with?
A. I don't know the answer to that.
Q. You don't know the answer to that. Okay.

Let's go to page 31 in your report. You say, "Dr. Lewis saw the patient for initial visit on 6-28-18." Do you say that in your report?

A. I do.
Q. You believed that at the time you authored this report, I suppose you believed up until the time you realized the mistakes in your report on Sunday, that Dr. Lewis was the first person at TPC to see Andrew Peterson?
A. That's correct.
Q. You've later learned that that's incorrect?
A. Correct.
Q. Which means you've learned that there are videos and medical records that you didn't review?
A. That I was able to review later, yeah.
Q. Okay. When did you review these additional videos and medical records?
A. These were -- I reviewed them again on Sunday.
Q. Just on Sunday?
A. Mm-hmm.
Q. So up until Sunday you believe Dr. Lewis was the first person to see Andrew Peterson. On Sunday you realize he wasn't the first person?
A. To my knowledge, as far as I can recall.
Q. Did you modify your report after realizing the mistake on Sunday?
A. I did not.
Q. Did you look through those videos to see if maybe some of the things you think Dr. Lewis didn't do were done by other

people?
A. They were -- I did look at that, yes.
Q. Okay. And you found that there were additional things in terms of treatment for Andrew Peterson that were done on prior visits, right?
A. That were offered, yes.
Q. Yeah. Now, it is reasonable for a physician to rely on the statements made by other providers in the course of treatment of a patient?
A. Correct.
Q. In fact, you -- are you an attending physician?
A. Yes.
Q. You as an attending physician rely on the statements made by your residents as to what they've done with the patient?
A. Correct.
Q. Now, you sometimes want to verify, right, because they're residents?
A. Right.
Q. But you can rely on it, right?
A. Right.
Q. Because residents are doctors?
A. Correct.
Q. Dr. Lewis is permitted to rely on the statements and treatments done by physician assistants, right?
A. Correct.

Q. He's allowed to rely on the statements made by medical assistants?
A. Correct.
Q. He's able to rely on the statements made by a radiologist in a report?
A. Correct.
Q. He doesn't need to independently verify the accuracy of that information, right?
A. He's allowed to rely on it. He's also in a supervisory role for some of the people that you've stated in there. And then we also believe that when possible, you can also review radiology images in addition to looking at the report. But, yes, I understand what you're saying.
Q. Certainly. That makes a lot of sense.

Now, the critique that you offered with respect to Dr. Lewis's treatment of Andrew Peterson is that a minimal examination was performed and a medical decision making involved a plan for the controlled substance Norco. Did you say that in your report?
A. Yes, I did.
Q. So minimal exam and Norco was one of the medications prescribed.

You also state that he was prescribed Zanaflex and recommended for a shoulder injection despite still needing to try conservative measures.

Now, my question for you, Dr. Mehta, is did you look into the videos that you didn't see until Sunday to determine if other conservative treatments were looked at or attempted and whether or not there was a more thorough physical examination done of Andrew Peterson?

A. So the answer is yes to your question.

Q. And you actually found that on his initial visit, January 4th, 2018, Tatyana Bezpalko conducted a physical examination of Andrew Peterson?

A. On a separate encounter, yes.

Q. Yes. And it's reasonable for Dr. Lewis to see the results of that physical examination and to incorporate that into his medical decision making?

A. From a prior visit, is that what you're referring to?

Q. Yes.

A. It -- he -- he can -- he can review that then, but there is his own physical examination, medical decision making to be made --

Q. Can you point --

A. -- on this -- on this particular visit.

Q. Can you point to part of the ASIPP guidelines that says a physical examination must be performed at every visit?

A. It doesn't say that specifically.

Q. Can you point to the portion of the CDC guidelines that says a physical examination must be done every visit?

A. Doesn't say that specifically.
Q. In fact, the topic of discussion between Dr. Lewis and Andrew Peterson was an MRI, correct?
A. An MRI, yes.
Q. Yes. And an MRI of a shoulder will tell you a lot more than a physical examination will, isn't that right?
A. I disagree with that.
Q. You disagree. But it will tell you exactly what is going on in that shoulder joint, correct?
A. It is just another tool for your decision making. It gives you insight into what may be explaining what's happening.
Q. So Dr. Lewis has a prior physical examination from another provider and an MRI in his hand that determines the patient has shoulder problems and a subjective complaint of pain, and it's your belief that it was still inappropriate for a pain medication?
A. I'd like to further answer that by saying you're -- you're referring to an examination performed on a separate visit, not at the time of the visit that Dr. Lewis was conducting.
Q. And you don't have any guidelines to suggest that a separate physical examination must be performed at every single visit?
A. When you're starting to go beyond just --
Q. The question is specifically about guidelines, not about your opinions or your beliefs or what concerns Dr. Mehta. The

question is about where in the guidelines does it say you must do a physical examination for every single visit?
A. When doing a decision on opioid, you would want to have a more thorough examination.
Q. That's -- that's nonresponsive to my question. I'm asking you where in the guidelines that you've cited -- sir, you could have cited any guidelines you wanted to in your report to support your belief and you cited two guidelines. Where in your guidelines does it say you must do a physical examination every single visit?
A. It does not say that.
Q. Doesn't say it.
You're also aware that in the prior visits, conservative measures were attempted but didn't work for Andrew Peterson, correct?
A. Correct.
Q. You heard him say in the video when Tatyana asks whether physical therapy was tried, he clearly indicates that it didn't work?
A. Correct.
Q. Okay. You don't mention in your report that the patient said physical therapy didn't work; you said conservative treatments weren't offered, right?
A. That's correct, I did say it.
Q. You reviewed all the medical records in this case?

A. Correct.
Q. But you still believe that, at least up until Sunday, that Dr. Lewis was the first person to see this person at TPC?
A. Correct.
Q. Okay.
(Brief pause)
MR. CHAPMAN: Government was gracious enough to point me to the fact that Andrew Peterson's patient chart is 120B so I'm --
MS. McMILLION: That might not be true, sorry.
(Brief discussion held off the record)
MR. CHAPMAN: I'm sorry for the delay, Your Honor. We're just trying to figure out exhibit numbers.
THE COURT: Okay.
(Brief discussion held off the record)
BY MR. CHAPMAN:
Q. Doctor, I'm going to show you Government's Exhibit 120B, page 8, which has already been admitted. Is this one of the pages that you looked at during your review in this case?
A. I believe so.
Q. And you see the date here, 1-4-2018, correct?
A. Correct.
Q. And this is an encounter form indicating the patient was seen this date?
A. Correct.

Q. So when you looked at this page prior to Sunday, did you not come to the conclusion that his first encounter was on January 4th, 2018?
A. No, I did not come to that conclusion.
Q. You did not. Okay.
And then the provider that he saw on 1-4-2018 is circled as Tatyana, is that right?
A. Correct.
Q. And after you saw that circled word, Tatyana, that name, did you not come to the conclusion that Dr. Lewis wasn't the first person to see Andrew Peterson that day?
A. I did not.
Q. Okay. I'm guessing that if you didn't see that page, I'm going to show you 120B, page 9, maybe you didn't see this page. Does Andrew Peterson say where the pain is located?
A. I see that, yes.
Q. You see in shoulder and back, right?
A. Correct.
Q. Okay. So Andrew Peterson is seeking pain treatment that day, right?
A. Correct.
Q. So this visit wasn't for something else, right?
A. Correct.
Q. It's for the same reason Dr. Lewis saw him?
A. Correct.

Q. Now, Andrew Peterson indicates that he saw a doctor in the past in Wisconsin, right?
A. Correct.
Q. And he indicates that a doctor previously treated him in Wisconsin, correct?
A. Correct.
Q. There's a question here on the encounter form, "Have you received either of the following: physical therapy and chiropractic care?" Would you consider physical therapy and chiropractic care to be conservative measures?
A. I would.
Q. Those are nonopioid treatments, right?
A. Correct.
Q. And you think that pain management physicians should see if nonopioid treatments have been conducted and were successful?
A. Correct.
Q. And in this case, at the very least it says that he attempted these, correct?
A. Correct.
Q. Would the fact that he's now in a pain management physician's office suggest that those were unsuccessful?
A. It would be taken into context, but not necessarily.
Q. But common sense, right? If these were successful with his doctor in Wisconsin, he probably wouldn't be stepping into

a pain management clinic?
A. The -- you could interpret it several ways. You could say you had this problem in the past and you've had physical therapy in the past and come to the physician's office for repeat physical therapy. This at this point is just telling us "I have a pain and I've had this treatment in the past." It doesn't go to the conclusion that you've mentioned.
Q. But you know from watching the videos, at least on Sunday, that those treatments weren't successful?
A. Correct.
Q. Now, it's also important for a physician like Dr. Lewis and a PA working at the practice, it's important what other medications might have been tried and whether or not they worked, right?
A. Correct.
Q. In this case Andrew Peterson reports he's previously taken oxycodone, and then there's hydro and Norco as question marks, and then there's another drug, I believe it's Nexium, is that correct?
A. Yes.
Q. And then Flexeril and Soma, and he also attempted Gabapentin but doesn't know the dosage, right?
A. Correct.
Q. Some of these medications would be considered conservative measures?

A. Some of them, yes.
Q. That would be likely Flexeril, perhaps Gabapentin, although that might be controversial, right?
A. Correct.
Q. But certainly we also know that at least according to Andrew Peterson's report, he'd attempted higher strength medications like oxycodone, hydrocodone and Norco?
A. Correct.
Q. Okay. So we know that he's at least attempted those medications in the past?
A. Correct.
Q. After seeing those forms and hearing Andrew Peterson on video indicating that these other methodologies were attempted, is it still your belief that conservative measures weren't attempted for Andrew Peterson?
A. It is not.
Q. It's not your belief anymore?
A. Correct.
Q. So if you had the chance to retype out this report, you might change it to say conservative measures were attempted?
A. On that one, yes.
Q. Thank you.
You're also aware, and I'm showing you again Government's 120B, that Andrew Peterson came back one more time -- well, let me just make sure we walk through this

appropriately. First visit he sees Ms. Bezpalko. The next visit he sees Mr. Brent Russell who you know is a PA as well, correct?
A. Correct.
Q. And then the next visit he sees Dr. Edu, correct?
A. Correct.
Q. And then after that he sees Dr. Lewis?
A. Correct.
Q. So, in fact, Dr. Lewis wasn't the first person Andrew Peterson saw; in reality he was the fourth?
A. Correct.
Q. All right. And this sheet here indicates that Andrew Peterson saw Dr. Edu, and you're aware from your detailed review of these records that Andrew Peterson was prescribed hydrocodone at each visit before he saw Dr. Lewis?
A. Correct.
Q. Okay. Is it your belief then, sir, that Dr. Lewis should have abruptly stopped Andrew Peterson's hydrocodone prescription?
A. It should have been discussed with him but not abruptly stopped, no.
Q. No, he should have continued to prescribe, right?
A. Should have made a decision on what treatment he was going to make. Whether that's an opioid, whether that was the best suited one at that time, I'm not sure.

Q. Okay. So okay to continue the prescription, but you would have liked to see a little bit more in terms of treatment plan?
A. Correct.
Q. Now, do you recall Dr. Lewis in the first statement he made to Andrew Peterson was quite aggressive: "When are you going to get surgery?"
A. Right.
Q. Right? Dr. Lewis was saying, "We need surgery to fix this joint." Well, he wasn't saying, "We need it." He was saying, "You should get a consult for it," right?
A. Right.
Q. Pain for two years following an acute injury, you may want to talk to an orthopaedic surgeon?
A. Correct.
Q. That would have been another conservative, non-opiate measure?
A. I mean I -- I wouldn't say it's a conservative, nonopioid measure, but it's a -- it's a treatment.
Q. I see what you're saying and I think that's a very fair statement. Surgery's not always the best option for people, right?
A. Correct.
Q. But it's important to consider alternatives to opiates such as surgery to see if that might correct the underlying disease as opposed to masking it with medication?

A. Correct.
Q. And Dr. Lewis wanted Andrew Peterson to do that, right?
A. He did.
Q. Okay. He also suggested using some corticosteroid in the joint, actually I think it was right shoulder, in the joint to reduce some of the inflammation?
A. Correct.
Q. Have you had a chance to review -- I think we talked -- you testified about this a while ago. Have you had a chance to review the 2022 draft of the CDC guidelines?
A. We've talked about it, yes.
Q. And you've reviewed it?
A. Correct.
Q. Do you believe that that would be an authoritative document when evaluating a physician's conduct?
A. Correct.
Q. Because you used the 2016, and so it makes sense that the update is helpful as well?
A. Correct.
Q. This is a rather long document so if you'll bear with me. Now, sir, are you aware that the 2022 CDC guidelines actually state, "Interventional approach -- approaches such as arthrocentesis and intra-articular gluco" -- I'm sorry, this word is tripping me up today and it didn't trip me up yesterday. "Interventional approaches such as arthrocentesis

and intra-articular glucocorticoid injection for pain associated with rheumatoid -- rheumatoid arthritis, osteoarthritis and subacromial corticosteroid injection for rotator cuff disease can provide short-term improvement in pain and function." Long sentence, but are you aware that the 2022 guidelines discuss that specifically?

A. Yes.

Q. Dr. Lewis was attempting to recommend to this patient a very similar corticosteroid injection into the shoulder to relieve inflammation, correct?

A. Correct.

Q. And relieving inflammation can reduce pain?

A. That's correct.

Q. And relieving inflammation can reduce a patient's dependence or use of opiates?

A. Correct.

Q. In fact, Dr. Lewis mentioned to Andrew Peterson that if he's able to get these injections, medication may be able to be decreased?

A. Correct.

Q. So what Dr. Lewis was doing with Andrew Peterson was continuing his medication while discussing treatment alternatives that could result in a tapering and elimination of opiate medications?

A. Correct.

Q. Dr. Mehta, this wasn't a pill mill, right?
A. That's not what I -- I don't even know how to answer that.
Q. These aren't the activities of a pill mill doctor, right?
A. Are you -- maybe you want to define what a pill mill doctor is.
Q. Somebody flagrantly giving out medications to anybody who asks for them. That's not what was happening here?
A. No, not -- I wouldn't say that.
Q. We have conservative treatment with a low dose opiate and a suggestion for treatments that will resolve the pain, right?
A. Correct.
Q. In fact, the 2022 CDC guidelines would actually recommend against a rapid taper or reduction in opiates in this case, right?
A. In this case it's not the same sort of opioid that they're describing in terms of longstanding opioid, high dose opioid, high number of quantity. So a reduction or taper or elimination could have been appropriate in this case.
Q. It could have been, but the CDC recommends 10 percent per month?
A. CDC is one particular guideline, but 10, 20, 30 percent could be discussed.
Q. Okay. So a prescription could still be given, but if a taper was agreed on by Andrew Peterson and Dr. Lewis, that would start at 10 or 20 percent a month?

A. Well, remember, it's not just a sole decision of Mr. Peterson. It's a medical decision that Dr. Lewis is going to make.

THE COURT REPORTER: Doctor, could you pull the mic --

THE WITNESS: I'm sorry.

THE COURT REPORTER: -- just -- no, you're -- just a little closer please.

Q. It's -- it's a dual decision between the physician and patient, right?

A. Ultimately the responsibility falls on the physician to actually provide the prescription.

Q. Certainly that's the case, the physician needs to determine the medical need. But when a patient has already been put on opiate pain medication as part of their treatment plan, the decision to taper according to the CDC should be shared between the physician and the patient?

A. Should be shared, meaning a discussion, plan, but there are instances of where the decision may not be in full agreement by the patient.

Q. Certainly. If the patient's diverting, right?

A. If -- what -- whatever the reason. It could be that it's causing harm, it could be that it's diversion, it could be that a patient's not utilizing the medication and therefore does not need it.

Q. Great. Any evidence that Andrew Peterson was diverting pain medication, and I mean the persona of Andrew Peterson, as it appeared to Dr. Lewis?
A. Persona? I mean there was a -- I think we talked about earlier red flags, conversations that were had about which type of medications Mr. Peterson was requesting, had previously used, something that you want to use caution in prescribing to any patient.
Q. See, Dr. Mehta, I -- I say evidence and you say red flags, and I think we have a bit of a disagreement here. There is no evidence that Andrew Peterson, the patient that presented to Dr. Lewis, was diverting his controlled substance medication, correct?
A. There is things to suggest that there were discrepancies in how the opioids were being used.
Q. Those discrepancies didn't rise to the level of ripping a patient off of their medication, right?
A. It should have been considered.
Q. Considered but not definitive?
A. It is -- is something that I believe, yes, you could have discontinued the medication.
THE COURT: Okay. How much longer here, Mr. Chapman?
MR. CHAPMAN: I'm -- I'm not sure, Your Honor.
THE COURT: Well, we're getting into overkill and I want to get this man out of here today. I'd like you to do

maybe 20 minutes, we'll go 20 or 30 minutes with Mr. Margolis and we'll get the government on redirect, because we are beating the same lamp repeatedly now, so let's move it up.

MR. CHAPMAN: I can move on, Your Honor.

THE COURT: Yep. Thank you.

BY MR. CHAPMAN:

Q. You're also aware that the 2022 CDC guidelines discuss a minimum effective dose of medication for a patient, correct?

A. Correct.

Q. And they discuss that minimum effective dose of being 5 to 10 MME per dose or 20 to 30 MME per day?

A. Correct.

Q. Prescribing lower than that may have absolutely no effect on a patient, right?

A. Disagree with that.

Q. Well, that's what the term lowest starting dose means, doesn't it?

A. Well, again, it can be tailored to each patient. This is a guideline but it's decided per patient.

Q. Let me read from the CDC and see if your position is the same. "The lowest starting dose for opiate-naive patients is often equivalent to a single dose of approximately 5 to 10 MME or a daily dosage of 20 to 30 MME." That is the CDC saying for most patients, a starting minimum effective dose is 20 to 30 MME?

A. I will disagree with that.
Q. Okay. What was Andrew Peterson's starting dose by Ms. Bezpalko?
A. Go back to -- it was Norco 5, 5 milligrams.
Q. And what's the MME? I think it's a one-to-one ratio?
A. Correct, so 5.
Q. How many -- how many MME per day?
A. Again, that's probably around the 15 to 20.
Q. 15 to 20. So right around the minimum effective dose, at least according to the CDC but not you?
A. Correct.
Q. Okay. Let's move on to patient Victoria Loose. We talked about the opiate prescribing standard, but there's another standard that you used to evaluate this case and that is the healthcare fraud standard, right?
A. Correct.
Q. And when evaluating the injections that were offered by the Pain Center, you needed to determine whether or not those injections were medically necessary?
A. Correct.
Q. And you looked at all of the records available to you?
A. Correct.
Q. Of six patients that you testified on the witness stand?
A. Correct.
Q. I promise you I will not use the word caudal during my

examination about this witness, but I want to go into some other territory. In your report, I'm referencing page 24 related to the counts against Dr. Lewis, you state, "The patient received multiple injections in absence of conservative treatment and without documented evidence of benefit and therefore medically unnecessary." Is that what you said?

A. To continue.

Q. Yeah. Is it -- is it your belief that Victoria Loose didn't have conservative treatments prior to coming to the Pain Center?

A. I -- it is -- no, that is not my belief.

Q. You'd like to change your report?

A. I would like to modify that, yes.

Q. To include that she did have conservative treatments?

A. Correct.

Q. In fact, we heard from Mr. Weiss there was apparently a spinal cord stimulator that was used?

A. Correct.

Q. We knew that she was referred by Dr. Mark Rosenberg for treatment, right?

A. Correct.

Q. And that person was an orthopaedic surgeon?

A. Correct.

Q. And that person performed multiple back surgeries on this patient?

A. Correct.
Q. You're aware that she was undergoing physical therapy as well?
A. Correct.
Q. And those are considered conservative treatments?
A. Yes.
Q. Okay. So if you could modify your report now, you would add in all of those treatments and you would determine that she received conservative treatments prior to injections being performed?
A. Yes to that statement.
Q. Thank you.

Now, let's -- since we've changed our first opinion, let's go to the second. Without documented benefit, is it your testimony that Dr. Lewis performed an SI joint injection on Victoria Loose without documentation of benefit?
A. The benefit that was documented was basically on the same day of the procedure, so...
Q. Okay. You would like the benefit to be documented on a subsequent day?
A. Correct.
Q. Did you look through the entire record to determine if on a subsequent visit benefit was documented?
A. Benefit was documented but then ultimately went, again, another preplanned procedure.

Q. Okay.
A. So --
Q. You say in your report that no benefit was documented, but you say on the witness stand that "my problem is that benefit was documented on the same date, and even though it was documented on a subsequent date, another procedure was planned for that date." Is that what you're saying on the witness stand?
A. The subsequent date of the procedure or the next procedure then documented the benefit of the prior procedure, but it was already predetermined that that procedure was going to occur.
Q. Do you know whether or not if the patient said there was no benefit when checking in for her procedure that day, the next procedure would have occurred?
A. Repeat that what you said.
Q. Sure. Do you know whether or not Victoria Loose would have undergone a subsequent procedure if she walked into the clinic that day and said the last one didn't work?
A. I don't know that.
Q. No. But benefit was documented because the patient said she benefitted and she underwent a second procedure that day?
A. She underwent a second procedure.
Q. Because benefit was documented?
A. It was documented.
Q. Would you like to change your report that says no benefit

was documented?
A. I would change that statement, yes.
Q. Okay.
MR. CHAPMAN: I think I was able to speed things up, Your Honor. I just have a few more questions.
THE COURT: Excellent. Thank you so much.
BY MR. CHAPMAN:
Q. Dr. Mehta, you've testified on direct exam that you are a board certified anesthesiologist?
A. Correct.
Q. Isn't it true that your board certification has (coughing in courtroom)?
THE COURT REPORTER: Wait, I didn't hear that.
A. I'm sorry.
Q. Isn't it true that your board certification has expired?
A. No, that's not true.
Q. Isn't it true that on December 31st, 2020 your board certification lapsed?
A. That's not true.
Q. Okay. Isn't it true that on your CV it indicates your board certification lapsed?
A. A CV may have been dated at that time but it's not lapsed. It's never been lapsed. If I can explain what -- what it is, it's the ABA, the Anesthesia Board Association, basically changed the rulings on board certification so there's no more

exams every ten years. Now there is something called Maintenance of Certification, and that's what I am doing and compliant with.

Q. Isn't it true that when you look yourself up on the board certification website that lists your credentials, it says expired?

A. I -- I have not looked, but I've completed all the tests.

Q. Okay.

A. So if that is the case, then that's an error, but I am definitely board certified

Q. Did you submit your Maintenance of Certification to the appropriate authorities?

A. It's through the Anesthesia Board, yes.

Q. Now, finally, your review in this case, you testified you reviewed six charts, but you also reviewed a hundred charts as well, right?

A. Correct.

Q. The six charts that you reviewed you reviewed in a detailed way?

A. More detail, yes.

Q. Okay. But as we see, there were some mistakes made?

A. Correct.

Q. The hundred charts, how much time did it take you to review those hundred charts?

A. I don't remember that specifically.

Q. Do you know how many pages you reviewed?
A. It was a large number of pages.
Q. Did you review those with the same rigor that you reviewed the six charts?
A. I put in my best effort on all of them.
Q. Is it possible that some mistakes were made in your review of the hundred charts?
A. It is possible, yes. I -- I'm -- I'm human, yes.
Q. Okay.
MR. CHAPMAN: May I have a moment, Your Honor?
THE COURT: Yes.
Q. Doctor, I appreciate your time today. I don't have any further questions, okay?
THE COURT: Okay. Thank you, Mr. Chapman.
And Mr. Margolis will finish up. Go right ahead.
MR. MARGOLIS: Thank you, Your Honor.
THE COURT REPORTER: Mr. Margolis, I just exited out of my program. Excuse me one second.
(Brief pause)
Excuse me one second.
MR. MARGOLIS: Take your time.
(Brief pause)
THE COURT REPORTER: All right. I'm so sorry for the interruption.
MR. MARGOLIS: Thank you. May I proceed, Your Honor?

THE COURT: Yes, please do.

CROSS-EXAMINATION

BY MR. MARGOLIS:

Q. Dr. Mehta, good afternoon.

A. Good afternoon.

Q. My name is Laurence Margolis. I represent Dr. Christopher Russo. One of the benefits of going last is that I have the opportunity to hear all of these good lawyers and whittle down, and the Court always appreciates my brevity so I will try to be brief.

A. Thank you.

Q. Get you back on that plane to New York in short order hopefully.

A. Thank you.

Q. One thing I do want to get straight because I'm a little confused about the -- the time situation and what was discovered Sunday before trial, the errors, the mistakes, so I'm going to briefly go over that again.

A. Okay.

Q. You were retained in this matter sometime in the early part of 2020, is that correct?

A. I -- I don't recall.

Q. You said -- I think you said the early COVID period, is that...

A. Sometime around that time.

Q. How does that happen, do they -- do you sign a contract, were you retained, a retention letter? How do they -- how do you contract with the government?
A. There was a contract, yes.
Q. A written contract?
A. Yes.
Q. You signed your name on it?
A. Correct.
Q. Okay. With a pen?
A. Correct.
Q. Okay. Faxed it over or emailed it to them?
A. That's right.
Q. Okay. And that was -- but you don't have the date, you don't have that in front of you?
A. I don't have it in front of me, I'm sorry.
Q. Okay. And then over the course of the next months I assume, five, six, seven months, you received documentation from Ms. McMillion's office, is that correct?
A. Correct.
Q. And you said you -- you had 50 or so conversations or communications with her during the course of this job for you?
A. Correct.
Q. And -- and many of those I assume were before you signed the report on October 31st of 2020, correct?
A. Correct.

Q. Do you know how many of those were? Was it -- was it all of them, the majority of them? I mean you talked to her after that too I assume.
A. I wouldn't be able to answer. I don't know the answer.
Q. Okay. And you signed your report on the 31st of 2020?
A. Correct.
Q. And then now we are going on two years from that date, correct?
A. Correct.
Q. And the day before trial is when you discover there were errors to that report?
A. I discovered a few days before, as I mentioned.
Q. I thought you said Sunday --
A. I --
Q. -- the day -- the day before you come in to testify.
A. No, even a few days before that as I was prepping for this I did discover that.
Q. Okay. And you got on the phone and called Ms. McMillion's office?
A. Not on that day.
Q. Okay. And you made no modifications in writing to that report before your testimony today?
A. No, not submitted to anybody.
Q. Okay. Mr. Weiss started, and I was trying to keep count of the various errors to his report or your report. I'm

counting between 10 and 15 up until your testimony right now. Is that a fair number, there's been between 10 and 15 errors to this expert report you submitted?

A. Yeah. If you -- maybe 10, 10, 12, something like that. But I think if you look in the overall number of things that were reviewed and number of procedures documented, it is a small percentage of those.

Q. The seven patient files you reviewed, is that what you're speaking of in terms of the --

A. And the number --

Q. -- conclusions about them in the report?

THE COURT REPORTER: Wait, wait, wait. You both talked on top of each other. "...is that what you're speaking of in terms of the..."

Q. Review of the report I think is what I said.

A. Yes. And I'm referring to the number of individual procedures and so forth that I was trying to document.

Q. Okay. Okay. And some of those errors were typographical I think you said?

A. Correct.

Q. Some of them were caused by a computer spellcheck?

A. Correct.

Q. And some of them were substantive, as Mr. Harrison pointed out with a copy and paste situation that he talked about?

A. Correct.

Q. And then you said that there may be other errors still that you found?
A. Correct.
Q. Something about a -- a -- a caudal epidural?
A. Well, that's the same thing you were alluding to earlier.
Q. Well, you -- I -- I -- you said that you had found additional errors I believe that you hadn't discussed yet. I'm trying to understand what other errors may be in the report that we haven't talked about yet.
A. To my knowledge, I don't believe there are other errors.
Q. Okay. So you're comfortable that everything else in this report is true and accurate to the best of your ability?
A. I mean obviously if I read it again, I would -- I would --
Q. Take your time.
A. -- try to proofread.
Q. We got a little time. Read it again. Read it regarding MM first, Michelle Morzynske, Dr. Russo's client who you alleged he gave an unnecessary caudal epidural to. That's Count 32 in the government's indictment. And I can put up the record if you need me to, Doctor. I think I will put it up.
A. Yes. It was -- here it was also the caudal versus cervical issue.
Q. Okay.
A. That was my mistake.
Q. So --

A. And then there was one other mistake that I noted which is --
Q. Hold on, I'm sorry. Let me write this down. What was that first thing you just said, sir?
A. There are a few instances where I mentioned cervical and it's actually a caudal epidural.
Q. So I assume you're referring to page 26 of your report is the first mention of cervical epidural steroid injection or is there another one I missed?
A. I believe it's page 27.
Q. Yep, page 27 at the top?
A. Correct.
Q. And then in the -- and so that's wrong, it's not cervical is your testimony today?
A. It's -- it's to be caudal.
Q. Okay. And this is not one of the errors that you caught in the last few days after having this matter for almost going on two years now? This is a new catch for you?
A. I only caught it recently.
Q. As in now?
A. No, I -- I have it on my page here as noted, but we have not discussed it.
Q. Is that one of the ones that you let the government know about was wrong in your report?
A. I mentioned that there were errors where -- that I mis --

mistook cervical and caudal.
Q. And -- but you didn't mention specifically in relation to Dr. Russo?
A. I did disclose a bunch of errors. I -- I think I -- I did as well.
Q. Okay. And there's actually three different places in your report in reference to substantive Count 32 against Dr. Russo where you say cervical epidural steroid, right?
A. Correct, there's three.
Q. And so for each one that's wrong in your report?
A. Correct.
Q. And actually that's the complete bases of the charge of your -- your -- your conclusion: "The patient received a cervical epidural steroid injection without clear indication and was requesting to be treated for her low back pain." So that's not a typographical error, that's not one of the acronym typographical errors like Mr. Weiss was pointing out, correct?
A. You've asked two things there, but the -- it is not a typographical error and that -- that it's not a autocorrect issue, but I do know and -- and I'm aware that a cervical epidural is not applied for back pain.
Q. Okay. Low back pain is often treated with a caudal epidural, is that correct, sir?
A. Correct.
Q. And that was the bases, that error three times on the same

page was the bases of your opinion relative to the fraud charge against Dr. Russo, correct?
A. Correct.
Q. And you didn't find it for a year and a half after taking 50,000 or 50 hours' worth of time?
A. I believe I've answered that, yes.
Q. So would you like to retract your statement from yesterday?
A. Which statement?
Q. About Dr. Russo doing an unnecessary caudal epidural?
A. No, I would not like to retract that.
Q. Why is that?
A. We're discussing in the report the difference of cervical versus caudal in the sense you're referring to the mistake.
Q. Fair enough. Fair enough.
A. So if I intended to write caudal, that's the basis of my decision.
Q. Why was a caudal -- so you're -- you're -- what you're saying is you did intend to write caudal?
A. Correct.
Q. You just missed it three different times on the page?
A. I believe you asked me that, but yes.
Q. Okay. And what was your -- what is your opinion as to why a caudal epidural was not warranted in this instance?
A. Part of it is the overall findings on the MRI which are,

again, disk bulges in multiple locations that are L3-4, L4-5, L5-S1.

Q. And what about that would make it not indicative of caudal?

A. It's overall a relatively minor or it could be argued as a normal finding.

Q. Could be argued. Can reasonable minds differ?

A. I'd say that it -- the standard would be that it's a conservative finding and a minor finding there.

Q. Let's go over the chart and see if there's any other errors and then we'll get to the MRI, okay?

A. Yes.

MR. MARGOLIS: Your Honor, is that up? Is it not seemingly working?

THE COURT: Well, who's displaying? Defense?

MR. MARGOLIS: I should be connected. I did it this morning. Let's try this. There we go.

Q. So this is Michelle Morzynske's clinical report from 9-16-16, is that correct?

A. 9-19.

Q. Sorry, 9-19.

You -- your report states at page 26 at the bottom that the patient was initially seen by Dr. Russo, is that correct?

A. Correct, yeah.

Q. Okay. And where did you come with that finding, Doctor, where'd you get that information? It says Dr. Pashley on the report, on the clinical data.
A. That's true.
Q. Do you know who Dr. Pashley -- does Dr. Pashley even work for the Pain Center, have you ever seen him -- his name as an employee?
A. I don't recall Dr. Pashley as a --
Q. If I told you Dr. Pashley was the referring physician, would you accept that statement as true?
A. Yes.
Q. If I told you that was Dr. Bothra's handwriting, would you have any reason to doubt that?
A. I have no reason to doubt it.
Q. So you were supplied the information that this was Dr. Russo, is that fair to say?
A. Correct.
Q. And you did no due diligence to see whether or not it actually was Dr. Russo, correct?
A. To the best of my ability I tried to attribute it to who it was.
Q. To the best of your ability. You're an intelligent man, right? We've heard your credentials. You're working for the U.S. government right now at $500 an hour. You didn't ask them, "Who is that doctor? I've never seen the name Dr.

Pashley before." Right? You didn't ask them to check the handwriting sample for you to see if it was Dr. Russo's or Dr. Bothra's, is that correct?

A. I did not ask those questions.

Q. So you didn't do it to best of your ability; you just relied on what was handed to you, correct?

A. In good faith, yes.

Q. Thank you.

So Dr. Bothra sees this individual first time. She presents to Bothra and she complains of low back pain. She's had it for the last ten years, is that fair to say, according to the report?

A. Correct.

Q. She complains of radicular pain, right?

A. I actually wasn't sure. I thought that that was not radicular, so I wasn't sure what that was.

Q. The second under number 1, is that not look like radicular pain now that we're talking about it?

A. It says the word radicular but there's a -- I -- I don't know if that was a N or a -- I thought that was --

Q. Okay.

A. -- not radicular. I'm --

Q. Okay.

A. -- sorry about that.

Q. No worries. It's perhaps on the MRI though, right? She

says that -- oh, what is radicular pain, by the way, can you tell the jury what that is?
A. Radicular pain is pain going down extending towards the extremities.
Q. Pain that shoots down the leg?
A. Correct.
Q. Not new pain from -- from lifting a heavy box or -- or doing furniture over the weekend that we had to do, right?
A. I'm sorry?
Q. It's not acute pain that just happened over the weekend from lifting a heavy box?
A. Based on the time, it's -- no. It's ten years.
Q. Thank you.

Dr. Bothra also describes a bilateral -- chronic bilateral hip pain on Ms. Morzynske.

MR. CHAPMAN: We lost it.

MR. MARGOLIS: Oh, geez. I'm going to have to keep doing it. Can you see it now?

THE COURT: I can. Go ahead.

BY MR. MARGOLIS:
Q. Dr. Bothra also describes chronic bilateral hip pain on this woman, is that correct?
A. That's correct.
Q. Diagnosis, scoliosis of the spine?
A. Correct.

Q. Hypertension and coronary artery disease?
A. Correct.
Q. Depression?
A. Right.
Q. There's an X-ray of both hips, shows minor degenerative changes, yes?
A. Correct.
Q. Also an X-ray of her lumbosacral spine. Do you see that?
A. I can't see that part of the --
THE COURT REPORTER: I'm sorry, I didn't hear.
A. I can't see that portion.
Yes, so there is an X-ray of lumbosacral spine.
Q. Thank you. Thank you for correcting my pronunciation.
Degenerative changes are noted, yes?
A. Correct.
Q. Degenerative disk disease noted on X-ray by radiologist, mild scoliosis?
A. Correct.
Q. Spurring, lung spurs are seen on the X-ray?
A. Correct.
Q. There was also an X-ray of the cervical spine of the neck, sorry, cervical spine?
A. You'll have to scroll further down.
Q. Sorry. Is that not in that chart?
So what is Dr. Bothra's orders there? Can you see

that?
A. On the right-hand side, I believe that's where it says urine drug screen, it is gel packs, PT.
Q. What is PT, sir?
A. Physical therapy.
Q. Thank you.
And he orders an MRI scan of her lumbar spine, correct?
A. Correct.
Q. Wants to see her back in two weeks?
A. Correct.
Q. He doesn't prescribe her a back brace, correct?
A. Correct.
Q. She would have been a decent candidate for one perhaps with that history, no?
A. Not sure. I don't think so.
Q. You're not denying that it wouldn't have been a bad candidate with all that degenerative disk disease?
A. Well, I think degenerative disk disease is something that we should probably define. I know that you may not allow me to do that.
Q. Well, we'll move on. You can do that on -- on redirect.
He also ordered Baclofen. Do you see that?
A. You'll have to -- Baclofen, yes.
Q. Ten times. "Patient not due for pain meds." Do you see

that?
A. Yes.
Q. So Dr. Bothra doesn't order her a back brace, doesn't give her any pain medicines, and he prescribes her a non-narcotic, non-Schedule II relaxant. Is that -- what -- what's Baclofen?
A. A muscle relaxant.
Q. Thank you.
Ms. Morzynske doesn't come back right away. Do you remember she's the one where her husband wasn't getting the medication and she said, "I'm out of here, I'm never coming back"? There was that big dispute. Do you remember that?
A. Yes.
Q. Louis I think is his name, Louis Morzynske.
A. Correct.
Q. I don't want to talk about him, but what is interesting about him, and I believe if you recall, his X-rays or his MRIs were actually in Michelle Morzynske's file. Do you remember that?
A. I do recall that.
Q. And he actually had cervical imaging, right?
A. Correct. If I -- actually I don't -- I can't recall --
Q. I think --
A. -- off the hand.
Q. Well, you are accurate because that is my recollection as well. And that just made me think that perhaps that is the

reason you kept writing cervical, cervical, cervical throughout Dr. Russo's treatment of Ms. Morzynske because you read -- and I did the same thing reviewing this case. His -- because he -- they wouldn't take him as a patient so they threw his stuff, his records in the file.

MS. McMILLION: Your Honor, is there a question?

THE COURT: Yeah.

BY MR. MARGOLIS:

Q. Is it possible that's how you mixed up the cervical/caudal in this instance, sir?

A. I genuinely don't know how that happened.

Q. So it's possible?

A. Anything is possible, but I -- I think we've talked about the mistake that I've made.

Q. Seven months later she comes back in. There's a note there, "UDT 9-19-16." That was a test she took there. "Positive for opiates. New patient." Do you see at the bottom of the top chart there?

A. Correct.

Q. Okay. Now we're scrolling down to Dr. Russo's handwriting, Dr. Russo's notes. I know it says Dr. Bothra. Medical assistants make mistakes, happens all the time, yes?

A. Sounds like mistakes that I've made.

Q. It's a little bit different.

A. Yes, sir.

Q. So "52-year-old female, seen once." He -- Dr. Russo underlines that. Do you see that?
A. Yes.
Q. "Wait seven months to return for low back pain and hip pain." Dr. Russo reviews her MRI scan with her, and I'd like to go over that a little bit because it's above my pay grade, as they say, but I think it's helpful to discuss exactly what the radiologist and then Dr. Russo relied on.

Now, Mr. Chapman went through this in some detail and I'll just go back to it. It's completely reasonable for one doctor to rely on another doctor's imaging, radiology reports to base -- to inform and base Dr. Russo or that other doctor's opinion, is that fair? A poorly worded question.
A. I mean I guess in a -- a broader sense, that when I refer a patient to one of my colleagues, the colleague relies on what I have determined.
Q. Yes.
A. But each case is looked at individually. If I see a patient a long time back and there's different issues, then I would expect my colleague to take into account what I write but also make their own medical evaluation and decision making.
Q. Understood. As far as imaging, radiology reports, MRIs, X-rays, that reliance is completely reasonable and happens all the time?
A. Correct, yes.

Q. Okay. So this MM's MRI shows "L2-3 bilateral nerve hole [sic] narrowing."
A. Neuroforaminal.
Q. Thank you.
THE COURT REPORTER: Wait, I'm sorry, what?
THE WITNESS: Neuro, n-e-u-r-o, f-o-r-a-m-i-n-a-l.
Q. I appreciate you doing that because I was about to struggle with it.
A. I should test you.
Q. "L3-L4 disk bulge, right greater than left." Do you see that?
A. Correct.
Q. "Nerve -- nerve hole narrowing may affect the right L3 nerve root." That's the radiologist talking, right?
A. Correct.
Q. He's able to rely on other doctors.
A. Right.
Q. Practicing -- practicing medicine builds on itself as they say, right?
A. Correct.
Q. "Facet arthritis is noted at this level," yes?
A. Correct.
Q. "MRI shows facets may be enlarged and inflamed."
A. Correct.
Q. "No FJI," facet joint injection, "because the pain

radiates." Is that correct?
A. Where -- where are you reading that? I'm sorry.
Q. Sorry. "Disk bulge." So that is what would be standard for an interpretation by a pain doctor, correct? You don't do facet joint injections if the pain's radiating, is that fair?
A. No, they -- they -- you -- it is possible. There are radiating patterns of facet-related pain.
Q. Okay. But typically, customarily, if it's radiating pain, radicular pain, that doesn't indicate for facet injections, is that a reasonable interpretation?
A. It is thought that facet is more axial or back pain.
Q. That's -- that's all I'm talking about.
A. Yeah. Okay.
Q. Thank you.
"L4-L5 level there is a disk bulge" -- did I already go over that -- "with bilateral nerve hole narrowing. Also has facet arthritis at this level." And then it says, "L5-S1 level, bottom of spine where it joins the sacrum, the sacrum." And what is -- what does that mean, "L5-S1 level, bottom of spine where it joins the sacrum"?
A. Where are you reading that? I'm sorry.
Q. Where is that?
A. I don't see the word sacrum.
Q. "Disk bulge" -- so I'm just interpreting what most likely Dr. Russo explained to me about this.

MS. McMILLION: Objection, Your Honor. That calls for speculation as to what counsel is interpreting it to be.

MR. MARGOLIS: I totally agree, Judge.

THE COURT: Good. Go ahead.

BY MR. MARGOLIS:

Q. Also notes "Facet arthritis at this level"?

A. Which level are we referring to? I'm sorry, just --

Q. L5-S1.

A. Correct.

Q. So she has arthritis up and down her back, is that fair to say?

A. She has arthritis at multiple levels, yes.

Q. The nerves against her leg are being scraped against those small little nerve holes as they try to squirt out of the spine, is that what the radiation, the radicular pain is?

A. It's -- again, it's -- I think you're trying to give a lay explanation.

Q. Correct.

A. I truly respect that. Again, you know, there is context of MRI findings in trying to make a determination of what the treatment would be. In this -- in this case this patient has disk bulges. They have some areas of facet arthritis. Yes, I would say that's the case.

Q. Okay. Says, "She declines physical therapy, hurts too much," right?

A. Correct.
Q. "Sent by her PCP to get her pills."
A. Correct.
Q. "Dr. Russo plans to do a caudal epidural." Do you see that?
A. Correct.
Q. Steroid injection?
A. An epidural steroid injection.
Q. He prescribes her Norco 10 three times a day, correct?
A. Correct.
Q. Relatively low dosage -- dosage according to the CDC and your testimony today, yesterday?
A. Correct, similar dose opioid.
Q. Baclofen?
A. Correct.
Q. And he also --
A. Can you scroll -- scroll down? I think you're --
Q. Sorry.
A. Are you trying to read from something or are you just...
Q. And he also notes that Ms. Morzynske tried and failed a nerve pain pill, the non-narcotics, said it doesn't work for her.
A. Neurontin.
Q. Thank you.
THE COURT REPORTER: I'm sorry?

THE WITNESS: Neurontin.
Q. And do you see that note there with the star next to it?
A. I do.
Q. What does that say to you?
A. Would you like me to read it?
Q. Oh, that's a different note, I'm sorry. This is the note I'm talking about here. In your report, let's go to your report for a second, you discuss that "she tested positive for Benzodiazepines that were not addressed by the doctor." Do you see that note right there, Doctor?
A. Which -- which part of the note?
Q. At the top where the arrow is saying "discussed with patient"?
A. Correct.
Q. So that's not true actually. Dr. Russo did discuss that with Ms. Morzynske, didn't he?
A. He discussed the two things that are documented there but not the Benzodiazepine.
Q. Well, he had a discussion with her about drugs and narcotics and being safe according to that.
MS. McMILLION: Again, Your Honor, if the defense counsel has a question, but his interpretation of what happened is not at issue here.
THE COURT: Okay. All right. Well, we know that and the jury knows 'cuz I've told them several times, questions are

not evidence. The evidence is coming from the answers on the stand. I think Mr. Margolis likes to say things to make transitions and we've had a little dialogue.

And keep going, Mr. Margolis, please.

BY MR. MARGOLIS:

Q. According to that, Doctor, Dr. Russo tried different options to treat Ms. Morzynske, didn't he? Low dose, caudal epidural, Baclofen, physical therapy, all that was tried with this patient, correct?

A. Correct.

Q. Multimodal approach, correct?

A. Correct.

Q. A specialized treatment plan, some narcotic, low dose, plus the epidural?

A. Correct.

Q. It's what you testified to yesterday, it's what you said the guidelines call for?

A. Called for multimodal treatment, yes.

Q. Correct. Ms. Morzynske, if you recall, if you -- do you recall her storming off after that and calling back the clinic and complaining, do you remember that?

A. I mean I was not there at that time but --

Q. I'm saying from the record.

A. From the record, yes. There was a note recording her behavior.

Q. Correct. We can go over that if you like. "Michelle Morzynske called the office and stated that she or her husband will not be returning to the Pain Center because we would not give her husband Louis anything for pain and what we are doing for them isn't helping. Michelle stated she and Louis will go to another pain center and she just wanted to let us know. Michelle requests pain meds that we would not" and we assume "give her."

So she and her husband are pill seeking, is that fair to say?

A. There is concern about that, yes.

Q. Of course. She wants the hard stuff and Dr. Russo wouldn't give it to her, is that fair from that?

A. I mean if you're -- you're -- referring hard stuff to being the opioids.

Q. Stronger, correct.

A. Stronger medication.

Q. Yes.

A. She's looking for medication.

Q. "Pain meds that we won't give her." He gave her low dose, she storms off mad because it's not high enough. That can be interpreted as "you didn't give me something strong enough," fair?

A. Correct.

Q. Okay. She does come back however. Three weeks later she

shows up for her caudal epidural. Dr. Russo reviews her urine drug screen. There's hydrocodone and Suboxone in her system. He notes this, that he discussed her urine results with her, yes? We already went over that.

A. Correct.

Q. This shows due diligence by Dr. Russo with his patient, correct?

A. I think we've talked about the interpretation of the results and so forth, but yes, he had a urine screen and he was making interpretation.

Q. Physical therapy, Neurontin, low dose, trying a multimodal approach with a difficult patient?

A. Again, I think we're using this term low dose. It's still an opioid.

Q. Of course. We're all aware of that, Doctor. Thank you.

A. Right.

Q. He performs it with fluoroscopic guidance, and there was a nice picture of it in the file. Do you recall seeing that?

A. Yes.

Q. Confirms that Dr. Russo placed the needle in the epidural space in the spinal canal. That's how those work, correct?

A. Correct.

Q. She never came back after that, did she?

A. Correct.

Q. A back brace was never ordered, correct?

A. Correct.
Q. She had signed a narcotic agreement, correct?
A. Correct.
Q. And Dr. Russo, I don't believe he prescribed her any opioids on the day of her injection, is that correct?
A. No.
Q. It's not correct or no, he didn't?
A. He did not.
Q. No pills given to him that -- given to her that day. So this person had, according to the chart, failed conservative treatments, and you're still saying a caudal epidural was not the right thing to do, right?
A. Again, in the interpretation of the overall results of the MRI findings and also X-rays, so forth, a caudal doesn't really make sense in that patient.
Q. Okay. Is that not something that reasonable minds, reasonable doctors could take a different approach on?
A. I think that most would -- would say that a caudal isn't necessarily indicated there. That's my -- my belief.
Q. But most means that some would, yes?
A. Again, there may be folks that think that a caudal is. I mean I -- I noticed that in this practice they use quite a few caudal epidurals.
Q. Well, let's talk about those folks. Mr. Weiss brought up a journal, a society, ASIPP, that you used to be a member of?

A. Correct.
Q. And they -- they publish articles called "Focused Review." Have you seen some of those "Focused Review" articles that are published in the journal?
A. Correct.
Q. And have you heard of Vijay Singh or Laxmaiah Manchikanta?
A. Yes.
Q. You've heard of Dr. Manchikanta?
A. Correct.
Q. He's a recognized authority, he's the -- the guru?
A. He's an accomplished pain physician.
Q. They call him Lax, right?
A. Lax.
THE COURT REPORTER: I'm sorry, they call him what, Lax?
MR. MARGOLIS: Lax.
Q. Are you familiar with the 2002 Volume 5 Pain Physician Review that he and Dr. Sing, [phonetic], Singe [phonetic] -- how am I saying that bad?
A. Sing [phonetic].
Q. Thank you.
Wrote called "Role of caudal epidural injections in the management of chronic low back pain." Have you read that 2002 publication peer review?
A. I've not read that 2002 one. I mean that's quite a bit of

time, as we've talked about.
Q. Okay. I'd like to read you Lax's indications and then his conclusions about caudal epidurals and you can tell me whether you agree or disagree, okay?
A. Okay.
Q. "Caudal epidural steroid injections" --
THE COURT REPORTER: Wait, wait. Slow down.
MR. MARGOLIS: Sorry.
Q. "Caudal epidural steroid injections are indicated in patients with chronic low back pain who have failed to respond to conservative modalities of treatments. The procedure should always be performed under fluoroscopy. While caudal epidural steroid injections may be performed for any type of low back pain with or without lower extremity pain nonresponsive to conservative modalities of treatment, they are properly indicated in patients negative for facet joint pain or patients who have a combination of discogenic component with facet joint pain." Do you agree with Lax's interpretation there of what's indicated?
A. That's a conclusion made in 2002. I think we've gone beyond doing caudal epidurals there.
Q. So let me read the conclusion and you tell me whether or not you disagree with Lax there, Dr. Manchikanta. "Caudal epidural steroid injections are simple, safe and effective techniques for managing chronic low back pain. Considering the

cumulative evidence available in the literature, caudal epidural steroid injections are as effective as numerous other interventions applied in managing chronic low back pain, if not superior.

"An interventional pain physician needs to individualize the choice of treatment to each patient and personal experience. They are best performed under fluoroscopic visualizations."

So you're telling me you disagree with Dr. Manchikanta, with Lax?

A. I think you actually read a statement that's very important to say there.

Q. Okay.

A. If you want to read it again, you -- you --

Q. Which part?

A. The individual assessment.

Q. "Needs to individualize the choice of treatment to each patient and personal experience."

A. Correct.

Q. I --

A. So in this patient, and also since 2002, caudal epidurals have not been utilized for these types of conditions, and I -- I believe even Dr. Manchikanta has gone on to modify what he has utilized as treatment for these types of indications. This is a statement from 2002.

Q. We're not talking in the Dark Ages, sir; that was 20 years ago.
A. We -- we just talked about evolution of pain care.
Q. They're still safe and simple, yes?
A. They're safe, they're simple.
Q. They still provide relief from pain, yes?
A. They can.
Q. Relief from low back pain, yes?
A. Would there have been a better suited treatment is what I --
Q. Okay. That's fair, that's fair. But saying it's medically unnecessary and he's committing a crime because of doing something that is safe, simple, effective, recognized, provides the patients relief is different, right?
A. I would say yes, I agree with that statement.
Q. Thank you.

I want to talk about DS or Denise Souligney. She is on page -- starting at page 28. This is a complicated patient, this was a complicated patient, yes?
A. Correct.
Q. Do you remember -- do you remember Ms. Souligney's file?
A. It was extensive.
Q. Quite. I won't go over each and every treatment of Ms. Souligney's, but I do want to establish the extent and nature of her injuries. And if you recall offhand, you can tell me,

but you don't have her medical record in front of you probably, do you?
A. I do not.
Q. Okay. Let me know if you -- you disagree with my assessment of her injuries. 5-16 -- 5-3-16 Ms. Souligney presents to the Pain Center at its Eastpointe location. You're familiar that there were a couple different offices or locations that were under the umbrella of the Pain Center?
A. Correct.
Q. And the Eastpointe was where Dr. Kufner -- that was his exclusive domain. Did you have knowledge of -- do you know that?
A. I recall reading that, yes.
Q. Okay. She presents with failed lumbar back surgery syndrome. That's failed back syndrome. I think you were talking about that earlier.
A. Correct.
Q. That's when -- what is it? Can you tell me what that is just so I can explain to the jury? I -- I forgot what you said.
A. About failed back surgery?
Q. Yes.
A. So it's, again, the -- the condition of pain that goes on beyond after the surgery. Also we talked about that it's maybe called post-laminectomy syndrome.

Q. Thank you.
A. It may be back pain, leg pain, you know, specific areas, combinations of those two.
Q. And it's failed because the surgeon can't do any more for it and the pain is still there. Is that why they call it failed back -- back syndrome surgery or...
A. Yeah. It -- actually, the reason for the name change is that surgeons were -- resented the -- the fact that it was called failed. It's an absence of further surgical indication and the patient still has pain.
Q. Surgeons can be tense about that kind of stuff.

After a surgery like that, the patient will have rods and screws, plates in the back?
A. Correct.
Q. For life?
A. Unless surgically removed.
Q. Unless they do another surgery, yes.
A. Correct.
Q. She also presents with a host of other pain complaints from past surgeries. Do you recall that?
A. Correct.
Q. Both knees, her left elbow, both shoulders, both hips, neck and low back. Is that fair to say, is that accurate?
A. Correct.
Q. All surgeries?

A. She had a number of surgeries too, yes.
Q. Prosthetic or fake joint in her knees, elbow, neck and back?
A. Correct.
Q. Like with the back surgery, she has pins and screws and plates throughout her entire body?
A. Correct.
Q. Based on that history alone, you would agree -- if you don't, let me know -- that she has legitimate pain, legitimate complaints, pain complaints?
A. That's correct.
Q. The fact that she was on pain pills and a little Xanax is not overwhelmingly surprising to us?
A. You know, again, the fact that she's on medication is not surprising. We can argue that what's the appropriate ones, but...
Q. That's fine. I don't want to argue about it yet.
Dr. Kufner sees her in '16 and -- well, let's talk about all his -- I don't want to go through each and every one, but he performed, Dr. Kufner performed, a litany of procedures on this woman over the course of 14 months, give or take. In 2016 Kufner did 11 separate injections, is that correct? And I'm counting bilateral as two.
A. Got it. I was trying to add them up.
Q. Yep. Yep.

A. I mean there were a number of them. I don't want to waste the Court's time adding each one up.
Q. So according to my count, between May 25th of '16 through 9-6 of '17, Dr. Kufner did -- performed 18 separate injections on Denise Souligney. Is that square with what you have to say or -- or see?
A. That's -- I believe that's correct, yes.
Q. This was not Dr. Russo's patient up until Dr. Kufner left and turned her over to him. Do you -- did you get that from the records?
A. I believe so.
Q. All right. And Dr. Kufner actually had scheduled -- Dr. Russo was charged in Counts 33 and 34 for SI joint injections or -- and one SI joint injection, is that correct?
A. I don't recall exactly, but...
Q. Because it's not clear from your report exactly why Dr. Russo was charged, is it? You said, "Substantive counts relating to" -- this is on page 30 of your report, bottom of the page. "Substantive counts relating to DS: Counts 28 and 29, 33 and 36, 40 and 42," and you say healthcare fraud. "The patient received numerous injections in the absence of conservative treatment and without documented evidence of benefit and therefore medically unnecessary to continue. The patient also underwent radiofrequency ablation of facet joints L-3 through 5 that were previously fused and thus not

medically -- medically necessary." Is that -- did I read that right, Doctor?
A. Correct.
Q. So who did L3-L5?
A. I would need to go back to the record to --
Q. On page 29, dated 8-30 -- or actually no, he might have done it twice. Dr. Russo never did L3 through 5 RFA, correct?
A. I would need to be able to look at the record to -- to verify that.
Q. Well, if I tell you it was Dr. Kufner, do you have any reason to doubt what I'm saying?
A. Correct. I -- no, I don't have a reason to doubt you.
Q. Thank you. Thank you.

Dr. Kufner left the clinic sometime in late October, early November I believe. Are you aware that Dr. Kufner left the clinic?
A. I'm aware.
Q. Okay. Are you aware he filed a lawsuit against Dr. Bothra and the Pain Center?
A. I'm not aware of that.
Q. A qui tam, a qui tam case?
A. I'm not aware of that.
Q. You're not aware that he filed it in July of that 2017?

MS. McMILLION: Objection, Your Honor. Asked and answered.

THE COURT: Sustained. Keeping going, Mr. Margolis.
BY MR. MARGOLIS:
Q. We've talked about reliance on another doctor's care plan, right? You've mentioned it today, yesterday. It's not unreasonable for one doctor to rely on another. He should do his own assessment, make sure it's warranted, but it's common in the practice of medicine.
A. Correct.
Q. So if Dr. Kufner schedules a procedure that is warranted in the records, medical records, with a patient, a patient of this type, significance of injury, it's not unreasonable for Dr. Russo to follow that treatment plan, is it?
A. It would be expected that any doctor would want to make their own evaluation and plan to decide on whether that procedure is appropriate. If, for example, one of my colleagues were to ask me to do a procedure on their patient and I felt it was not appropriate, I would not perform it because ultimately I would be the one responsible.
Q. Of course. But if the patient had expressed a reduction in pain from previous procedures to that area and the pain had returned, is there any reason not to do the procedure again?
A. But it would be, again, to take more detail into the specifics of what the procedure was. Should every single thing that was done in that previous one be repeated? And we talked about the areas of fusion. And so could it be a slightly

different procedure? It's ultimately a separate event and needs to be decided at -- with the appropriateness of that particular time.

Q. Between the doctor and the patient?

A. Correct.

Q. And that was in '17, and -- and you gave your opinion just about three years after the fact and claimed, without any specificity in your report, that it was medically unnecessary, is that fair to say?

A. Correct.

Q. And is it probably deemed medically unnecessary because of what you saw Dr. Kufner doing over the course of the last 15 months? Did that impact or affect your decision about that one procedure that he did on 11-16 or the procedure Dr. Russo did on 11-16?

A. It was that individual procedure itself.

Q. Okay. But you -- can you tell me right now what was wrong with that procedure?

A. Which -- which date are you referring to?

Q. Well, Dr. Russo was charged with performing the SI joint injection on 11-16-17.

A. No, I would not be able to answer -- answer that.

Q. Thank you.

And another point that is not clear in your report, over the course -- it lists -- and I'm still on page 29 -- that

Dr. Kufner had been prescribing her Norco, this is Ms. Souligney, Norco 10 four times a day. Number 120, that means four times a day, right?
A. Yes.
Q. Baclofen 10/60. Her MAPS were okay. Do you see those at the -- the top half of the page on 7-20 is what I'm looking at.
A. Correct.
Q. And then down after Dr. Russo has taken over, her Norco is reduced, isn't it? Look at 2-21.
A. Correct.
Q. And actually on 11-16, the date of the procedure, is -- says Norco 10 milligrams, but it doesn't list -- list the --
A. Quantity.
Q. -- quantity, but do you have any reason to doubt me that that was the day that Dr. Russo reduced her medicine?
A. I do not.
Q. So his first day stepping in to do a procedure, Dr. Russo follows Dr. Kufner's care plan with this impossible -- impossibly injured, horrendously injured patient and he reduces her meds, yes?
A. Correct.
Q. Then he performs radiofrequency ablation on 3-14 to DS. Do you see that?
A. Correct.
Q. And that's what's been listed in Counts 35 and 36 of the

government's indictment.

Similarly to what we don't see about why it's not medically necessary, you're not able to tell me what was wrong with that procedure, right, from looking at your report, are you?

A. Trying to understand why it was not bilateral at that case.

Q. Which?

A. On 3-14.

Q. Was that the reason for your opinion, because that's not something that I saw in your report. Is that something you have come up with now?

A. Um, it is one -- one -- the ongoing treatment that I was concerned about for this -- that -- that case.

Q. That's what I assumed.

A. Yeah.

Q. From Dr. Kufner before Dr. Russo even got there, yes?

A. Correct.

Q. And he's not charged with the other procedures, he's only charged with the one on 3-14?

A. Correct.

Q. Are you aware of -- thank you.

A. Yes.

Q. Thank you.

THE COURT: Okay. You're closing in on an hour. Are

you --

MR. MARGOLIS: Really?

THE COURT: Yeah, very definitely.

MR. MARGOLIS: I'll finish, Judge. Thank you.

THE COURT: Okay. Thank you.

BY MR. MARGOLIS:

Q. And those procedures, I don't want to say invasive, horribly invasive, but they're -- they can be painful, right?

A. They can be.

Q. Tell me what, in several seconds for this Court or several -- 30 seconds, why and what kind of pain and what happens to the person from a radiofrequency ablation, sorry.

A. They're a needle-based procedure.

Q. But they're under sedation so the procedure itself shouldn't hurt too much?

A. If they're under sedation, it should be lower in terms of pain.

Q. But it's the pain after the fact that they sometimes feel, is that fair to say?

A. It's generally a soreness.

Q. I thought some people could feel horrible pain for like a week or something after and then it takes -- or couple days and then it takes effect?

A. That's not typical.

Q. Okay. So it's not -- doesn't take a week or two to -- for

the medicine -- or for it to work, the -- the fusion, the -- the burning of the nerves?

A. There's a delayed response. I think that's a different question.

Q. Okay. So they can still feel the pain that doesn't go away from what the procedure is supposed to do until a certain time period?

A. That's true.

Q. Okay. And -- and for a longstanding patient who's in pain, it's not unreasonable for a doctor to give low dose opioid to -- after a procedure like that, correct?

A. On an individual basis, perhaps.

Q. Okay. And that is what in your report you identify a Count 54 against Dr. Russo. You charge him with being -- sorry, you didn't charge him with anything. He is charged with being a drug trafficker for giving that prescription to after the RFA. Do you see page 31 at the top, "The patient received repeated prescriptions for Norco to entice the patient to further undergo, which the patient reported that she only underwent -- each of these was outside the course of" --

THE COURT REPORTER: Wait.

MR. MARGOLIS: Sorry.

THE COURT REPORTER: "... was outside the course of..."

MR. MARGOLIS: "Professional medical practice." I'll

leave it that.
Q. So you kind of group 54 and 55 there. I believe 55 was probably Dr. Kufner's count; I know it was. But you're not saying it's completely unreasonable for Dr. Russo to prescribe a low dose opioid after that procedure, right?
A. We would talk about the quantity of pills, you know. So could you prescribe something for the temporary relief and how long that would be needed for is I guess also discussed.
Q. But part of that was the conclusion about it was given for more injections. Do you see that in there, "for future"? You said further injections, that he gave it on 3-14-18 for further injections. Do you see that "further" word there?
A. Yes.
Q. But if you look at her chart, she didn't have any more injections, did she?
A. Correct.
Q. Dr. Russo never ordered any after that date, right?
A. As -- as far as I know, I think the records also came to an end too if I recall, but I have -- I'll have to go back and look at that.
Q. No, you can speak to the government. There are EMRs at that time.
A. Okay.
Q. So you weren't aware that Dr. Hersh Patel, another doctor, continued to prescribe the same dose that Dr. Russo did? Do

you know Dr. Patel?
A. I do know Dr. Patel.
Q. Have you spoken with him about this matter?
A. I have not.
Q. Have you spoken with him since you've been hired in this case?
A. I have not. Well, I -- let me rephrase that. I've spoken to him but I have not talked about the case.
Q. Are you friends?
A. We are colleagues, yes.
Q. See each other socially?
A. No.
Q. Don't go out to dinner with the fam, with the wives?
A. No, sir.
MR. MARGOLIS: Judge, I'm wrapping up.
THE COURT: Okay.
BY MR. MARGOLIS:
Q. But let me just hone in -- strike that. I can --
MR. MARGOLIS: Let me go consult with my client.
(Brief pause)
Q. You recall after Dr. Russo took over the treatment of Ms. Souligney that they tried to titrate her Xanax down?
A. I actually do recall that, yes.
Q. And that's a good thing, right?
A. Correct.

Q. Thank you.

A. Thank you.

THE COURT: Thank you, Mr. Margolis.

(Excerpt concluded)

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C E R T I F I C A T I O N

I, Linda M. Cavanagh, Official Court Reporter of the United States District Court, Eastern District of Michigan, appointed pursuant to the provisions of Title 28, United States Code, Section 753, do hereby certify that the foregoing pages 1 through 161 comprise a full, true and correct transcript excerpt of the proceedings taken in the matter of United States of America vs. D-1 Rajendra Bothra, D-3 Ganiu Edu, D-4 David Lewis and D-5 Christopher Russo, Case No. 18-20800, on Tuesday, May 24, 2022.

s/Linda M. Cavanagh
Linda M. Cavanagh, RDR, RMR, CRR, CRC
Federal Official Court Reporter
United States District Court
Eastern District of Michigan

Date: June 2, 2022
Detroit, Michigan